How can health systems make healthcare more accessible for populations experiencing homelessness? A realist and policy analysis

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Declaration and Statement of Plagiarism

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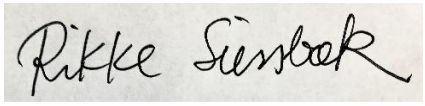

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Dedication

This thesis is dedicated to my grandmothers.

To my Mormor, Inger Mortensen, who always delighted in me and everything I did. She would have had a keen interest in this work and would have been so proud of me. And to my Farmor, Ruth Siersbæk, who had a great love of learning which she passed on to me. Had she been born in a different age, she would have done a PhD of her own.

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Glossary of terms

Context: environments, settings, circumstances or structures that trigger mechanisms. Anything which triggers, impedes or blocks the action of a mechanism (Wong et al., 2013)

Context-mechanism-outcome configuration (CMOC): configuration that explains the causative relationship between a mechanism which is triggered in a given context and as a result produces an outcome (Wong et al., 2013)

Mechanism: a pre-existing, latent causal power or force (eg norms, belief systems, gender, class and sequential processes) which is activated in a particular context leading to an outcome. Mechanisms cannot be directly measured or seen (Wong et al., 2013)

Outcome: impact, change or action arising when a particular mechanism is activated in a particular context (Wong et al., 2013)

Programme theory: a combined set of theoretical explanations of how a particular process, intervention or programme is expected to work (Wong et al., 2013)

Realist approach: the realist approach to research used in realist review and realist evaluation is a theory driven way to explain generative causation in areas of study that are highly complex and in which empirical testing is not possible (Wong et al., 2013)

Relevance: the determination of whether a particular study, report, article etc is relevant to the research question (Wong et al., 2013)

Rigour: the determination of whether a particular finding or piece of information in a given source was arrived upon in a way that was robust and faithful to the particular method being used. If a study was done well adhering to its method it is more likely to be rigorous however all sources of data can yield pieces of helpful information (Wong et al., 2013)

Summary

Problem

Populations experiencing long-term homelessness and complex needs face difficulties accessing healthcare. Prior research has predominantly focused on the individual characteristics that contribute to those difficulties and how to improve access from that perspective. Meanwhile, there is a dearth of research focusing on how health systems can make services accessible for such vulnerable populations. The aim of this thesis is to explain health system factors that impact healthcare access among populations experiencing long-term homelessness and complex needs, and to propose ways to improve access.

Methods

Over three studies, one building on the next, the thesis examines the problem aim from different angles. The first study is a realist review, the second study a realist evaluation, and the third study a policy analysis. Data were collected via systematic and non-systematic literature searching, and via realist and semi-structured interviews. Realist approaches and policy analysis methods were used.

Results

Taken together, the three studies propose important health system factors which improve healthcare access. They found that high-level health system goals have to drive integrated, coordinated and multidisciplinary modes of providing healthcare. To support such delivery of care, services have to be adequately funded and resourced on an ongoing basis to enable practitioners to have the capacity to be flexible and adaptable in how they deliver care, and to build continuing relationships with patients. Appropriate levels of specialisation should be developed so everyone working in health services have a baseline knowledge of characteristics of vulnerable people and how to best engage with them, with some practitioners needing high levels of specialisation which can then be consulted and deployed when needed. The cultures in which healthcare is delivered must be inclusive and trauma-informed.

Conclusion

Health systems create the conditions in which healthcare encounters take place. This thesis has implications for the planning, funding, organising and evaluating of healthcare services in Ireland and internationally to make such services more accessible to populations experiencing long-term homelessness and complex needs.

Outputs

Publications

Siersbaek, R., Ford, J. A., Burke, S., Ní Cheallaigh, C., & Thomas, S. (2021). Contexts and mechanisms that promote access to healthcare for populations experiencing homelessness: A realist review. *BMJ Open*, *11*(4), e043091. https://doi.org/10.1136/bmjopen-2020-043091

Siersbaek, R., Ford, J., Ní Cheallaigh, C., Burke, S., & Thomas, S. (2021). Making healthcare accessible for single adults with complex needs experiencing long-term homelessness: A realist evaluation protocol. *HRB Open Research*, *3*, 73. https://doi.org/10.12688/hrbopenres.13154.2

Conference presentations

Siersbaek R. Contexts and mechanisms that promote access to healthcare for populations experiencing homelessness: a realist review. Pathways from Homelessness 2021 Conference; 10 March 2021; London (online)

Siersbaek R, Ford J, Burke S, Ní Cheallaigh C, Thomas S. Contexts and mechanisms that promote access to healthcare for populations experiencing homelessness: a realist review. Mini-oral and poster presentation presented at: International Realist Conference 2021; 18 February 2021; Dublin (online)

Siersbaek R. Access to healthcare for long-term homeless populations: a realist review. Oral presentation presented at: SPHeRE Conference; 25 February 2020; Dublin.

Siersbaek, R, Burke, S, Ní Cheallaigh, C, Thomas, S. Delivering equitable healthcare access for homeless adult populations: initial findings from a realist review. Poster presented at: SPHeRE Conference; 26 February 2019; Dublin.

Chapter 1 Introduction

1.1 Chapter outline

This chapter introduces the research in this thesis which aims to explain health system factors that impact healthcare access among populations experiencing long-term homelessness and complex needs. Three sequential but inter-related studies seek to explore how health systems can be more accessible to populations with particular vulnerabilities, in this instance – people who experience homelessness and complex needs. The background to the thesis and its three studies is described, and the stage is set for the subsequent chapters by exploring and defining the key concepts under examination in this research: homelessness, healthcare access and health systems.

The research in this thesis takes place in an Irish setting, focused on Dublin where the majority of people experiencing homelessness in Ireland reside. This introduction includes an overview of where and how health services for people experiencing homelessness in Dublin are provided.

Key sections of this chapter include a discussion of the link between homelessness and poor health outcomes, the complex nature of healthcare access, and the decision to apply a health systems lens in the thesis. The three studies undertaken with their aims and objectives will also be introduced in detail and I will discuss my own stand point in relation to the research. The chapter ends with an outline of the thesis.

The three studies are:

1. A realist review of the international literature resulting in a programme theory of how to best make healthcare accessible to populations experiencing homelessness;
2. A realist evaluation, building on study 1 using data collected via interviews with healthcare staff and practitioners in Dublin, which shows that health system fragmentation causes service delivery to be complex and that short-term health system goals and funding cycles negatively impact healthcare accessibility;
3. A policy analysis building on the two previous studies to situate their findings in an Irish setting and to explain how the causal mechanisms uncovered play out in Ireland as influenced by the historical roots of the health system and modern health policy making.

1.2 Background to the thesis

People who experience long-term homelessness often have poorer health outcomes than their housed peers (Aldridge et al., 2017; Luchenski et al., 2018). As a result, they have a need for more frequent and more comprehensive healthcare interventions but at the same time, as a population group, they experience more difficulties in accessing healthcare (Aldridge et al., 2017; Fazel et al., 2014; Luchenski et al., 2018; Ní Cheallaigh et al., 2017; O'Reilly et al., 2015; O'Toole, Buckel, Bourgault, Blumen, Redihan, et al., 2010). As observed by Tudor Hart in 1971, the people who need healthcare services the most often are the ones who receive it the least (Tudor Hart, 1971). This observation still holds true and with extreme and tragic effects for people at the sharp end of inequality, as typified by people experiencing homelessness and complex needs.

Long-term homelessness is often associated with 'tri-morbidity', the presence of mental ill health, physical ill health, and drug and alcohol misuse, which causes and amplifies poor health outcomes and leads to premature ageing and frailty. And yet when people who have frequent healthcare needs are unable to access it, health problems often get worse and compound with each other. If care is thus delayed, when a need is finally addressed, the care needed is often more complex and intensive, and it comes with a greater cost (de Sousa et al., 2018; Hewett et al., 2012; Marmot. et al., 2010; O'Reilly et al., 2015; The King's Fund, 2020). For these reasons, the focus of this research is to understand how healthcare can be made more accessible for populations experiencing homelessness in order to best meet their health needs in an appropriate and timely manner, potentially improving their health outcomes and freeing up resources to provide other care.

This thesis is focused on populations experiencing long-term homelessness and complex needs as an extreme exemplar case of people with multiple disadvantage and complex needs whose encounters with healthcare services are likely to reveal most of the challenges which other deprived population groups encounter to different degrees when accessing healthcare.

1.2.1 Homelessness

Homelessness represents an extreme form of socioeconomic deprivation and social exclusion (Levitas et al., 2007; Ní Cheallaigh et al., 2017). According to the European Typology of Homelessness and Housing Exclusion (ETHOS), homelessness occurs in four ways:

- Rooflessness (sleeping rough, without any shelter);
- Houselessness (having somewhere to sleep but in a temporary shelter or institution);

- Living in insecure housing (eg, insecure tenancies, threat of eviction, violence); and
- Living in inadequate housing (overcrowding, unfit housing, caravans on illegal campsites) (FEANTSA, 2017).

There are numerous subgroups within populations experiencing homelessness, including single adults and families. Some single adults have children, but often their children do not live with them (O'Reilly et al., 2015). It is important to note that there is significant heterogeneity within the homeless population, with a more intense burden of ill-health in chronically homeless adults (O'Sullivan et al., 2020).

1.2.2 Homelessness in Ireland

Homelessness is a significant problem in Ireland. The numbers of individuals and families experiencing homelessness were both on the rise for years prior to the start of the COVID-19 pandemic. The homelessness numbers peaked in October 2019 with a total of 10,519 people reported as accessing emergency accommodation in that month (Focus Ireland, 2021b).

Additionally, evidence suggests that there is an unknown additional number of people in Ireland who are unsuitably housed. These people are not counted in the statistics above because they do not access emergency accommodation (Focus Ireland, 2021a). However, as suggested in the European Typology of Homelessness and Housing Exclusion (ETHOS) (FEANTSA, 2017) described in section 1.2.1, homelessness occurs on a continuum and the official numbers represent only a portion of the actual problem.

Before 2014, family homelessness was uncommon in Ireland but since then the numbers have grown and held steady at approximately 1,600 families accessing emergency accommodation at any given time throughout both 2018 and 2019, with around two thirds of those living in Dublin (Focus Ireland, 2021b). However, during the COVID-19 pandemic, partly due to an eviction ban being put in place, those numbers have fallen dramatically to 932 families reported as accessing emergency accommodation in June 2021 (Focus Ireland, 2021b, 2021c).

Family homelessness is often women's homelessness as homeless families in Ireland are typically single-parent, female-led (Focus Ireland, 2021c, p. 7). During the COVID-19 pandemic, the gap between the numbers of adult women and men experiencing homelessness widened as women's homelessness decreased while men's homelessness held steady, since October 2019, at just below 4,000 (Focus Ireland, 2021b, 2021c). In June 2021, there were 3,886 men reported as accessing emergency accommodation while that same number for women was 1,963 (Focus Ireland, 2021b).

1.2.3 Homelessness and health

Populations experiencing homelessness along the full spectrum in the ETHOS definition discussed above in section 1.2.1 face both poorer health outcomes and more difficulty accessing healthcare than housed populations. However, chronically homeless individuals experience worse health outcomes than those experiencing intermittent homelessness or as a one-off crisis (Argintaru et al., 2013; Fazel et al., 2014; Khandor et al., 2011). Populations experiencing homelessness access primary care less often than housed populations and use costly unscheduled acute healthcare at a higher rate than their housed peers (Fazel et al., 2014; Ní Cheallaigh et al., 2017; O'Toole, Buckel, Bourgault, Blumen, Redihan, et al., 2010).

Populations experiencing homelessness have a much earlier onset of chronic illnesses and multimorbidity than their housed peers (Fazel et al., 2014). They also have a much higher prevalence of problematic substance use and mental ill health (The King's Fund, 2020). They have often experienced childhood trauma and it is common to have encountered several adverse childhood experiences (ACEs) such as violence in the home, the death of a parent, physical or sexual abuse etc (Bramley et al., 2015; Herman et al., 1997; Luchenski et al., 2018). As a result, individuals who experience homelessness often live lives marked by multiple and enduring disadvantage which takes a profound toll and often results in premature ageing, disability or death (Cornes et al., 2018).

Populations experiencing homelessness develop physical frailty and cognitive impairment much sooner than their housed counterparts. A report which measured physical frailty and cognitive impairment in a group 31 of people experiencing longstanding homelessness and complex needs living in supported long-term homeless accommodation in Dublin, estimated their biological age to be 10-20 years older than their physical age (de Sousa et al., 2018).

With all the factors discussed in this section taken together, people experiencing long-term homelessness have extremely poor health outcomes. A study by Ivers et al from 2018 found that the median age at death of a homeless person in the Dublin Region between the years 2005-2015 was 42 years old. Broken down by sex, the median age of death for homeless women was 37 years old and for men was 44 years old (Ivers & Barry, 2018).

1.2.4 Healthcare access

Healthcare access is not just the act of arriving at a health clinic or hospital and walking over the threshold. The degree to which a health service is accessible is not merely due to its opening

hours or the location of a given clinic. These are just two among a range of important and complex set of factors.

Based on the work of Aday and Andersen, Penchansky and Thomas, and Levesque et al, this thesis views healthcare access broadly as a process that takes place on a continuum. To successfully access healthcare, an individual has to be able to conceive of a health need, to feel empowered to do something about the health need, to be able to reach a service and to be able to engage on an ongoing basis to access care continually as needed (Aday & Andersen, 1974; Levesque et al., 2013; Penchansky & Thomas, 1981).

The particular focus of this thesis is on *health system* factors that impact healthcare access for populations experiencing long-term homelessness and complex needs. The framework that is best suited to understand healthcare access from a systems lens is Aday and Andersen's 'A Framework for the Study of Access to Medical Care' from 1974 (see Figure 1). This framework is divided into five areas: 'Health policy', 'Characteristics of health delivery system', 'Characteristics of population at risk', 'Utilisation of health services' and 'Consumer satisfaction'. Where Levesque et al and Penchansky & Thomas' frameworks are focused on the patient journey, Aday and Andersen has an additional layer of health policy and system factors. Here 'health policy' covers financing, education, human resources and organisation, and 'characteristics of health delivery system' covers resources (volume and distribution) and organisation (entry and structure), all of which are key to this thesis (Aday & Andersen, 1974).

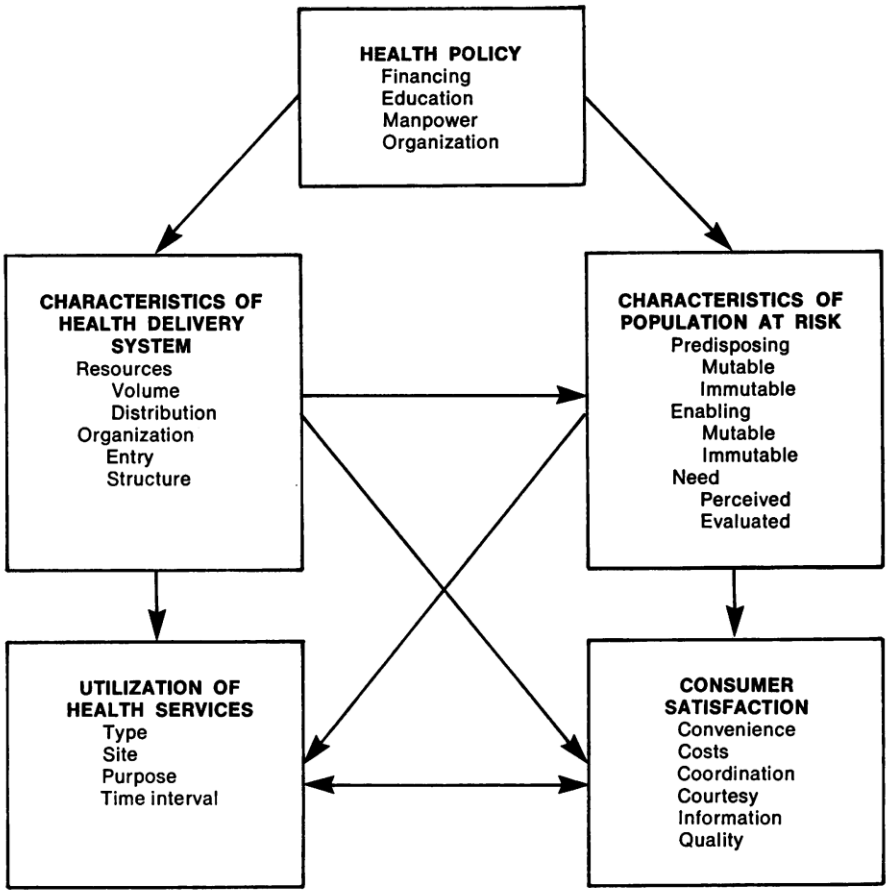

Figure 1 Framework for the study of access (Aday & Andersen, 1974)

Aday and Andersen write that 'health policy' is the starting point for considering healthcare access because this is the domain in which political decisions are made which have a downstream impact on whether, how and to what degree healthcare is accessible. In addition, they state that health planners and policy makers are often concerned with evaluating the effects of different policies on healthcare accessibility (Aday & Andersen, 1974).

Meanwhile, 'characteristics of health delivery system' represent the 'arrangements for the potential rendering of care to consumers' via the resources put into systems and how those are organised. Resources include labour and capital while organisation is 'what the system does with its resources'. Entry refers to how people gain access, for example arriving at a place of care, while structure is used to describe what happens following entry to the system, for example who provides treatment and how.

In addition to using Aday and Andersen's framework to conceive the supply side of the health access equation, the WHO health system building blocks framework discussed below has also

been useful in focusing this work on the high-level system factors that impact on healthcare access, which is the overall lens of this research.

1.2.5 Health systems and healthcare access

Health systems are complex open systems with a multitude of inputs and outputs interacting to produce intended and unintended outcomes, a major goal of which is to provide preventive, curative and rehabilitative care to the people who need it at the right time and at the right place.

The inputs that go into a health system according to the WHO building blocks (Figure 2) are service delivery; health workforce; information; medical products, vaccines & technologies; financing; and leadership/governance. These inputs set the stage for everything a health system is tasked with doing, including making services accessible. The analyses in chapters 3, 4 and 5 will focus on these building blocks and a number of related concepts to conceive the contextual factors in which the stage is set for healthcare access to play out, and to build theories about the ways in which health systems impact healthcare accessibility for populations experiencing homelessness (WHO, 2007).

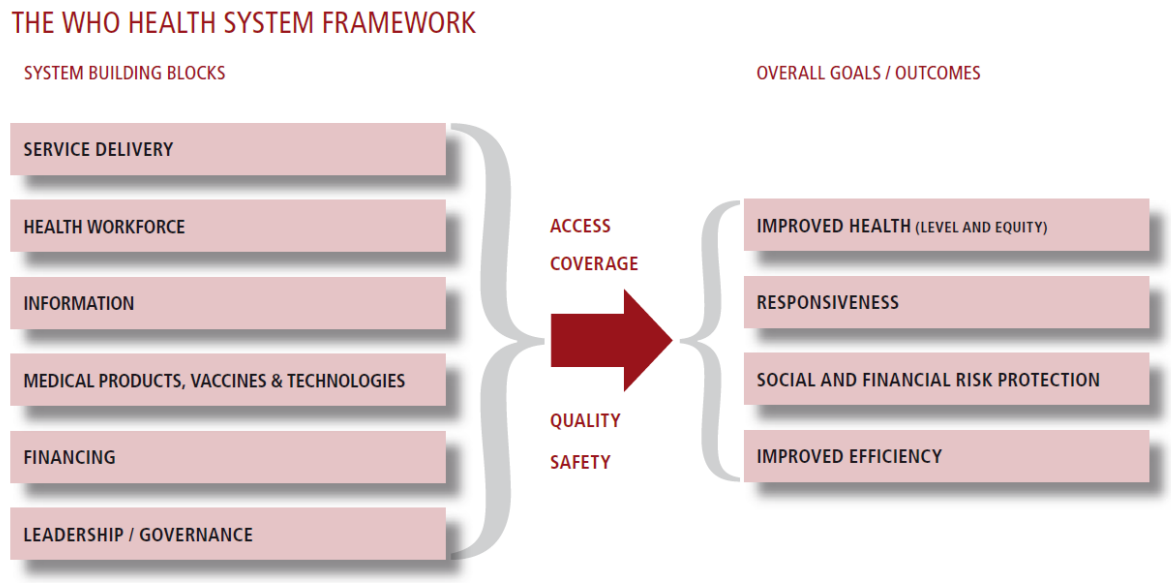

Figure 2: WHO building blocks framework

1.2.6 Homeless healthcare within the current Irish health system

The majority (currently approximately 70 percent) of people experiencing homelessness in Ireland live in Dublin (Department of Housing, Local Government and Heritage, 2021) where the majority of services are also located (Department of the Environment, Community and Local Government, 2015). For that reason, the overview of health services below will focus on those services provided in Dublin in order to set the scene for studies 2 and 3 in particular. The service

provision landscape described below is not meant to be exhaustive, rather it is a brief description of how services are organised and delivered, included in order to provide a sense of the setting in which this research is situated.

1.2.6.1 Primary care

There are a number of ways a person experiencing homelessness can access primary care services in Dublin. They can seek care from a mainstream GP practice for free if they have applied for and received a medical card. Typically one would expect that a person experiencing homelessness would have a very low income and meet the means test to qualify for a medical card of having an income below €184 per week for single people under the age of 66 (Citizens Information, 2021). However, accessing healthcare for this cohort is more complex than formal eligibility and existing research has shown that homeless people in Ireland use relatively less primary care and relatively more secondary care in comparison with housed populations. This is at least partly due to the experience of stigma in mainstream GP settings (Ní Cheallaigh et al., 2017; O'Carroll & Wainwright, 2019).

Because homeless individuals often do not seek out mainstream GP services, a number of specialist homeless primary care services exist to fill this gap (Keogh et al., 2015). In Dublin a specialised GP practice, GMQ Medical, provides free access to a range of general practice services and also provides drug and alcohol addiction treatment. GMQ is primarily funded through charges to the public health system as its patients are typically medical card patients (GMQ Medical, 2017). Another specialised homeless health service, a charity called Safetynet Primary Care, funded by the Health Service Executive's Social Inclusion Division, offers accessible primary care services at their physical location in North Dublin. They also provide in-reach services in a number of homeless accommodation sites and utilise a mobile van through which services are provided several evenings a week at different locations around Dublin. They also provide services to other socially excluded populations beside those experiencing homelessness like asylum seekers, prisoners, and Roma populations (Safetynet Primary Care, n.d.).

An array of homelessness NGOs who offer various services connected to the complex needs of homeless individuals (eg housing, addiction services, daily life supports, counselling, etc) also provide primary care services in some of their locations. For example, Merchants Quay Ireland has a nursing and GP clinic and a dental clinic onsite and also provide mental health services at their location in the south inner city, as well as various drugs and alcohol addiction treatments across the country (Merchants Quay Ireland, n.d.). Depaul Ireland provide onsite primary care services at several of their homeless accommodation sites. They also run a peer advocate

programme that teaches and manages a cohort of people with prior lived experience of homelessness who act as peer advocates with people currently experiencing homelessness when they are accessing health services (Depaul Ireland, 2021). Dublin Simon runs a Health Service Executive Social Inclusion-funded Step-Up-Step-Down intermediate care centre which is a 12 bed unit providing short-term semi-acute medical and nursing care for homeless people either getting ready for a hospital admission or recovering from one (Dublin Simon Community, n.d.).

1.2.6.2 Secondary care

Acute care is provided to anyone in the population in any of the public hospitals around the country free of charge to those with a medical card and with a fee up to a maximum of €800 per year for those without (Nolan et al., 2014). In Dublin, each of the two large city centre hospitals, St James's Hospital and The Mater each employ a specialised inclusion health team which is contacted anytime a person, who is admitted as an inpatient or presents to the Emergency Department, is identified as currently experiencing homelessness or being at risk of homelessness (or if they live in homeless accommodation) (Dublin Homeless Hospital Discharge Oversight Committee, 2019; O'Carroll, 2021).

These inclusion health teams seek to coordinate the care for the person experiencing homelessness and with the aid of the Dublin Homeless Discharge Protocol they start the process of ensuring a successful discharge from hospital as soon as the patient is first admitted (Dublin Homeless Hospital Discharge Oversight Committee, 2019).

With just two hospital inclusion health teams in the city, it stands to reason that a majority of the care provided in acute settings to anyone experiencing homelessness is necessarily provided by clinicians who do not specialise in understanding and meeting their specific needs. Similarly, out-patient care provided to homeless populations, which is typically provided in acute hospital settings in Ireland, is most often provided by clinicians who are not inclusion health specialists. This lack of expertise is reflected in two recent ethnographic studies by Dr Austin O'Carroll focusing on the patient-practitioner encounter as experienced by individuals experiencing homelessness accessing healthcare in Dublin (O'Carroll & Wainwright, 2019, 2021). Interviewees in these studies share experiences of feeling blamed and distrusted by many non-specialist healthcare practitioners.

Hospital settings require patients, including those experiencing homelessness, to navigate large often sprawling complexes to find the right office. Inclusion health teams and peer and/or key

workers from NGOs can be drawn on to assist with navigating health services if the need is known (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; O'Reilly et al., 2015, p. 77).

1.2.6.3 Allied health

With high rates of multimorbidity in populations experiencing homelessness, individual patients often benefit from a range of allied health services including physical therapy and occupational therapy. In the public healthcare system, these services are most often provided in acute settings and so individuals experiencing homelessness have to access such settings to avail of them. Like other secondary care services, these are often provided by clinicians who do not have particular training in or knowledge of the needs of homeless populations (Broderick et al., 2020; Houses of the Oireachtas, 2017, p. 79).

1.2.6.4 Mental health and addiction

There are two dedicated multidisciplinary community mental health teams, one based in North Dublin and one in South Dublin, which are specifically tasked with providing mental healthcare for populations experiencing homelessness. Patients with severe and enduring mental health diagnoses are referred to these teams by primary care clinicians, hostel managers or addiction support workers (Health Service Executive, n.d.).

Additionally there are a number of alcohol and drugs treatment programmes offered by statutory Health Service Executive programmes and through NGOs like Dublin Simon, Analiffey Project and more (O'Carroll, 2021).

Despite the common co-occurrence of mental ill health and addiction, services in Dublin are not sufficiently integrated or coordinated. Treatment for each is generally separate and kept within its own service and professional domain (Proudfoot et al., 2019).

1.2.7 The research gap

There is a large body of international research which examines healthcare access for populations experiencing homelessness from the point of view of the individual person who has a health need (Aldridge et al., 2017; Baggett et al., 2010; Campbell et al., 2015; Cornes et al., 2018; Gill et al., 2013; Hewett et al., 2012; Homeless Link and St Mungo's, 2012; O'Carroll & Wainwright, 2019; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016). Studies have identified barriers at an individual patient level to accessing healthcare related to:

- **Resources** such as access to means of transportation, lack of childcare, difficulty taking time off work, money to pay fees;

- **Knowledge** such as understanding symptoms of illness and the degree to which healthcare interventions can make matters better, awareness of clinic locations;
- **Psycho-social factors** such as lack of trust in healthcare practitioners based on previous poor experiences, fear of health interventions, fear of bad news, fear of a bad outcome;
- **Competing life needs** such as making money, finding somewhere to sleep eg a hostel bed, acquiring substances.

Such research illuminates important factors that inform policy makers and healthcare practitioners about the barriers that individual people face before arriving at a healthcare service in the first place.

On the other hand, there is a dearth of research examining the healthcare access equation from the point of view of the system that is responsible for providing the care. Without the knowledge to understand how health systems make healthcare more or less accessible for populations experiencing homelessness, there is a risk that the focus is placed inappropriately on individual patients both in exploring solutions to problems of inaccessibility but also in placing responsibility and blame on those people who need services and also experience significant vulnerability.

Sniehotta et al (2017) argue that health inequalities will not be eliminated by focusing on either upstream or downstream approaches. In other words, we need to understand both systems' and individual level factors to solve multifaceted problems and, critically, to understand the relationships between patterns of behaviour, practices and actions in complex systems, and how they impact on each other in feedback loops rather than in passive linear flows (Sniehotta et al., 2017).

This research will add to the existing body of literature and contribute to expanding the knowledge base of healthcare accessibility for populations experiencing homelessness by identifying how health systems' planners, managers and leaders can take responsibility for making their services more accessible to vulnerable populations. In turn these learnings can promote easier healthcare access for other populations as well.

1.3 Research aims and objectives

The overarching aim of this thesis is to explain health system factors that impact healthcare access among populations experiencing long-term homelessness and complex needs, and to propose ways to improve access.

The research undertaken in this thesis is divided into three studies:

- A realist review of peer-reviewed review studies examining healthcare access for populations experiencing homelessness;
- A realist evaluation building on the review in study 1 which uses some of the findings from the review as a jumping off point to examine health system goals, fragmentation and funding arrangements in relation to healthcare access for populations experiencing homelessness;
- A policy analysis of 1. the historical background to the policies, priorities and practices which have shaped the delivery of healthcare access for populations experiencing homelessness in Ireland; and 2. the high-level national policies which frame the overlapping areas of practice which influence healthcare access for populations experiencing homelessness: health, housing and addiction.

The aims of the studies are:

- Study 1: To review the published literature to explain how health systems impact healthcare accessibility for populations experiencing homelessness
- Study 2: To examine, building on study 1, how funding procedures and health system performance management impact service settings, staff, and practitioners, and their ability to make themselves accessible to populations experiencing homelessness
- Study 3: To analyse the historical background to conceptions of healthcare access in Ireland as well as to analyse current policies that govern healthcare access for populations experiencing homelessness in Ireland to inform findings and recommendations specific to the Irish health system.

Two of the three studies in the thesis use a theory-driven realist approach in the school of Pawson and Tilley (Pawson, 2006a, 2013; Pawson & Tilley, 1997). The approach was chosen because it is best suited to the research questions and the complexity of the area of study, as discussed in more depth in the following chapters. The two realist studies build on each other with the realist evaluation in chapter 4 taking its starting point in two of the context-mechanism-outcome configurations (CMOCs) developed in the realist review (chapter 3) to analyse a subset of the review findings in more depth.

The third study uses policy analysis to then place the findings from study 1 and 2 in an Irish setting by exploring the historical and policy background to how health services are provided to populations experiencing homelessness. Policy analysis is the method used as it is best suited to answer the questions under consideration. This analysis builds directly on the findings of the

realist evaluation in study 2 in the same way that it builds on the realist review in study 1. The full thesis is designed in this way to have each study build on the one before it, and to together contribute answers to the overarching question of the research here: how and why health systems impact healthcare accessibility for populations experiencing homelessness.

Each study is presented in a similar manner to an academic paper published in a peer-reviewed journal. The only component of a typical journal article they lack is a set of recommendations for future research and for policy makers. These recommendations appear at the very end of the thesis after the studies have been brought together in a unified analysis in chapter 6. Because the studies each build on and add layers of understanding to each other, I chose to leave the recommendations as one combined section at the end.

The focus of the thesis is on explaining how health system factors influence healthcare access at the patient level. The data used for the three studies come from various levels of aggregation because health system decisions have effects at different levels. These include the macro level where national policy, budgeting, and health system planning decisions are made; the meso level where healthcare organisational planning is done and where structures are created, and governance and leadership decisions are made; and finally at the micro level where practitioner and patient interactions take place and where patients' experiences of health services are shaped.

1.4 My standpoint

Views on homelessness and on the equal distribution of healthcare resources are inherently political and as such I find it important to reflect on my views here early in on in this thesis as I am aware of my own bias which has both guided my choice of topic and the way I have carried out the analysis. I reflect again in section 6.6 in the concluding chapter on research reflexivity and my own development as a researcher in this regard, across the course of the work I've undertaken.

Fundamentally, I believe that allowing homelessness to exist in wealthy societies such as the one in which I live is immoral, unfair, unjust and illogical. It is immoral to allow some people to manage their traumas and severe health problems in wholly unsuitable conditions with no stability and little comfort. It is unfair that in the lottery of life some people end up in life circumstances which lead to homelessness, often through no fault of their own. It is unjust when these people are not helped immediately and emphatically to get on the right track to physical, mental, social and spiritual healing. And it is simply illogical to allow some human beings to live lives without their basic needs met when we have the option to change their circumstances but

instead let their suffering go on until they become severely ill and damaged. At such a stage their care is much more expensive and their journeys back to the kind of life they and we all deserve so much more challenging.

More broadly the unequal distribution of healthcare is problematic for many groups in society beyond those experiencing homelessness. The difficulties populations experiencing homelessness face in accessing healthcare is an indication of the difficulties experienced by other groups of varying degrees of vulnerability.

I do not have any first-hand lived experience of homelessness nor do I have clinical or professional experience working with populations experiencing homelessness. To mitigate for this, I have spent time since I started my PhD training attending meetings with health and social care practitioners and various fora including as part of a quality improvement group for the inclusion health service in St James's hospital in Dublin, as an observer to the interdisciplinary group of practitioners who meet weekly in Dublin to discuss individual patient cases, and as an active part of the team which manages the All-Ireland Inclusion Health Forum. In addition to this, I drew on the experience of one of my PhD supervisors who spent five years working as an outreach worker with young people who experienced homeless in Dublin and of another of my PhD supervisors who is a consultant in St James's hospital in Dublin and leads their inclusion health service.

While my basic beliefs are that homelessness is abhorrent, I did not go into this research process with a strong notion of how to best make services accessible to people experiencing homelessness. I have tried to remain very curious and open-minded to understand what makes healthcare accessible and why, as I have encountered various practitioners and people with lived experience of homelessness over the last three years.

Throughout the PhD work, I have checked my findings with a variety of people including my PhD supervisors and independent experts to mitigate potential biases. I have invited comments from people holding different kinds of expertise, with different kinds of life and professional experiences to mine, in respectful and open ways.

1.5 Thesis overview

This thesis consists of six chapters and is based on three studies. The first chapter is the introduction which sets out the rationale for the programme of study, the research questions and provides some background and definitions on key concepts in the thesis: homelessness and health, healthcare access, and health systems.

The second chapter describes the methodology, which in this thesis is partly based on a realist approach in the school of Pawson and Tilley (Pawson, 2006a, 2013; Pawson & Tilley, 1997). It describes the realist approach and the ontology and epistemology it builds on. It also describes policy analysis and documentary analysis, which are the methods used in the third chapter. Additionally, it discusses why realism was the appropriate approach for studies one and two and why policy analysis was the right method for study three.

Chapter three encompasses the first study in the thesis: a realist review of health system factors which impact access to healthcare for populations experiencing homelessness and complex needs. The chapter describes the full study from start to finish, covering two rounds of literature searching, iterative analysis, synthesis and theorising, and presents a coherent final programme theory which brings together all the findings at a high level of abstraction. Most sections in this chapter are the same as sections of an article which I published along with my PhD supervisors in the BMJ-Open earlier this year.

In chapter four, building on chapter three, the second study is a realist evaluation examining the impact of the length and source of funding cycles and performance management measures on whether or not health systems are accessible to populations experiencing homelessness. Like the realist review, this chapter outlines the particular approach that was taken in conducting that study including explaining the data collection approach, iterative analysis, synthesis and theorising, and the development of a final coherent programme theory.

Chapter five, building on chapters 3 and 4, explores the historical background that has shaped the way healthcare is provided to populations experiencing homelessness in Ireland, as well as an analysis of current Irish policies governing healthcare access for homeless populations. It places the findings of the realist studies in a specifically Irish setting.

Chapter six presents a unified synthesis of the two realist studies and the policy analysis. It then provides a discussion of the thesis as a whole, including the findings of the three studies and their strengths and limitations, as well as reflections on the use of realist and policy analysis approaches. It finally suggests policy and practice implications and ideas for future research.

The below figure (Fig 3) shows the outline of the thesis:

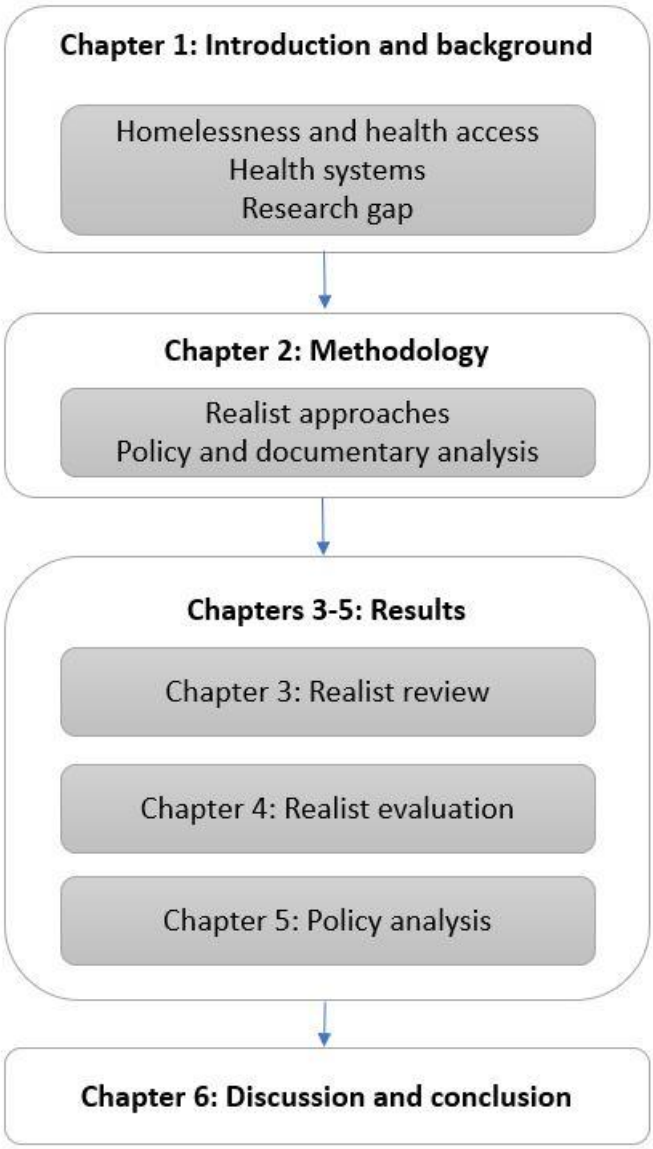

Figure 3: Thesis overview

Chapter 2 Methodology

2.1 Chapter outline

In this chapter I outline the methods used in this thesis. I first describe realist approaches as used in realist review/synthesis and realist evaluation in the school of Pawson and Tilley (Pawson, 2006a, 2013; Pawson & Tilley, 1997) as used in studies one and two. I explain the ontology and epistemology underlying the approach and the kinds of research questions the approach is particularly suited to, for example the study of social phenomena where causality cannot be directly measured or observed, and situations and interventions that are complex. I discuss how realism conceives of causality and the concept of emergence. I next explain how

realism works in practice by detailing how research is carried out through the development of programme theories, using iterative research designs.

I also explain the policy analysis methods used in study three and the rationale for the study. Analysis of historical and recent policies relevant to healthcare access for populations experiencing homelessness in Ireland is carried out with a view to devising findings and recommendations specific to the Irish health system. The policy analysis also facilitates further explanation and application of the findings from the realist studies and identification of factors which influence the Irish contexts in which people experiencing homelessness access (or do not access) healthcare.

Much of this chapter is dedicated to explaining realist approaches. Understanding these and gaining an expertise in using realism was a large part of the work I undertook to produce the research presented in this thesis. As such, I have focused on explaining them for the reader as they are not as well known or established, or perhaps as intuitive to a non-expert as policy analysis is.

2.2 Realism in the school of Pawson and Tilley

There are several of schools of thought and research approaches that are called 'realist' or have 'realist' or 'realism' in its name. A prominent orientation in realist research is critical realism which is based on the work of British philosopher Roy Bhaskar who introduced key features of a realist understanding of the world such as a view of reality as being 'mind-independent' and the basic ontological interpretation of the world as existing in three domains: the real, the actual and the empirical (Gorski, 2013; Maxwell, 2011) – see more in section 2.2.2 below. Realist research builds on Bhaskar's work but in this thesis, I am using the particular branch of realism, sometimes called scientific realism, in the school of Pay Pawson and Nick Tilley as described in their seminal work *Realistic Evaluation* (Pawson & Tilley, 1997) as well as in *Evidence-based policy* (Pawson, 2006a) and *The Science of Evaluation: a Realist Manifesto* (Pawson, 2013) written by Pawson alone.

Realism in the school of Pawson and Tilley is a 'general logic of social science . . . a tool for understanding how social programmes work and . . . a framework for understanding their complexity' (Pawson, 2006a, p. 73). It is a 'methodological orientation, or a broad logic of inquiry that is grounded in the philosophy of science and social science' (Pawson, 2006a, p. 17). They consider it the 'principal post-positivist perspective, whose place is at the centre of things where it steers a path between empiricist and constructivist accounts of scientific explanation' (Pawson, 2006a, p. 17).

In other words, realism is not a method as such. Rather it is an approach to research based on an ontological and epistemological standpoint which makes use of data generated from any method. Rycroft-Malone et al explain it as follows:

> One of the strengths of realist review is the approach's firm roots in philosophy and social sciences. Rather than being a method or formula, it is a 'logic of enquiry', which enables a flexible, all-embracing approach to explanation of what works for whom in what circumstances and in what respects. Rather than controlling for real life events, realist synthesis provides a framework for working with and untangling the complexity of real-life implementation (Rycroft-Malone et al., 2012).

Acknowledging that social systems are open systems with constant variability, produced by endless components and forces, realist work is built on 'a common understanding of some very basic building blocks of social science, such as the nature of causation, the constitution of the social world, the stratification of social reality, the emergent nature of social change and so on' (Pawson, 2006a, p. 18).

According to Pawson and Tilley, realism 'avoids the traditional epistemological poles of positivism and relativism' (Pawson & Tilley, 1997, p. 55), instead sitting in the middle between positivism and constructivism.

Where much of natural science research relies on the positivist idea that what can be measured is what can be proven to exist and to cause things to happen, social science research, Pawson and Tilley argue, cannot use a similar positivist paradigm to measure and understand causation. A medical experiment might attribute a given effect to an intervention if the intervention group experiences a given change between the pre- and post-intervention tests while a control group does not. In that case, a researcher can infer that the intervention has caused the outcome seen in the intervention group based on the succession of events: pre-test, intervention, post-test, outcome (Pawson & Tilley, 1997, pp. 32–33).

However, drawing conclusions regarding causality based on the succession of events does not work well when looking at socially determined phenomena such as healthcare accessibility or homelessness or health systems which are the topics of this thesis. This is because there is no neat and bounded way to isolate the treatment effect in a highly complex social system. In understanding causality when studying these phenomena, generative theory helps us understand causal relationships which we cannot measure, where an internal feature changes due to liabilities or powers within the social systems and in individuals. One reaction may well trigger another, as in the successionist explanation above, but only under certain circumstances (Pawson & Tilley, 1997, p. 34). For example, a person may experience a healthcare facility as

hostile because they are homeless and there is societal stigma against people experiencing homelessness. A housed person will not experience that same hostility. When seeking to understanding causality in the experience of hostility in a healthcare facility one cannot simply do a pre- and post-test. One has to understand the social and cultural forces at work and the 'liabilities, powers, and potentialities of the programs and subjects whose behaviour it seeks to explain' (Pawson & Tilley, 1997, p. 34).

Additionally, using a positivist approach in social science research does not produce an understanding of the intervention itself – why it works or does not work, for whom it works or does not work, in what circumstances, to what extent, and so on. Pawson and Tilley call this the 'black box problem' – the intervention is a black box and positivist research approaches produce only descriptions of outcomes, not an understanding of why programmes work or not (Pawson & Tilley, 1997, p. 20).

At the other end of the spectrum, constructivists argue that the nature of reality is dependent on our ability to observe it and is as such shaped by the human consciousness that analyses it. Pawson and Tilley argue that this is not correct either when explaining social phenomena and causality within them because it does not acknowledge that there are forces in the world which are real and act in the social world free of human interpretation (Pawson & Tilley, 1997, pp. 17–18).

Rejecting both positivism and constructivism, Pawson and Tilley argue both that there is a reality that is independent of our ability to observe it and that there are many features of that reality which cannot be objectively measured, as discussed in the next section.

Scientific realism also questions the notion of the hierarchy of evidence in evidence-based medicine, often rendered as a pyramid, where systematic review and meta-analysis sits at the top as the highest, most valid form of evidence for use in healthcare practice, followed by randomised control trials, then cohort studies, then case control studies and finally case series/report studies which is considered to be the weakest, least valid study design (Murad et al., 2016). Pawson argues that standardisation of procedure and the ability to replicate a study as is the case in systematic review methodology, does not guarantee a valid result. He says that this is because it is impossible to make every single decision made across a piece of research synthesis transparent – some degree of judgment and intuition is involved in every stage of an evidence synthesis of any method (Pawson, 2006a, pp. 51–55; 181–182, 2006b).

2.2.1 Ontology and epistemology

Scientific realist ontology in the school of Pawson and Tilley rests upon a specific understanding of reality namely that there is an external reality independent of the ability of humans to observe it. Further, because we know we cannot directly observe all of reality, the conceptualisation of ontology also posits that there are various levels of reality, which can impact on each other (see more in 2.2.2) (de Souza, 2014; Greenhalgh, Pawson, Wong, et al., 2017a; Jagosh, 2020; Pawson & Tilley, 1997, pp. 63–65).

With that in mind, scientific realist epistemology posits that there is no final truth and that humans have no ability to fully grasp reality. However, we can understand parts of reality and keep adding to that knowledge through theory building and theory testing (Williams, 2018).

2.2.2 Levels of reality

Realism builds on the ontological idea proposed in critical realism of social reality being stratified into three overlapping levels: the empirical, the actual and the real. *The empirical* domain is that which we can observe and measure empirically. *The real* is the domain where latent powers (mechanisms) reside and *the actual* is the level of reality where these forces are activated leading to causal outcomes which can be measured in *the empirical* domain. The hidden layers of reality, *the actual* and *the real*, exist independent of our ability to observe them. They represent a 'mind-independent' reality (de Souza, 2014; Greenhalgh, Pawson, Wong, et al., 2017a; Jagosh, 2019).

Therefore, in realist research, we view anything that has an effect on the social world as being a *real* force that exists in the world even if it is hidden from our perception. For example, a healthcare organisation could be trauma informed and have a culture which promotes an understanding of the impact of social exclusion on populations experiencing homelessness. In such a context, a causal power or mechanism arising might be that staff act empathetically and use their knowledge and expertise to understand clients' needs and behaviours because they understand their life experiences. The mechanism is hidden but still has a real effect that is produced in the specific context in which these health practitioners work which embraces the notion that trauma has a real and lasting impact on people, and needs to be understood and accommodated.

This will happen with some regularity and in patterns we can describe but it will not always happen because causal patterns in the social world are subject to many different generative

forces. Realist research is designed to detect the causal powers and the contexts in which they activate and to analyse the outcomes they produce (Pawson, 2006a, pp. 21–22).

The notion that reality is 'mind-independent' is based on the idea that the social and the natural world are both inter-dependent with, and independent of, our understandings of them. In realist research it is understood that humans are inter-dependent with the world in that we can affect natural and social systems and be affected by them. Realist research also understands that natural and social systems exist and exert their own power independent of human judgement and understanding of them (Greenhalgh, Pawson, Wong, et al., 2017a). As an example, in a context where a healthcare system is dominated by a culture that is stigmatising and suspicious of people who experience homelessness, stigma is a social construct and a causal force which can cause healthcare staff to be dismissive of patients, have poor communication skills, be unmotivated to help etc. And in that case, stigma is not just a construct in the individual practitioner or staff member's own consciousness. It is the result of a shared set of values and beliefs that many people in society agree to and as such is a real force which is mind-independent and which has real effects. A person can stigmatise another without fully understanding or subscribing to the constellation of judgements which are ascribed to a person experiencing homelessness.

As indicated in the examples in this section, in this thesis, realist review and realist evaluation approaches are used to move beyond descriptions and rather to theorise about the causal, generative mechanisms that underlie the actions taken by policy makers, managers and practitioners in health systems in relation to making healthcare accessible. In this research, their actions are seen as resulting from causal mechanisms which arise in complex social contexts.

2.2.3 Complex social programmes

Interventions in health and social care are not free-standing entities that operate alone, context-free. Rather they are implemented and function within existing complex social and open systems. Complex social systems such as healthcare systems, comprise a complex interplay of individuals, policies, structures, and institutions with social processes occurring at different societal levels from micro to macro (Gilson, 2012; Pawson & Tilley, 1997, p. 63). Researching open systems is a complex and messy undertaking which researchers often seek to manage by creating research designs which are better suited for closed systems while artificially attempting to isolate a section of an open system (Pawson, 2006, p. 18). In the realist view of the world this is not a useful approach as 'social interventions are always *complex systems thrust amidst complex systems*' (Pawson, 2006a, p. 35).

Unlike other review and synthesis methodologies such as systematic review and meta-analysis, which rely on the assumption that the same programme can be carried out in various locations and the outcomes of each implementation can be compared, realist reviews assume that interventions are not reproducible as they will always be implemented in different contexts. Realist research therefore looks at similar kinds of programmes or research or data to build and test theories about underlying causal mechanisms that may be at play across various interventions to create particular outcomes. These may be from a similar field or a different field of study - as long as the mechanisms are similar, research from a different field may help to inform a realist inquiry especially if little previous research has been carried out (Pawson, 2013, pp. 83–84).

In attempting to gather and synthesise evidence about an intervention or programme that operates within complex social systems, according to Pawson et al (2005) the problem is one of complexity: 'in health services and other public services, we are dealing with complex social interventions which act on complex social systems'. Realism attempts to work *with* the complexity to generate understanding of complex social programmes or areas of study by focusing on explaining how, for whom and to what extent something works rather than isolating particular factors to judge whether something works of not. It is an approach which 'learns from (rather than controls for) real-world phenomena such as diversity, change, idiosyncrasy, adaptation, cross-contamination and programme failure. It engages stakeholders systematically – as fallible experts whose insider understanding needs to be documented, formalized and tested, and provides a principled steer from failed one size-fits-all ways of responding to problems' (Pawson et al., 2005).

According to Ray Pawson (2013) complex programmes are characterised by the following features (acronym VICTORE):

- **Volitions**: the outcome of a programme will depend upon how participants respond to the intervention – 'subjects respond under different motives and at a different tempo' (pp34-35)
- **Implementation**: the implementation chains of a programme are long both in terms of the actors involved at different parts of a social system and the action taken by those actors (eg the experience of a patient traveling through a patient pathway from primary care consultation, to tests, to waiting times, to a potential specialist appointment, to more waiting, to potential treatment and follow up, etc). As a result, implementation chains 'are prone to inconsistency and reinterpretation, blockages, delays, and

unintended consequences' and they are often 'sites for contestation and sometimes they are thrown in into reverse as one responsible group chooses to ignore or countermand the expectations of their predecessors in the chain' (pp35-36)

- **Contexts**: the context of an intervention refers to the circumstances in which it takes place. Layers of context are 'infinitely complicated, intertwined and in motion' (pp36-37) (see more on 'context' below in section 2.3.2)
- **Time**: an intervention's history, timing and sequencing contributes to complexity because the intervention does not represent a clean slate but will be affected by an organisation's culture and existing practices which have developed over time, and phenomena such as path dependency (pp37-39)
- **Outcomes**: complex programmes have multiple intended and unintended outcomes – a simple pre- and post-test paradigm is seldom enough. Measurement of complex social outcomes is difficult, and outcomes do not speak for themselves and interpretations can vary. What gets measured changes the behaviour of programme providers and participants (pp39-40) (see more on 'outcomes' below in section 2.3.4)
- **Rivalry**: complex social programmes are not implemented in a vacuum. Typically, programmes develop and change over time while co-existing with similar and overlapping programmes relying on similar causal mechanisms to solve similar problems. Programmes borrow ideas from each other making it difficult to attribute a particular effect to a particular complex social programme. Additionally, complex policy systems may have a number of goals some of which individually may clash (pp40-42)
- **Emergence:** the idea that complex social programmes made up of many components and actors, produce emergent effects when components of a programme or in a system combine or act on each other to produce new components which are more than the sum of their parts (pp42-43) (Pawson, 2013)

2.2.4 Causation

A key feature of realist research is the search for causation and a central goal of realist inquiry is to understand what is causing something to happen in the social world, while also understanding that mechanisms firing in a given context cannot be observed. Therefore, we must theorise about what is happening based on either primary or secondary data.

Many positivist study designs rely on explaining causation by taking a measure, conducting an intervention and then taking a second measure. The effect of the intervention is ascribed to any difference between the pre- and post-test. However, scientific realism contends that the

interventions in the social world typically are too context-dependent to say that an observed effect is necessarily the result of the intervention. Social interventions are 'black boxes' with too many different things going on to possibly ascribe simple causality to them. Rather realist research is interested in understanding what goes on inside the black box. In other words, scientific realism is interested in explaining how and why generative causation happens rather than to say that it does or does not (Pawson & Tilley, 1997, pp. 59–63).

The basic realist equation is written as context + mechanism = outcome or C+M=O. The theory behind generative causation posits that causal mechanisms hold the *potential* of transformation at the level of the real. In the realist equation the causal power lies with mechanisms which are the latent powers in the social world which are triggered in some contexts and not in others. When they are triggered, they cause an outcome to happen but only in the right conditions. Examining these causal relationships provide the means for explaining social phenomena both when an outcome arises and when it does not (Pawson & Tilley, 1997, p. 34). I will provide more detail about what is meant by context, mechanism and outcome below in sections 2.3.2, 2.3.3 and 2.3.4.

Causality in a social world shaped by complexity depends on a web of factors which is why the same intervention may have wildly different outcomes in different contexts. Pawson explains:

> A mass of different contextual constraints lurks in wait for every programme and the interrelationships, institutions and structures in which it is embedded all sap its fortune. Despite the differences in such circumstances, it is possible to provide a general picture of how context works. It operates by constraining the choices of stakeholders in a programme. Programme subjects are always faced with a choice, but it is both a well disposed and a loaded one. They have different pre-given characteristics that leave some well disposed and some badly disposed, to the programme theory. They enjoy different pre-existing relationships that leave some well placed and some ill placed to take up the opportunities provided by the intervention. They come to programmes with power, or lack of it, which enables some to resist and some to embrace the ideas of the programme. There is always a choice but it is never a matter of free will. Programmes are met with constrained choices, located in pre-existing conditions, and these, as well as the processes internal to the interventions, determine the balance of winners and losers (Pawson, 2006a, p. 25).

Central to realism is that it does not purport to find causal patterns which always occur in a given context. Rather, realist research uncovers patterns which occur with some regularity, some of the time, and in a way we can predict through theorising. Some causal mechanisms work in a particular setting for a particular group and in another setting for another group. When we can analyse what works for whom in what settings, we have an opportunity to create and tailor interventions to best produce intended outcomes with some regularity. Realists use

the term ‘demi-regular’ outcomes to describe these patterns of causality and outcome (Pawson, 2006a, pp. 21–22).

2.2.5 Emergence

Another important concept used in realist research is that of emergence, which is the last item in the VICTORE acronym discussed above in section 2.2.3. Emergence is the idea that the ‘components in a system will often combine to produce novel components, thus continually changing the composition of the system under investigation’ (Pawson, 2013, p. 42). In other words, the whole of a complex social programme adds up to more than the sum of its parts. When a programme is introduced into an existing setting, it will interact with that setting and the people in it, and will trigger a variety of mechanisms which produce intended and unintended outcomes in long implementation chains which do not follow neatly along a linear progression but spiral out in a variety of directions. Interventions seek to produce change in outcomes but as they do, they may also change the conditions the intervention is built upon in the first place (Pawson, 2013, p. 42). As a result, things emerge through a compounding of effects. Elder-Vass explains: ‘An “emergent property” is one that is not possessed by any of the parts of the entity individually, nor when they are aggregated, without a structuring set of relations between them’ (Elder-Vass, 2005). For example, a health system is made up of many parts including healthcare practitioners, physical structures, equipment, software, policies etc but together these parts amount to something more than just their sum – together they emerge as a whole and complex social system.

Furthermore, each component part plays a specific role in relation to the other component parts. One part cannot simply be replaced with another without changing the whole (Elder-Vass, 2005). For this reason, in realist work, configuring the relationship between contexts, mechanisms and outcomes is a key step in the analysis. A significant portion of the literature that is published with the label ‘realist evaluation’ or ‘realist review/synthesis’ provides lists of unconfigured contexts, mechanisms and outcomes. Causality, however, can only be demonstrated in particular configurations showing the specific context in which a given mechanism fires to produce the outcome of interest (Pawson, 2013, pp. 21–27).

2.2.6 Abstraction

Realist work moves up and down levels of abstraction from being very close to the data in the initial stages of building context-mechanism-outcome configurations to ideally end up with a refined programme theory as a final product which explains a programme at a high enough level of abstraction that it can be transferred to different contexts (Pawson, 2006a, p. 76).

Geoff Wong's graphic representation below (Figure 4) provides a visual representation how abstract theory builds on many pieces of data which are close to the observed phenomena:

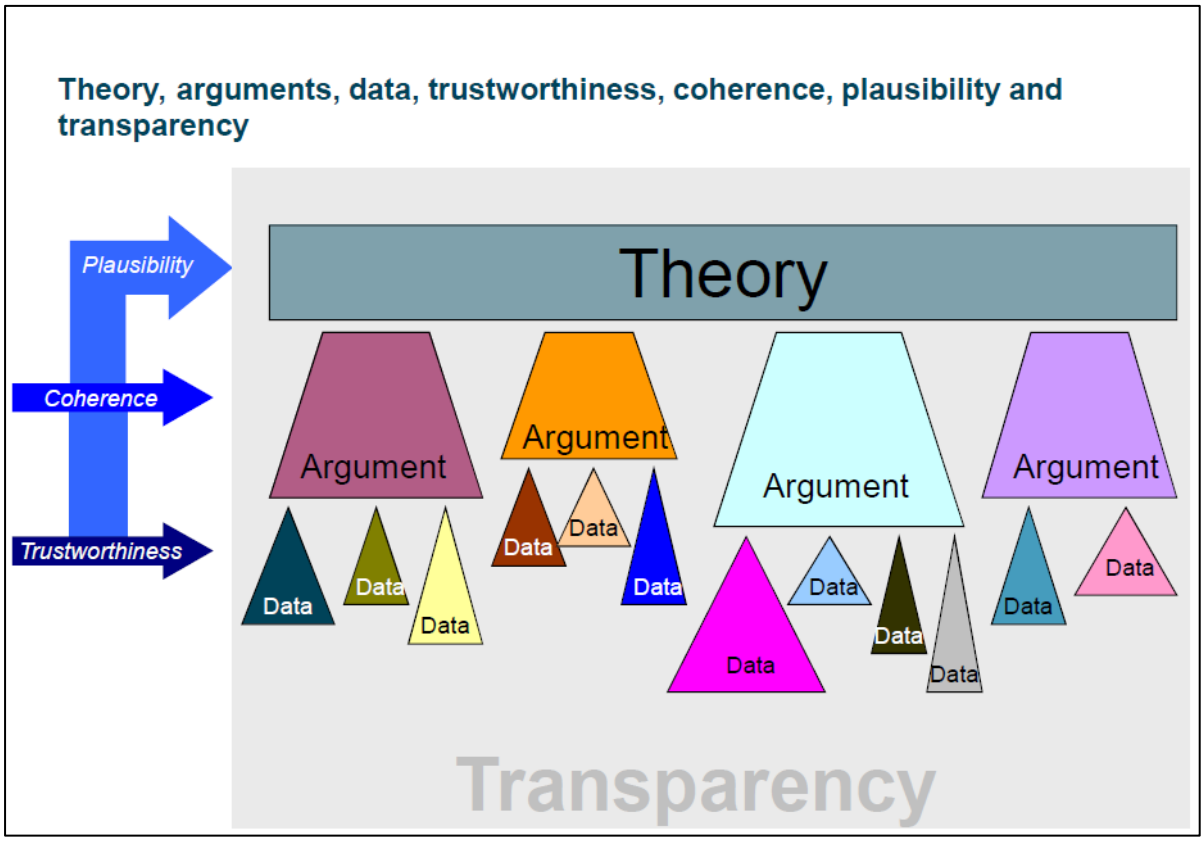

Figure 4: 'The relationships between theory, arguments, data, trustworthiness, coherence, plausibility and transparency'- (Wong, 2018)

Abstraction allows researchers to explain general processes and patterns of outcomes which can be used to 'elucidate many different empirical instances' (Pawson, 2013, p. 89) and it allows us to transfer explanations from one very specific area of study to others using causal generative theorising.

Terminology for describing theories at different levels also hint at the need to provide explanations at different levels of abstraction. Formal theories or substantive theories describe general conditions that apply across many different domains and which sit at a high level of abstraction, for example Attachment Theory in human development. Programme theory is situated closer to the data that the theory builds on and can be tested empirically (Greenhalgh, Pawson, Wong, et al., 2017b). CMOCs are building blocks for explanation which can be put together to create programme theory which sits at a higher level of abstraction (Marchal et al., 2018).

2.2.7 Programmes as theories

As discussed above, when we move a realist analysis to higher level of abstraction, we begin to see that the same theory can illuminate and explain causal mechanisms at work in a number of different settings. In any society there are myriad social, health and public policy initiatives which are meant to correct any number of societal challenges to bring about positive change. For example, when we look beyond the specific details of a given programme such those which encourage people to cycle to work by subsidising the cost of bikes; or promote physical activity by building exercise equipment in parks; or promote testing for communicable diseases by offering a monetary reward; or promoting the use of public transit by offering subsidised bus passes to school children, we see similarities. These types of programmes are all offering an incentive for people to behave in ways that are considered beneficial to society or to individuals.

The term 'programme' is used in realism not just to describe a specific intervention which employs specific tools to achieve a given outcome. Rather 'programmes' can refer to anything that is being done in a social system to produce an outcome. For example, the procedure of speaking to the secretary at a GP surgery before going to the waiting room is a programme which is organised to ensure, say, that the GP is aware that a patient has arrived and that any information about the patient which needs updating can be collected. However, this procedure is not likely to be conceived of as a 'programme' – it's just part of the normal running of the surgery.

Programme theory then is a theory about how something under study works. According to Davidoff et al theory is always at work in the programmes or interventions: 'although informal theory is always at work in improvement, practitioners are often not aware of it or do not make it explicit. The germane issue for improvement practitioners, therefore, is not whether they use theory but whether they make explicit the particular theory or theories, informal and formal, they actually use' (Davidoff et al., 2015).

Realist analysis is not then focused solely, or sometimes at all, on the specific aspects of a specific formal 'programme' under examination but on the underlying mechanisms that programme architects have employed under the assumption or theory that a specific outcome will be produced as a result. The theory of what that programme or action will produce, or 'programme theory', is the unit of analysis in a realist analysis. The central aim then of realist research is to analyse the 'process of policy abstraction and theory building rather than data extraction and number crunching' (Pawson, 2006a, p. 78).

A consequence of theory being the unit of analysis in realist research is that the kinds of evidence that is useful in building theory are more diverse than what is used in other methods. Where a systematic review will look at a number of primary studies to pool their results based on primary data to answer the question of whether something works or not, a realist review includes data that speaks about an intervention but also what goes on around the intervention – the context in which it was implemented, the response it generated in participants, who it worked for and not, to what extent and why (Pawson & Tilley, 1997, p. 164).

In addition to being a useful way of understanding something of the social world, the focus on theory in realist research is important when looking beyond the academic exercise itself toward policy influence. Rather than presenting data and findings which a policy maker must then interpret, realist conclusions of research are presented in an explanatory manner. Pawson says of programme theories that they 'are not simply evidence, they are explanations. They bring to life the reasoning to be gone through in making decisions' (Pawson, 2006a, p. 169).

2.3 Developing programme theories

With a focus then on developing useful explanations, the goal of realist research is to build explanatory programme theories that cast a light on causal mechanisms which produce the outcome of interest in a given context. Realist research is theory driven in that the unit of analysis is not data but theory – the effort of explaining and configuring causal relationships (Pawson, 2013, pp. 83–84).

While programme theories are explanatory frameworks, a key assumption in using the realist approach is that these explanations are based on partial knowledge and they will never be full and complete. Evidence is a 'never-ending network of conditionalities and contingencies' (Pawson et al., 2011) and as researchers we have to live with the fact that we will never be able to definitively describe how a complex social programme works or why. But programme theories work toward answers and explanations and give policy makers a foundation from which to understand the complexity, contingencies and conditionalities of the social world, and researchers then keep adding to that knowledge (Pawson et al., 2011).

A key challenge in conducting realist work then is to be willing to live with the knowledge that there is no final and clear answer at the end of a long research process. Flexibility and being able to accept uncertainty and unknowns are necessary to some extent. Narrowing the scope of a study and iteratively building on previous findings is a way to make it more manageable (Marchal et al., 2018).

2.3.1 Context-Mechanism-Outcome Configurations

Developing and building theory starts with the basic components of realist analysis: context, mechanism and outcome. Crucially, contexts, mechanisms and outcomes have to be configured into explanatory statements ('context mechanism outcome configurations' or 'CMOCs') that highlights the generative causal theory positing a particular interconnectedness between each element (Marchal et al., 2018; Pawson, 2013, pp. 21–27). A CMOC 'is a hypothesis that the programme works (O) because of the action of some underlying mechanism (M), which only comes into operation in particular contexts (C)' (Pawson, 2013, p. 22). This is often rendered as C+M=O. Below is the explanation of how context, mechanism and outcome are understood in this research.

2.3.2 Context

Context refers to the circumstances in which an intervention or a phenomenon of interest plays out. It is sometimes misunderstood to be just the setting of an intervention such as a clinic or the specific resources offered by an intervention such as a new piece of equipment or a new procedure, but it is much more than that. It is everything contained in an intervention and everything that was there before which has an effect on the intervention (Wong et al., 2017). Pawson offers 'the four Is' to encompass all the complex aspects of context:

- Individuals – the characteristics and capabilities of the various stakeholders in the programme
- Interpersonal relationships – the stakeholder relationships that carry the programme
- Institutional settings – the rules, norms and customs local to the programme
- Infrastructure – the wider social, economic and cultural setting of the programme (Pawson, 2013, p. 37)

2.3.3 Mechanism

Closely linked with context is the mechanism. Mechanisms are the key generative causal power which bring about an outcome if activated in the right context.

Pawson and Tilley speak about 'underlying mechanisms' as a useful metaphor for explaining the level of stratified reality at which mechanisms operate which 'captures the idea that we often explain how things work by going beneath their surface (observable) appearance and delving into their inner (hidden) workings' (Pawson & Tilley, 1997, p. 65).

Astbury and Leeuw explain: 'mechanisms are underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest' (Astbury & Leeuw, 2010). They propose three essential characteristics of mechanisms: '1. Mechanisms are usually hidden; 2.

Mechanisms are sensitive to variations in context; and 3. Mechanisms generate outcomes' (Astbury & Leeuw, 2010).

2.3.4 Outcomes

Outcomes result from the activation of a mechanism in a given context. Outcomes can be intermediate or final, intended or unintended. Outcomes typically occur in patterns where a specific mechanism triggered in a given context will produce a given outcome with some regularity but not always because the social world has endless variation (Pawson, 2006a, pp. 21–23).

2.4 Operationalising realist approaches

This section will give an overview of the general outline of steps undertaken in a scientific realist study to give a sense of how one takes the philosophy and principles outlined above and turn them into a way to do research.

2.4.1 Iterative research design

Scientific realist research is iterative as indicated in the below diagrams of a realist review (Figure 5) and a realist evaluation (Figure 6).

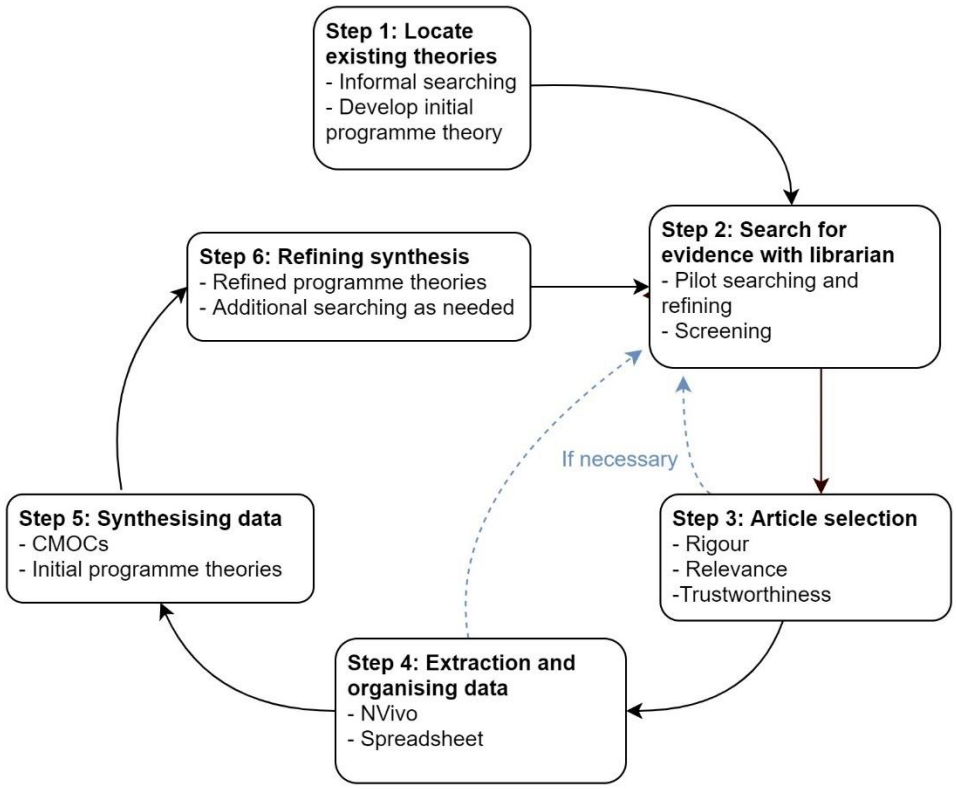

Figure 5: Stages of a realist review

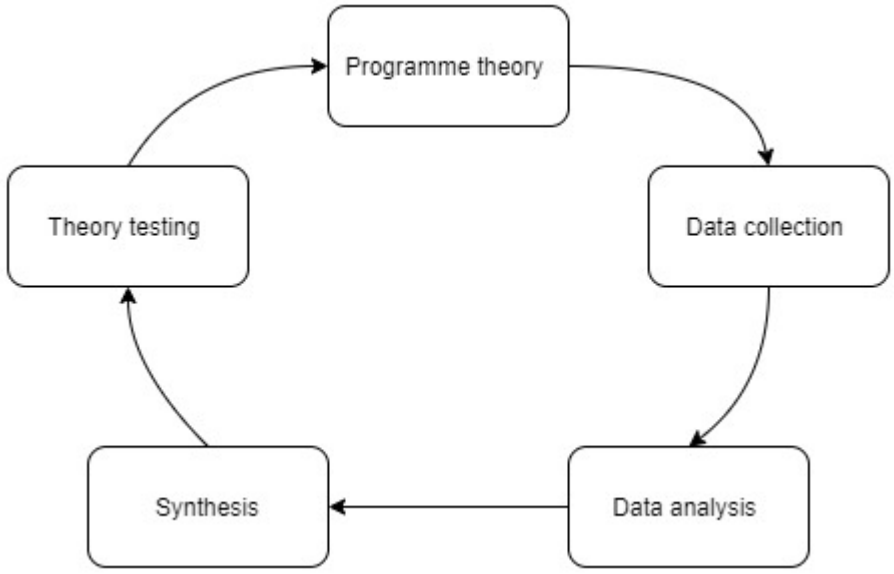

Figure 6: Stages of a realist evaluation

In each instance, the work starts and ends with theory. An initial theory is developed based on prior knowledge of the field of study, initial scoping reading, and consultation with experts such as programme architects, planners, practitioners and clients. Based on the initial theory, data are either collected via primary data collection methods in the case of realist evaluation or via systematic searching of the published literature in the case of realist review. The next step is

data selection in the case of realist review and then analysis in both cases. The analysis step can be done in different ways using different tools and computer applications eg excel or NVivo. The research in this thesis was done using NVivo and using both inductive and deductive coding. The next step then is synthesis of data done by building explanatory CMOCs and beginning to build programme theory. The final step then is to refine theory and to bring it to a higher level of abstraction where it can be applied in different contexts (Pawson, 2006a, Chapter 4; Pawson & Tilley, 1997, Chapter 4).

While this step-by-step description makes the process sound very linear, as Figure 5 indicates the research process does not typically take place in that way. Rather, it is common to go back to prior steps for example as one is analysing data and find that there are gaps in what has already been collected. Or when one is synthesising findings and it turns out that perhaps more and different coding of the data needs to take place, for example, if an unexpected subset of findings turns out to be significant and takes centre stage. The researcher can always go back to a prior step, making realism a flexible approach focused on producing meaningful theory rather than covering and engaging with all the data as one would in a systematic review.

This iterative process is a strength of realist work because it means that discoveries made during the research process can drive the work. But in the case of realist review, it also means that unlike other forms of evidence synthesis such as systematic review, a typical study protocol setting in stone search terms and inclusion and exclusion criteria cannot be produced ahead of time (Pawson, 2006a, pp. 41–42).

While realist review is similar to systematic review in that the first round of literature searching is systematic, later rounds can be more targeted to meet particular gaps in the data collected. And unlike systematic review, realist review is not intended to be exhaustive in the collection, review and synthesis of data covering a particular area because the unit of analysis is not the individual piece of data but theory to be built from several pieces of data. A level of theoretical saturation can usually be reached without reviewing any and all pieces of evidence on a particular intervention or a particular area of study (A. Booth et al., 2018).

2.4.2 Sources of data

Data used in realist work can come from methods in both qualitative and quantitative domains. Often valuable data come from a number of sources outside of published academic literature such as documents used to plan for and create interventions, needs assessments, grey literature from NGOs and governments, budgets, websites, newsletters, blog posts, social media etc. These are all sources of information which provide contextual and mechanistic clues about the

conditions in which a given intervention was first implemented and the goals it was set out to meet; about why it was done in that way; about for whom it might have worked particularly well and/or not (Wong, 2018).

Including data from a variety of sources and from ones that might otherwise not be seen as independent, reliable or methodologically sound is a challenge that requires a different approach to the treatment of data included in realist work. When appraising the quality of data, a whole document is not the appropriate unit of quality appraisal. Studies that are poorly done or blog posts that have a goal that has nothing to do with one's research, can contain nuggets of explanatory data which help to enlighten a realist piece of work (Pawson, 2006b).

Most research is not done from a realist perspective, so one is unlikely to find information about contexts or mechanisms, or why something works or not – one has to use the data at hand to construct a picture through theorising. For this reason, the researcher can evaluate the quality of parts of a study or other source of data and include relevant data when it helps to build CMOCs and programme theory. No formal tool for grading included studies in a realist review exist for the same reason – a part of a study that is useless in one realist review may be key in another. It is only in the process of doing the analysis in a realist review that it becomes apparent whether a piece of data is useful or not and that is when the quality can be fully evaluated (Pawson, 2006b).

This can sound rather permissive but as Pawson says, 'theory development is a dynamic process' where 'understanding builds throughout inquiry' (Pawson, 2006b). He further says:

> Evidential requirements thus change though time and quality appraisal needs to be sensitive to this expectation. The notion of 'explanation-sensitive' standards will ring alarm bells in the homogenized world of meta-analysis (though it does, incidentally, clarify the somewhat oxymoronic idea of 'permissive standards' mentioned earlier). However, there is nothing alien to scientific inquiry in such a notion. The iterative relationship between theory and data is a feature of all good inquiry. All inquiry starts with understanding E1 and moves on to more nuanced explanations E2, E3, … EN, and in the course of doing will gobble up and spit out many different kinds of evidence. Applying this model to research synthesis introduces a different primary question for quality appraisal, namely, can this particular study (or fragment thereof) help, and is it of sufficient quality to help in respect of clarifying the particular explanatory challenge that the synthesis has reached? Such a question can only be answered, of course, relative to that point of analysis and, therefore, in the midst of analysis. In short, the worth of a primary study is determined in the synthesis (Pawson, 2006b).

Quality appraisal in realist review evaluates sources on the 'rigour and relevance' of the piece of information being used. This means that included studies are assessed to determine 1. whether a particular finding or piece of information in a given source was arrived upon in a way that was

robust and faithful to the particular method being used; and 2. if the information is of relevance to the review question under examination. If a study was done well adhering to its method it is more likely to be rigorous; however all sources of data can yield pieces of helpful information depending on whether a particular study, report, article etc is relevant to the research question at hand (Wong, Westhorp, et al., 2013).

2.4.3 Analysis

Because the goal of realist research is to produce, test and refine theory, data analysis takes place through a theoretical lens where the researcher must focus on whether a piece of data informs a causal explanation, what part of the causal CMOC equation it fits with and how to best configure the data along with other data. A key feature but often overlooked aspect of realist research is the configuration of Cs, Ms and Os together (Pawson, 2006a, pp. 93–94).

The analysis will differ slightly based on whether one is building theories in a new area of research; or testing a theory based on a particular programme with the aim of evaluating how it works; or seeking to make a choice between a number of programmes by seeking to understand how each one works (Pawson, 2006a, pp. 93–96). A case where a specific programme theory is to be tested will seek to explore how the data explain or refute the underlying assumptions that were used to design the intervention. A theory building study will be less structured and more flexible in building its set of explanations.

2.4.4 Building programme theory

Pieces of data that contain explanatory fragments are put together to construct CMOCs using multiple sources. The process is iterative as the researcher takes the initial CMOCs and seeks to refine and refute them using more data as they go along. Once the CMOCs are fairly solid theories which are closely based on the data, CMOCs can begin to be consolidated to make programme theories at higher levels of abstraction (Pawson, 2006a, p. 96). Chapters three and four will describe in depth the actual process I followed in the research for this thesis and will clearly outline the process of analysis.

2.5 Rationale for using realist approach

I am using scientific realism in the school of Pawson and Tilley in this thesis because it is the approach best suited to the area of research: examining what health system factors make healthcare accessible or not for populations experiencing homelessness. As discussed above in section 2.2, scientific realism provides an alternative to both positivism and constructivism which is what makes it better suited to this thesis. Unlike positivist study designs it provides a

way to sort through the complexity inherent in that question rather than to try to control for it by creating an experiment which is nothing like the complex social world in which healthcare access is negotiated. Similarly, unlike constructivism, the approach is based on the understanding that there are causal forces in the world which are real and which exist whether or not we can perceive or measure them, and it allows us to study and explain them and understand how they interact with given contexts which we can see and describe.

Realist approaches are well suited to complex interventions or areas of study. Healthcare access and homelessness are both inherently complex concepts. Healthcare is accessed in open systems with many variables at play like timelines, changing need, a variety of physical locations, and where a number of treatments may be offered within a given healthcare programme based on various policies that dictate the running of a health system. Supply side factors including staffing, location, hours, and available resources, and demand side factors such as psychological factors, time available, knowledge of health need, and distance to service location, are variables that all interact and produce a number of outcomes. Services are delivered in complex settings that often have a specific culture dominated by hierarchies and clinical goals (Levesque et al., 2013). People experiencing homelessness live complex lives characterised by multiple and often chronic health needs, high levels of mobility, lack of access to facilities like a home or even a bathroom or toilet necessary to maintain health, and busyness in trying to meet their daily needs.

At the intersection of health systems and homelessness, healthcare is accessed in non-linear ways that produce a variety of both intended and unintended, short and long-term outcomes such as accessing all or parts of a course of treatment, receiving sufficient or insufficient care, giving up before care is actually accessed, and patient experiences of fear or stigma, etc. The result is that there is often no simple journey into healthcare for patients experiencing homelessness and that many interacting factors come together to produce outcomes which emerge as more than simply the sum of their parts.

Realist approaches attempt to produce findings which are more relevant to policy makers than systematic reviews typically do. Realist work tends to be more relevant because it offers causal explanations of a problem and provides understanding of the importance of contextual factors and variation in outcomes when a given service or intervention is implemented in different settings. Often complex interventions are heavily context dependent and it is impossible to implement an intervention in a new setting and expect it to behave how it did in another place. Therefore, policy makers need to know not only that something worked or it did not but that it

worked well in one setting and not so well in a different setting and why, so they can act accordingly and implement solutions to problems using resources well.

At the start of this research, I considered whether systematic review would be a good method for the study that eventually became the realist review described in Chapter 3. Systematic review is a method suited to 'identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a specific research question' using 'explicit, systematic methods that are selected with a view aimed at minimizing bias' (*About Cochrane Reviews | Cochrane Library*, n.d.). Systematic reviews aim to answer whether something works or not and is well suited to pooling the available evidence to answer clinical questions such as whether a particular medication works. However, systematic reviews are not well suited for producing findings that explain how, for whom, to what extent and why something works or does not. For that reason, and especially in a complex area of study, systematic reviews tend to produce rather unsatisfying findings that suggest that something works, or does not, or works to an extent (Rycroft-Malone et al., 2012). When I went in search of other approaches, I found that the scientific realist approach was best fit for this research.

2.6 Health Policy analysis

The third study (chapter 5) in the thesis is a policy analysis which builds on the previous two studies. This study places the findings of the two realist studies in an Irish political and historical frame of reference. It explains the broader policy setting in which the causal mechanisms uncovered and explained in the realist studies play out in the Irish health system. In doing so, it supports the overarching goal of the thesis of examining high-level system factors that impact healthcare access, this time through a policy analysis lens using the specific case of Ireland. This perspective makes this publicly funded research a more applied Irish output. In the sections below, I discuss policy analysis as a method and the approach to policy analysis taken in this thesis.

According to Buse, Mays and Walt, health policy is 'assumed to embrace courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health and health care system. It includes policy made in the public sector (by government) as well as policies in the private sector' (Buse et al., 2012, pp. 6–7).

Health policies are generally 'formal written documents, rules and guidelines that present policy makers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health' (Gilson, 2012, p. 28). The nominal intention behind crafting policy is to promote goals and typically the stated approach is to attempt to reach those goals

using evidence, often arising from research. However, evidence-based or evidence-informed policy-making is not always actually based on the best available evidence and of course the idea of what the best evidence is changes depending on who you speak to (Buse et al., 2012, Chapter 9). Health policy making is a contested, political endeavour and analysing it is not straightforward (Walt et al., 2008).

Analysing health policy is complex because the policy making process is complex and encompasses a number of players with various goals undertaking a number of processes to promote their chosen agenda. According to Walt et al, policy analysis 'is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand past policy failures and successes and to plan for future policy implementation' (Walt et al., 2008).

2.6.1 Policy analysis approach in this thesis

The policy analysis chapter in this thesis (chapter 5) explicitly builds on the two prior studies and maintains the realist view of ontology and epistemology while using different research methods because these are better suited to answering the questions under examination. It takes a long, historical view of the policy action and inaction that has led to the current landscape in Irish healthcare access for populations experiencing homelessness. In doing so, the analysis incorporates both primary sources in the form of present policy documents that currently govern areas related to health and housing, and secondary sources which describe the development of the Irish healthcare system.

The analysis does not seek to understand the full policy making process regarding a particular policy but rather to understand the values, policy intent, and extent of political commitment that have infused the whole area of policy making, and their historical roots, which impact healthcare accessibility for excluded populations in Ireland.

2.6.2 Policy analysis sources and methods

The policy analysis chapter in this thesis (chapter 5) is focused on two sets of literature: 1. high level modern Irish health policy documents, and 2. secondary research works analysing the historical and political roots of the Irish health system. Each set of documents was identified through searching explained in chapter 5 and each set was analysed using policy analysis methods.

The starting point for the analysis of modern policy documents was the three current high-level policies central to health and homelessness in Ireland – two key national health policies:

Sláintecare, *Healthy Ireland*, and the national housing policy: *Rebuilding Ireland*. From there, I selected other documents by snowballing sources cited in those three policies, through google searching, and through expert recommendations.

All sources are analysed using documentary analysis focusing not just on the content of the documents but also on what they say about the message and image policy actors are attempting to portray in both current and historical policy debates. According to Atkinson and Coffey 'documents are "social facts", in that they are produced, shared and used in socially organized ways. They are not, however, transparent representations of organizational routines, decision-making processes or professional diagnoses. They construct particular kinds of representations using their own conventions' (Atkinson & Coffey, 2004). Therefore, they argue, we cannot take at face value that what documents say happens is actually what happens.

With that in mind, I am interested in analysing the stories constructed by policy makers and in policy documents as relevant to healthcare access for populations experiencing long-term homelessness and complex needs. The analysis seeks to understand and explain the official representation of how the intersection of healthcare and deprivation is managed in Ireland, today and historically.

In chapter 6, the Discussion and Conclusion chapter, the findings of the policy analysis are then juxtaposed with the findings of the realist evaluation (chapter 4) to examine the differences and similarities between the aspirations for healthcare practice in Ireland and their realities as experienced by healthcare practitioners, managers and advocates on the ground. This is because, as Atkinson and Coffey say, 'documentary sources are not surrogates for other kinds of data. We cannot, for instance, learn through written records alone how an organization actually operates day by day. Equally, we cannot treat records - however "official" - as firm evidence of what they report' (Atkinson & Coffey, 2004).

2.6.2.1 Coding

Primary policy documents were coded in NVivo with conceptual codes created as the coding went along. While there was no list of a priori codes, the concepts which emerged were influenced by the frameworks used in the two previous studies and their high-level findings.

The goal of the policy analysis is to further illuminate the findings of the two previous studies by explaining how health policies impact health system design in relation to healthcare accessibility for populations experiencing homelessness. Therefore, the coding was intended to draw out the particular aspects of long, detailed policy documents that were directly related to the questions

under examination in the other two studies in the thesis rather than to analyse in depth the full policy on its own merits. The policy analysis study was undertaken after the realist review was completed and concurrently with the latter part of the realist evaluation, when the first rounds of coding and analysis in that study had already taken place. Key concepts in each of those studies were still fresh in my mind. For that reason, the coding was closely related to the two prior studies, thereby utilising all the PhD research to inform the policy analysis. Ultimately, this research seeks to inform policy that will lead to better access to healthcare for people who are homeless.

2.6.2.2 Analysis

Documents were analysed using documentary analysis methods. Bowen describes this method:

> The analytic procedure entails finding, selecting, appraising (making sense of), and synthesising data contained in documents. Document analysis yields data - excerpts, quotations, or entire passages - that are then organised into major themes, categories, and case examples specifically through content analysis (Bowen, 2009).

And:

> Document analysis involves skimming (superficial examination), reading (thorough examination), and interpretation. This iterative process combines elements of content analysis and thematic analysis. Content analysis is the process of organising information into categories related to the central questions of the research (Bowen, 2009).

When evaluating the documents, Bowen suggests the researcher should 'consider the original purpose of the document' and who it was produced for. Additionally, he suggests, the 'absence, sparseness or incompleteness of documents' suggests something about the area of investigation for example that little attention has been given to it.

2.6.3 Justification for health policy analysis

Health policy analysis adds a different high-level systems lens through which to view the other two studies in this thesis. The analysis is focused on specifically furthering the findings of the realist analyses and elevating understanding and utility of the transferable theories resulting from both in an Irish context by placing them in the frames of the Irish historical and cultural background as well as the current Irish policy landscape.

2.7 Chapter summary

In this chapter I have described realist approaches as used in realist review and realist evaluation in the school of Pawson and Tilley and have justified the use of this approach for the two studies in this thesis on the grounds that they are researching complex social programmes in a highly complex social system. I have explained the realist world view and ideas of how we can acquire

knowledge of the world. I have explored key realist concepts such as complexity, causal explanations, emergence, CMO constructions and more. And I have given a sketch of how scientific realist research is done in practice using an iterative, theory building approach.

Additionally, I have provided an overview of policy analysis and described the particular approach I am taking to policy analysis in this thesis, as well as discussing why it is useful and how it fits with the rest of the thesis.

Chapter 3. Realist review of access to healthcare for populations experiencing homelessness

3.1. Chapter outline

This chapter will explore the first study in this thesis, a realist review of how health systems impact healthcare accessibility for populations experiencing long-term homelessness and complex needs. This realist review was conducted in 2019-2020 and resulted in a publication (Siersbaek, Ford, Burke, et al., 2021) in the BMJ-Open, large sections of which are woven into the narrative below. Additional text not published in the article include supporting data such as quotes from the source publications and detailed explanations of the steps involved in the research, which did not fit in the published version. This additional information was published alongside the article in appendices but is part of the narrative here for ease of reading.

The text taken directly from the article uses the term 'we' throughout when discussing decisions made. I want to note here that while the article is written on behalf of a team of authors – hence 'we'- consisting of myself and my four PhD supervisors, the majority of the research and all the drafting was undertaken by me as first author with traditional support and guidance provided by the rest of the team.

The study follows the stages of a realist review described by Pawson (2006a) and outlined in chapter 2. An initial rough programme theory was developed, which unfortunately proved to not be particularly useful in guiding the following steps. A systematic search was done with the assistance of a librarian and iterative grey literature searching was undertaken later. Articles were screened and those which met the inclusion criteria were selected for inclusion. Coding of data took place in NVivo 12 after which data were extracted and synthesised into 73 CMOCs which were combined and merged into six consolidated CMOCs which formed the basis for the final building of an overarching programme theory to explain the findings of the review at a high level of abstraction.

3.2 Background

In this review we are primarily interested in understanding the health system factors that impact access to healthcare. We conceptualise health system factors and access using the World Health Organisation (WHO) building blocks framework (WHO, 2007), outlined in chapter 1, including service delivery, health workforce, and leadership/governance, and Aday and Andersen's Framework for the Study of Access to Medical Care (Aday & Andersen, 1974), also outlined in

chapter 1, with health system factors organised under the categories of 'health policy' and 'characteristics of health delivery system'.

Supply side factors describe the full set of inputs that go into a health system designed to meet the needs of full populations, as much as possible. However, systems designed to meet the needs of the majority may not adequately meet the needs of groups with specialist needs, including those experiencing social exclusion. In this study we explore how, why, in what circumstances and to what extent these inputs impact healthcare accessibility for the population of interest: single adults experiencing long-term homelessness and complex needs.

Such homeless single adults with complex needs may experience any of the types of homelessness outlined according to ETHOS (FEANTSA, 2017) above (ETHOS definition of homelessness explained in section 1.2.1). We use the term 'populations experiencing homelessness' to refer to this group in this article, as well as throughout the thesis. The lack of housing in and of itself is not the only driver of poor access to healthcare and poor health outcomes in this population. Homelessness is a marker for and is associated with 'tri-morbidity' - the combination of physical ill-health, mental ill-health, and substance misuse (Cornes et al., 2018). In addition to lacking stable housing, populations experiencing homelessness often face a host of health problems and addiction behaviours associated with complex life circumstances and events including early childhood trauma, incarceration, relationship breakdowns, violence in the home, assault, losing children into state care, poverty, lack of employment and more (Carver et al., 2020; Herman et al., 1997; O'Reilly et al., 2015). While these are common experiences, it is important to stress that they happen to varying degrees and sometimes not at all (Carver et al., 2020).

The majority of research exploring access to healthcare for homeless populations has focused on individual level factors and particularly on why, whether and how individuals experiencing homelessness do or do not access healthcare (Argintaru et al., 2013; Baggett et al., 2010; M. Booth et al., 2004; Campbell et al., 2015; Cornes et al., 2018; Elwell-Sutton et al., 2016; Hewett et al., 2012; Homeless Link and St Mungo's, 2012; Hudson et al., 2016b; Hwang et al., 2010; Kertesz et al., 2014; Khandor et al., 2011; O'Carroll & Wainwright, 2019, 2021; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Salem et al., 2013). A focus on individual level factors is illuminating but without understanding and balancing this with health system factors there is a risk that responsibility for accessing services is inappropriately placed with the individual (Aidala et al., 2016; Harris & Rhodes, 2013). This review synthesises health system factors that determine healthcare accessibility in order to explore how whole systems can make

appropriate healthcare services accessible to populations experiencing homelessness and complex needs.

In this study, and as discussed in chapter 1, we used the WHO's definition of a 'health system': '(i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health' (*WHO | Health Systems Strengthening Glossary*, n.d.).

3.2.1 Realist review aim

As discussed in section 1.2.7 and just above in section 3.2 the majority of the research regarding healthcare accessibility for populations experiencing homelessness is primarily focused on the perspective of the individual person seeking care.

A review of health system factors which improve access to healthcare for populations experiencing homelessness is needed because an individual-level analysis does not fully explain systemic causes of inadequate access to essential health services. This review sought to answer the following question:

- How, why, for whom, in what circumstances and to what extent can healthcare systems improve access to healthcare for populations experiencing long-term homelessness?

3.3 Overarching review methodology

The review followed an internal team study protocol (see appendix 1) based on Pawson's five iterative stages: 1. locating existing theories, 2. searching for evidence, 3. selecting articles, 4. extracting and organising data and 5. synthesising the evidence and drawing conclusions (Pawson, 2006a). The phases of the review are illustrated below in Figure 7.

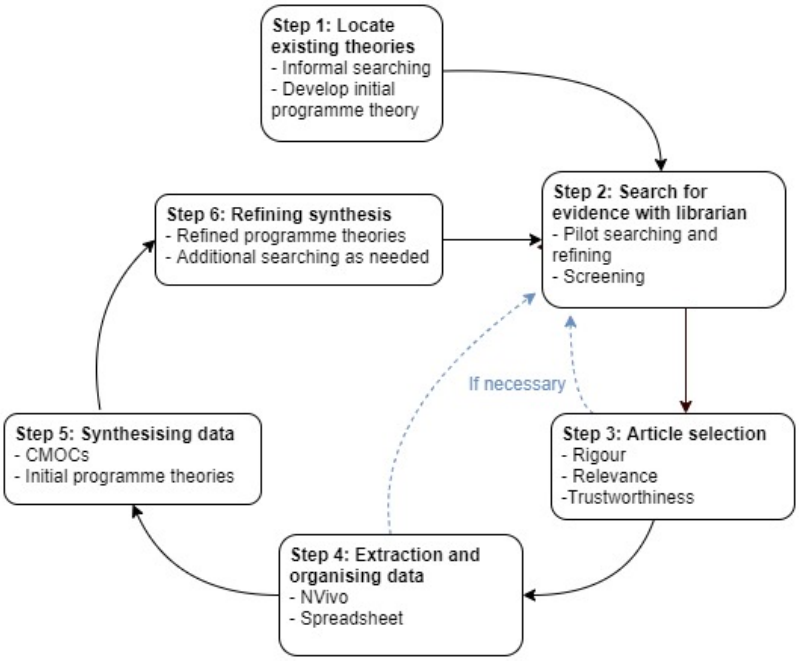

Figure 7: Stages of a realist review

A rough initial programme theory was developed based on informal reading and discussions with content experts in the area of homeless health. It listed potentially important contexts (eg long-term homelessness, regular source of care, competing subsistence needs, knowledge of symptoms and when to seek care) and mechanisms (eg stigma and discrimination, power dynamic between practitioner and patient, mistrust, fear, feelings of shame/low self-esteem) affecting the outcome of healthcare access for populations experiencing homelessness. The initial programme theory reflected our limited knowledge specifically regarding high-level health systems features that impact healthcare access for populations experiencing homelessness at the outset of the project. It was a way to get into the topic and formed the starting point for shared team knowledge but it did not turn out to be particularly useful in directing the further steps in the research, including literature searching and coding.

The initial programme theory is presented below in Figure 8:

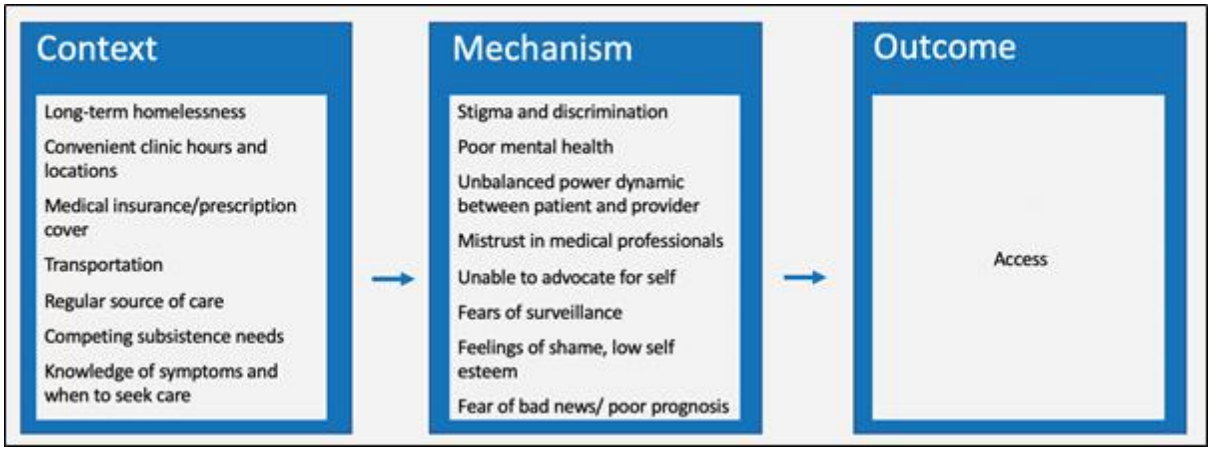

Figure 8: Realist review initial programme theory

3.4 Search strategy

Iterative searching took place in three rounds. First a systematic search of relevant published peer-reviewed review articles of any method took place. The study is a review of reviews and not of primary studies. The decision was made to limit the first round of searches to review articles because pilot searches returned a large number of results which were deemed too many by myself and my supervisory team given that the work of review and analysis was primarily to be carried out by one person who was a student and not an expert. Usually, realist reviews are carried out by research teams with experience with the approach and with several people sharing the work, and even in those conditions they take a lot of time, often more than a year, to complete. Additionally, because the research was taking a health systems lens, we felt that review articles would sufficiently identify a set of important high-level data which would make a good start and which could be expanded upon as needed, per realist approaches.

We did not use the initial programme theory to guide the systematic literature search as it did not point us in the direction of high-level health system features' impact on healthcare access for homeless populations. Rather, pilot searching suggested that including a number of search terms from the initial programme theory yielded a high number of unrelated articles. Instead, a subject librarian helped design the search strategy focusing on two broad thematic clusters: homelessness and healthcare access. Further pilot searching was undertaken and final search terms were agreed. A formal search of four electronic databases (Ovid MEDLINE, embase.com, CINAHL, ASSIA) was undertaken in April 2019. Results from each search were exported to Endnote X9 and deduplicated automatically and manually. Full search terms can be found in appendix 2.

Unlike in systematic review and other similar review methodologies, realist reviews do not seek to collect and account for every single relevant published study about a particular topic. The unit of analysis is not data but theory and a robust level of theoretical saturation can be reached without having considered every possible relevant data source. In the case of this study, the first round of searching found a lot of relevant data, however aspects of what I wanted to examine did not turn up which led to additional searching.

Additional searching was later undertaken in two rounds. First, citation tracking was used to locate important primary studies included in several of the reviews. And at this stage, further peer-reviewed and grey literature sources were included as recommended by an expert panel convened to support the study. Second, a search was conducted to identify additional relevant grey literature sources via the internet and websites of organisations working on homeless health. These sources were selected to shed further light on CMOCs that were not fully developed using the data resulting from the systematic search of the peer-reviewed literature and to build additional CMOCs to more fully answer the research question.

3.4.1 Selection and appraisal of documents

Studies were included based on their relevance to the review question, ie if they provided information about access to healthcare for homeless populations and would contribute to the development and refinement of programme theory. Only studies in English were included. RS (Rikke Siersbaek) screened all titles and abstracts and SB (Sara Burke) independently screened a random 10% sample. During the screening phase an initial evaluation of rigour and relevance was done, as was the case at later stages when additional literature was collected.

All searches and included sources are depicted below in Figure 9.

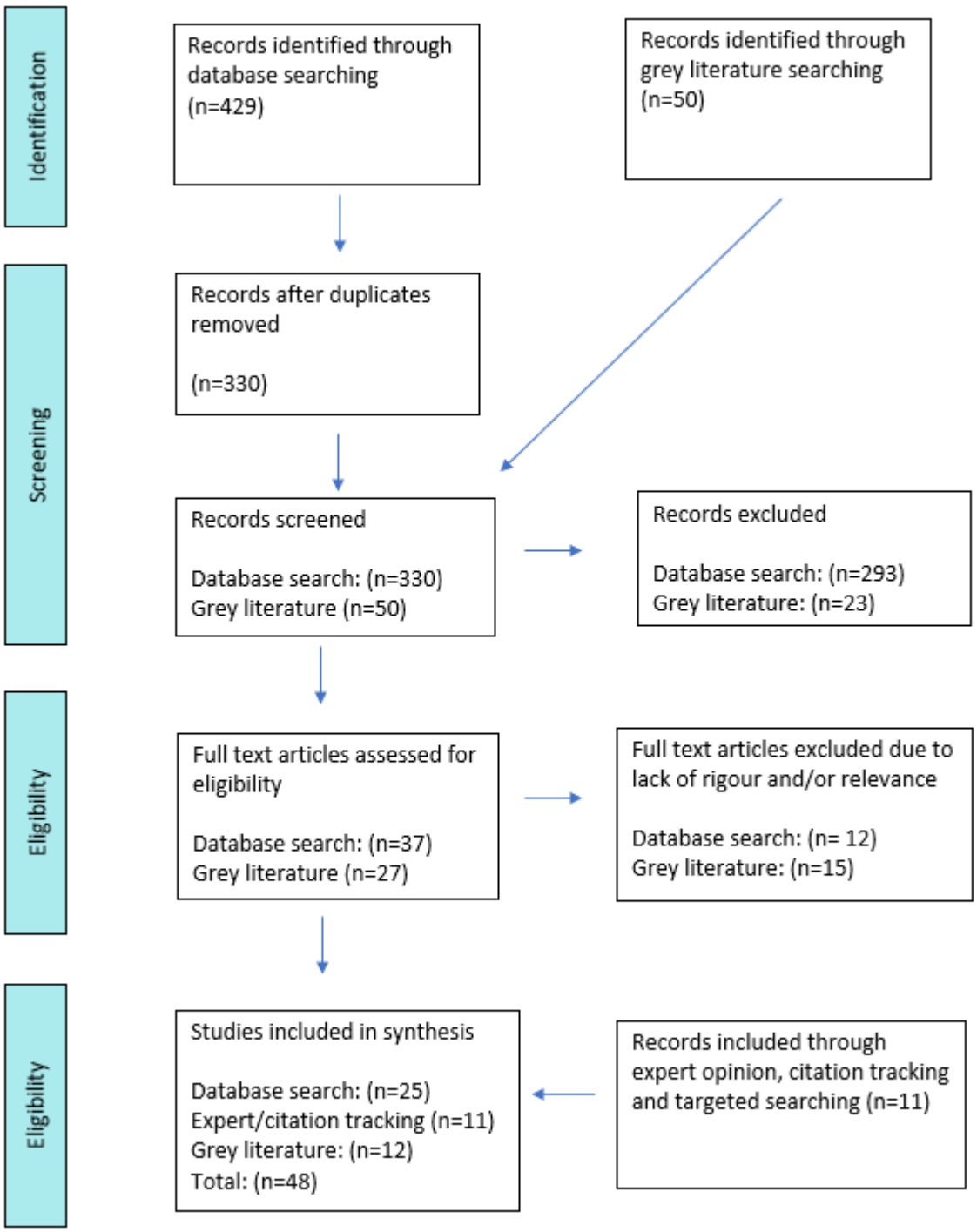

Figure 9: Realist review searches

3.4.2 Data extraction and analysis

After the screening of the peer-reviewed literature was completed, a summary table was created listing key features of each study (See Table 1 in section 3.5).

As the literature searching was an iterative process which took place on and off over a number of months, coding of the resulting data collected from each round of searching also took place

over several rounds. All coding was done in NVivo 12. The first round of coding of the peer-reviewed articles from the systematic search started with the articles deemed most useful regarding rigour, relevance and trustworthiness (eg articles that had rich data and had adhered to their chosen research methodology), as they were expected to best inform the development of CMOCs and programme theory. Coding was first done inductively with useful pieces of data assigned to thematic codes created by the researcher one by one through the coding process. Codes were then organised into groups depending on whether they were related to the individual seeking care, the healthcare practitioner and/or programme providing care or the health service/ health system in which that healthcare is organised. Labels of context, mechanism and outcome were also assigned when possible and at times not assigned if a code did not have a clear placement in a potential configuration. The rest of the peer-reviewed articles were coded deductively using the codes already created with more codes inductively added as needed.

3.4.3 Analysis and synthesis

Using a realist logic of analysis, CMOCs were then created from data in the review articles included after the first round of searching, drawing from several sources to construct each CMOC. All codes are available in appendix 3. The purpose of the analysis was to identify general patterns of outcomes which can be expected to occur when mechanisms are activated in the right context, with some regularity (also called 'demi-regularities'). In other words, the analysis identified outcomes which regularly, but not always and not in every case, result from the causal processes described in each CMOC discussed below.

The crafting of CMOCs took place by sorting codes from NVivo according to whether they mainly belonged to contextual factors, represented an outcome or whether they were mechanistic in nature. We then, through constant consultation of the literature, linked contexts, mechanisms and outcomes that fit together to explain underlying causation. We wrote a list of resulting CMOCs that all demonstrated a causative relationship affecting healthcare access for populations experiencing homelessness, as described in the data. This list of CMOCs was written in a Word document with its supporting data excerpts listed below. Iterative cycles of analysis then took place to refine, challenge and change the CMOCs based on the data. Through the analysis process, some CMOCs were eliminated and some were combined if they were similar to others.

Initial analysis resulted in two broad conceptual sets of findings: one related to how services are organised and delivered, and another related to the process of training and the development of

professional skills, attitude and awareness that allow staff to best provide such services. Based on team discussions and with the recognition that we would not be able to fully explore all findings, we decided to focus on the topics most relevant to the research question. The findings around service delivery and organisation were chosen as the focus for the next stage of the review.

3.4.4 Expert panel

The CMOCs generated from the data extracted from the peer-reviewed literature were further refined after a formal expert panel meeting with representation by members of an inclusion health team in a local hospital (consultant doctor and social worker), the director of policy for a national homeless charity, an inclusion health GP, a representative for the Health Service Executive, and two academics who work in the areas of homeless healthcare and health policy. This meeting took place in January of 2020, eight months after the systematic searches had taken place and after the subsequent screening, article selection, coding, and first round of CMO constructing. The goal of the session was to get feedback on the findings, particularly to understand if they resonated with the expertise of practitioners and researchers in the field, and to identify areas that needed further development.

An overview of realist approaches and the research findings up to that point was presented to the expert panel members and then a discussion took place with each person giving feedback to the research leading to further discussion among the group. The meeting took a total of two hours and was recorded for note taking purposes but was not considered data collection and is not included as such in the review.

The expert panel discussion led to the strengthening of the research in several key ways with the following two being the most important: First, a discussion of the diversity within populations experiencing homelessness resulted in refining the focus of CMOCs to outcomes relating to the specific homeless sub-population of single adults experiencing long-term homelessness and complex needs. Second, discussions revealed that sufficient data about a number of important health system features which impact access, eg financing, governance, organisational culture, policies and strategies, were missing from the peer-reviewed literature sources and various suggestions were made for sources that would inform that shortcoming.

3.4.5 Grey literature search

To attempt to more fully explain high level health system features which impact access additional data were collected then through citation tracking and through additional searching

of grey literature sources. The results of these searches were screened and then coded in a similar way to the peer-reviewed literature. Initial codes were developed inductively from the first several sources and then applied deductively with new codes created as needed as the remainder of the sources were coded. Labels of context, mechanism and outcome were assigned when possible and at times not assigned if a code did not have a clear placement. Contexts, mechanisms and outcomes are not static labels but can change in relation to each other eg something can be a context in one instance but a mechanism in another and an outcome can become a context for another CMOC depending on its explanatory role in the given configuration (Pawson & Manzano-Santaella, 2012). Codes were then organised into groups depending on whether they were related to the individual seeking care, the healthcare practitioner and/or programme providing care or the health service/ health system in which that healthcare is organised. These new data were then used to create more CMOCs using the new data combined with those collected from the first round of searching, and to further refine the existing set created from peer-review data, where useful.

3.5 Results

In total, 330 titles and abstracts were screened and 37 published review articles were deemed to meet the inclusion criteria, and these then underwent full-text review. Next, during a close reading of each full article, it was determined that 13 of the 37 articles that were initially included in the analysis did not fully meet relevance and/or rigour standards and they were thus excluded leaving a total of 24 articles for inclusion (see Table 1). All studies included in the reviews were from high income countries, the majority focused on the USA, Australia and the UK.

Number	Authors	Year	Title	Countries	Topic/intervention	Aims of review
1	Aidala, A; Wilson, M; Shubert, V; Gogolishvili, D; Globerman, J; Rueda, S; Bozack, A; Caban, M; Rourke, S.	2016	Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review	United States, France, Spain, Italy, Finland and South Korea	HIV treatment	To review the literature on the role of housing status for medical care and health outcomes among people with HIV infection
2	Brown, A; Rice, S; Rickwood, D; Parker, A.	2016	Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people	Australia, UK, USA, Canada	Mental health services	To review the literature on the barriers and facilitators to accessing and engaging with mental health care among young people from potentially disadvantaged groups.

3	Crock, E.	2016	Access to healthcare services for people living with HIV experiencing homelessness – a literature review	USA, Canada, Australia	Community nursing	To review the literature on strategies that enhance the ability of people living with HIV who are homeless to access health care services, in particular community nursing services.
4	Dawson, A; Jackson, D.	2013	The primary health care service experiences and needs of homeless youth: A narrative synthesis of current evidence	USA, Australia	Primary healthcare	To review the literature on access to primary healthcare services for homeless youth
5	Elliott, A.	2013	Meeting the health care needs of street-involved youth	Canada, USA	Full spectrum healthcare	To reviews reasons why youth turn to the street, risks of the 'street economy' and barriers to health care.
6	Hamilton, K; Tolfree, R; Mytton, J.	2018	A systematic review of active case-finding strategies for tuberculosis in homeless populations	USA, UK, France, Germany, Switzerland, Australia, Poland, Spain	Tuberculosis	To review the literature to determine the effectiveness of active case finding for TB control, and identify strategies to improve uptake of screening and the diagnostic pathway in homeless populations in low- and medium-burden settings.
7	Harris, M; Rhodes, T.	2013	Hepatitis C treatment access and uptake for people who inject drugs: a review mapping the role of social factors	Not specified	Hepatitis C treatment	To review the literature on barriers to hepatitis C treatment access, uptake and completion for people who inject drugs.
8	Hudson, B; Flemming, K; Shulman, C; Candy, B.	2016	Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research	USA, Canada, Sweden, UK, Australia	Palliative care	To review published qualitative research exploring challenges to palliative care access and provision.
9	Islam, M; Conigrave, KM.	2007	Assessing the role of syringe dispensing machines and mobile van outlets in reaching hard-to-reach and high-risk groups of injecting drug users (IDUs): A review	Norway, the Netherlands, Italy, Australia, Germany, Switzerland, France, Spain, USA, Canada, Russia, Bulgaria, Lithuania	Needle exchange	To review the effectiveness of syringe dispensing machines and mobile van or bus-based needle syringe programmes in making services accessible to hard-to-reach and high-risk groups of IDUs.

10	John, W; Law, K.	2011	Addressing the health needs of the homeless	UK and other not specified	Nursing	To review the literature on the health needs of homeless people and what role can nurses play in addressing homeless people's health needs
11	Jones, C; Perera, A; Chow, M; Ho, I; Nguyen, J; Davachi, S.	2009	Cardiovascular disease risk among the poor and homeless - What we know so far	Not specified	Cardiovascular care	To review the literature detailing the relationships between poverty, homelessness and cardiovascular disease.
12	Kaduszkiewicz, H; Bochon, B; van den Bussche, H; Hansmann-Wiest, J; van der Leeden, C.	2017	The Medical Treatment of Homeless People	Not specified	Primary and inpatient hospital care	Review the medical treatment of homeless people in Germany
13	Klop, H; de Veer, A; van Dongen, S; Francke, A; Rietjens, J; Onwuteaka-Philipsen, B.	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	USA, Canada, Sweden, UK, Australia, Ireland	Palliative care	To review the evidence of the concerns and palliative healthcare needs for homeless people, as well as the conditions for delivering good quality palliative care for the target group.
14	Lamb, J; Bower, P; Rogers, A; Dowrick, C; Gask, L.	2012	Access to mental health in primary care: a qualitative meta-synthesis of evidence from the experience of people from 'hard to reach' groups	UK, Finland, Switzerland	Mental health treatment in primary care	To review understand barriers to mental health treatment for eight socially excluded groups incl homeless.
15	Luchenski, S; Maguire, N; Aldridge, R; Hayward, A; Story, A; Perri, P;Withers, J; Clint, S; Fitzpatrick, S; Hewett, N.	2018	What works in inclusion health: overview of effective interventions for marginalised and excluded populations	Not specified	Healthcare, social care, housing	To review effective interventions that directly affect health (eg, pharmacology, counselling, screening, prevention) or the wider determinants of health (eg, housing, social support, training and education, employment, crime, and recidivism).
16	Lutge, E; Wiysonge, C; Knight, S; Sinclair, D; Volmink, J.	2015	Incentives and enablers to improve adherence in tuberculosis	USA, Timor-Leste, South Africa	Tuberculosis	To review the effects of material incentives and enablers given to patients undergoing diagnostic testing for TB, or receiving drug therapy to prevent or cure TB.
17	Martens, W.	2009	Vulnerable categories of homeless patients in Western societies: Experience serious barriers to health care access	Not specified	Primary care, mental health care, addiction treatment	To review healthcare access for especially vulnerable categories of homeless persons.

18	Robards, F; Kang, M; Usherwood, T; Sanci, L.	2018	How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review	UK, USA, Australia, Canada, New Zealand, and Portugal	Full spectrum healthcare	To review what is known about marginalized young people's access to, engagement with, and navigation of the health system in the digital age.
19	Sumalinog, R; Harrington, K; Dosani, N; Hwang, S.	2017	Advance care planning, palliative care, and end-of-life care interventions for homeless people: A systematic review	USA, Canada, Sweden	Shelter based palliative care programme, completion of advance directive, professional support home services.	To review the evidence surrounding advance care planning, palliative care, and end-of-life care interventions for homeless persons.
20	Tankimovich, M.	2013	Barriers to and interventions for improved tuberculosis detection and treatment among homeless and immigrant populations: a literature review	USA, UK, Spain, Israel, the Netherlands, Ethiopia	TB detection and treatment	To review barriers to the detection and treatment of TB in immigrant and homeless populations in the United States and to review effective interventions for improved detection and treatment.
21	Wallace, C; Farmer, J; McCosker, A.	2018	Community boundary spanners as an addition to the health workforce to reach marginalised people: a scoping review of the literature	USA, UK, the Netherlands, Australia, New Zealand.	Lay person patient navigators/peer workers/ link workers.	To review the literature on the role played, in health service delivery and health literacy development in high-income countries, by community-based lay persons
22	Weber, J; Lee, R; Martsolf, D.	2017	Understanding the health of veterans who are homeless: A review of the literature	USA	Public health nursing	To review the literature of what is known about the health of homeless veterans.
23	White, B; Logan, A; Magwood, G.	2016	Access to Diabetes Care for Populations Experiencing Homelessness: an Integrated Review	USA and Canada	Diabetes care	To review the literature to identify barriers and facilitators to accessing diabetes care and managing diabetes for homeless populations.
24	White, B; Newman, S.	2015	Access to primary care services among the homeless: a synthesis of the literature using the equity of access to medical care framework	USA	Primary care	To review the literature to identify barriers and facilitators to primary care access among the homeless.

Table 1: Characteristics of included peer-reviewed studies in realist review

An additional 23 primary peer-reviewed articles and grey literature sources were identified through citation tracking, from expert recommendations, and through a subsequent purposive search of the grey literature via Google and the websites of relevant organisations. The majority of these were from the UK.

Key characteristics of the additional sources of data are shown in the able below:

Characteristics of additional data sources used to build CMOCs	
Country	
UK (14)	(Cabinet Office Social Exclusion Task Force, 2010b; Crisis, 2002; Davis & Lovegrove, 2016; FEANTSA, 2019; Gill et al., 2013; Homeless Link and St Mungo's, 2012; Making Every Adult Matter Coalition, 2015; Page & Hilbery, 2011; St Mungo's, 2013; The Faculty for Homeless and Inclusion Health, 2018; The King's Fund, 2020; The Queen's Nursing Institute, 2018; Wilson & Astley, 2016)
Ireland (5)	(Focus Ireland, 2019; Mahon, 2016; O'Carroll & Wainwright, 2019; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Osborne, 2015)
Australia (3)	(Cortis & Blaxland, 2017; McMillan, 2013; Rural and Regional Health and Aged Care Services, 2009)
USA (1)	(O'Toole, Buckel, Bourgault, Blumen, Redihan, et al., 2010)
Type of document	
Grey literature (18)	(Cabinet Office Social Exclusion Task Force, 2010b; Cortis & Blaxland, 2017; Crisis, 2002; Davis & Lovegrove, 2016; Focus Ireland, 2019; Gill et al., 2013; Homeless Link, 2014a; Homeless Link and St Mungo's, 2012; Making Every Adult Matter Coalition, 2015; McMillan, 2013; Osborne, 2015; Page & Hilbery, 2011; Rural and Regional Health and Aged Care Services, 2009; St Mungo's, 2013; The Faculty for Homeless and Inclusion Health, 2018; The King's Fund, 2020; The Queen's Nursing Institute, 2018; Wilson & Astley, 2016)
Peer-review (4)	(Mahon, 2016; O'Carroll & Wainwright, 2019; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; O'Toole, Buckel, Bourgault, Blumen, Redihan, et al., 2010)
Other – homeless organisation magazine (1)	(FEANTSA, 2019)
Topic	
Homeless healthcare provision (12)	(Crisis, 2002; FEANTSA, 2019; Homeless Link, 2014a; Homeless Link and St Mungo's, 2012; Making Every Adult Matter Coalition, 2015; O'Carroll & Wainwright, 2019; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; O'Toole, Buckel, Bourgault, Blumen, Redihan, et al., 2010; St Mungo's, 2013; The Faculty for Homeless and Inclusion Health, 2018; The King's Fund, 2020; The Queen's Nursing Institute, 2018)
Homeless policy (1)	(Focus Ireland, 2019)

Inclusion health (6)	(Cabinet Office Social Exclusion Task Force, 2010b; Davis & Lovegrove, 2016; Gill et al., 2013; Osborne, 2015; Page & Hilbery, 2011; Wilson & Astley, 2016)
Cultural responsiveness (2)	(McMillan, 2013; Rural and Regional Health and Aged Care Services, 2009)
Workforce issues (2)	(Cortis & Blaxland, 2017; Mahon, 2016)

Table 2: Key characteristics of the additional sources of data for realist review

3.5.1 Focus of the review

Initial analysis resulted in two broad conceptual sets of findings: one related to how services are organised and delivered and another related to the process of training and the development of the right professional skills, attitude and awareness that allows staff to best provide such services. Based on team discussions and with the recognition that we would not be able to fully explore all findings, we decided to focus on the topics most relevant to the research question. The findings around service delivery and organisation were chosen as the focus for the next stage of the review.

3.5.2 Context-Mechanism-Outcome Configurations

Using the data collected from the three rounds of literature searching, a total of 73 individual CMOCs were generated through several rounds of analysis over the course of several months. There was overlap among some of the CMOCs but it was important to capture and articulate the relationship between each distinct context, mechanism and outcome and to interrogate whether they shared a causal relationship before combining some together and rejecting others.

Once that analysis was completed, we grouped together similar CMOCs into the six consolidated CMOCs as described in detail in the narrative below starting in section 3.5.2.1. A full list of the data that were used to construct them is available in appendix 4 with some indicative quotes included below.

In the CMOCs below, while the contexts operate on a health system or service level, mechanisms are activated within individuals (eg patients, healthcare practitioners, staff) which makes intuitive sense as a mechanism 'involves the interaction between particular inputs (or resources) and human reasoning, which produces a particular outcome (or not)' (Wong, Greenhalgh, et al., 2013).

3.5.2.1 Consolidated CMOC 1: Resourcing

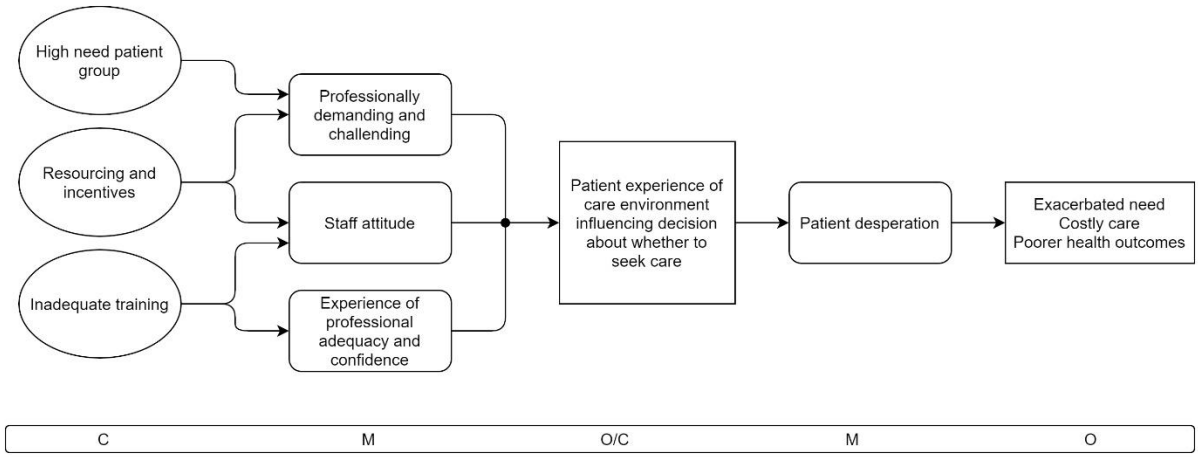

Figure 10: Realist review consolidated CMOC1

The first consolidated CMOC (Figure 10) explores contexts where mainstream healthcare practitioners and staff (in hospital and primary care settings) are expected to treat a high need patient group (long-term homeless populations with complex needs) but are not provided adequate resources and incentives (eg extra funding for longer appointments and more coordination) while also having inadequate expertise in the particular needs and life experiences of this group (Crisis, 2002; Davis & Lovegrove, 2016; Osborne, 2015; The Queen's Nursing Institute, 2018). This is reflected in this quote:

> The other issue is resources. Nine out of ten GPs in the Crisis survey felt that GPs need extra resources in order to provide homeless people with the same levels of access to GP services as the average person. Homeless people do present with multiple and complex needs which require extra resources and sometimes specialist knowledge. GPs and practice staff are not, in general, given any specialist training in understanding the specific needs of homeless people (Crisis, 2002).

And in this one:

> Health professionals described experiencing "feelings of failure or lack of achievement" when working with homeless people. Treating an individual with needs that are very different to those of their usual patient group, with little training could limit the provision of quality palliative care for this population. Inexperience in caring for people who are homeless may contribute to some of the attitudes health care professionals may hold towards homeless and may also contribute to their perceptions of stress and burden (Hudson et al., 2016b).

In these contexts, practitioners and staff feel that servicing patients experiencing homelessness is professionally demanding and challenging. They experience feelings of professional inadequacy and lack of confidence and display an unwelcoming attitude toward patients (Cabinet Office Social Exclusion Task Force, 2010b; Crisis, 2002; Davis & Lovegrove, 2016; Hudson et al., 2016b; O'Carroll & Wainwright, 2019; Osborne, 2015; Page & Hilbery, 2011; St Mungo's, 2013; White & Newman, 2015). As a result, patients' experiences of the care environment is a negative one which causes them to choose not to seek care at an appropriate

time (eg seeking care from a GP before a condition gets worse and acute care is needed) (Cabinet Office Social Exclusion Task Force, 2010b; Crisis, 2002; Gill et al., 2013; O'Carroll & Wainwright, 2019; The King's Fund, 2020; Wilson & Astley, 2016). These findings are reflected in the following quote:

> The negative attitude of other healthcare professionals can be a big hurdle for specialist clinicians working with these clients. Some staff are very judgemental and can be very discriminating against people who are homeless. This may be because of a lack of knowledge, understanding and skills needed to care for them. It is very important that all staff, including commissioners and managers, try to be accepting, non-judgemental and appreciate the additional basic requirements (Davis & Lovegrove, 2016).

The outcome of not seeking care when the care environment is not welcoming becomes a new context which leaves patients instead to seek care only when the need is emergent and out of desperation, and at a later stage than ideal and at a setting that is readily available (such as the ED) (Cabinet Office Social Exclusion Task Force, 2010b; Dawson & Jackson, 2013; Gill et al., 2013; Hudson et al., 2016b; O'Carroll & Wainwright, 2019). This results in exacerbated need leading to more complex, intensive and costly care which ultimately generates poorer health outcomes (Agency for Clinical Innovation, n.d.; Cabinet Office Social Exclusion Task Force, 2010b; Gill et al., 2013) as reflected here:

> People who are living on the street…it's much harder to access them. They don't come to us and they don't go anywhere for help until they're so sick that they're picked up by an ambulance – Health care professional (Hudson et al., 2016b).

And here:

> Whilst access to secondary care is often seen as an area of less concern than primary care, and the main issues identified mainly relate to cultural sensitivity, the admission and length of stay patterns for members of socially excluded groups are showing an underlying problem. These patients are admitted more often, stay longer and are re-admitted more frequently. This highlights a number of issues further upstream: that these patients struggle to access other services, and therefore they turn to secondary care, and that they are sicker and do not receive the same quality of care as other patients, particularly when looking at discharge arrangements (Gill et al., 2013).

3.5.2.2 Consolidated CMOC 2: Funding stability and source

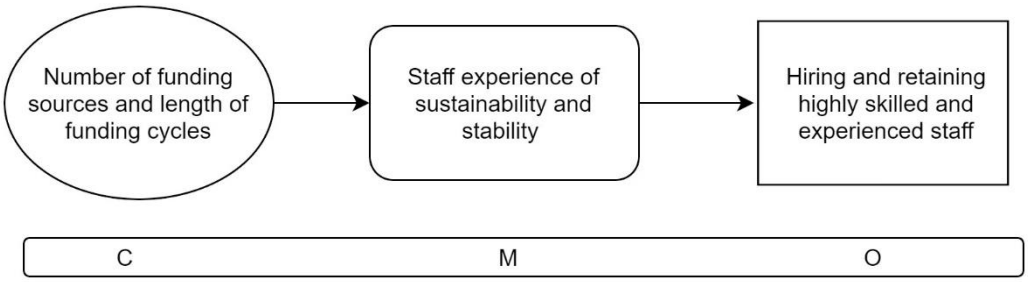

Figure 11: Realist review consolidated CMOC2

CMOC2 (Figure 11) shows that in a context where funding for health services comes from multiple sources and where funding cycles are short and unreliable, eg grant funding for specific purposes with a short duration (Gill et al., 2013; Page & Hilbery, 2011; The Faculty for Homeless and Inclusion Health, 2018; The King's Fund, 2020), staff members employed on short term contracts experience a lack of a sense of stability and sustainability because they are in a series of continual contract renewals and do not have job security and, especially in periods of austerity, may experience wage cuts and wage freezes. The precarious sustainability of the services they work for lead to staff being asked to do more with less. Work tasks change when pilot schemes and new initiatives bring additional goals tied to new funding while staff still have to complete existing tasks. Additionally, individuals working in these services are often seen by their managers as being naturally caring people who are intrinsically motivated to 'do good' and who do not need adequate pay and conditions because of the perception that their motivation lies elsewhere (Cortis & Blaxland, 2017; Focus Ireland, 2019; Mahon, 2016; The King's Fund, 2020; The Queen's Nursing Institute, 2018).

These findings are reflected in the following quote:

> Severe reductions in HSE [Health Service Executive] funding during the course of the recession placed a significant strain on the range of social care, mental health and physical health services which are essential in supporting people who are experiencing homelessness to exit to independent living. These cuts happened in parallel with a massive increase in the numbers of people who were homeless and an increase in the support needs of many groups. To a large extent, these cuts were absorbed through wage cuts and wage freezes for the staff in the voluntary sector. While the public sector is going through a process of pay restoration, staff in voluntary sector services, particularly those funded by the HSE, have seen little pay restoration and, frequently, no increments for several years. This is leading to recruitment problems in front-line services, just when need is greatest (Focus Ireland, 2019).

As well as this one:

> Non-profit staff is seen as motivated in distinctive ways when compared to workers in other

> sectors through greater commitment, stronger non-monetary orientation and greater degrees of altruism to serve others. The strong mission attachment among staff has led conventional wisdom to assume that they are seen as willing to work for lower salaries and fewer benefits because they associate so strongly with the organisational goals (Mahon, 2016).

Frequent changes make it difficult to achieve good outcomes for people who need extra time and attention and for whom forming trusting relationships with practitioners is particularly important in accessing care, as is explored below in CMOC5. The outcome is difficulties hiring and retaining highly skilled and experienced staff members (Cortis & Blaxland, 2017; Focus Ireland, 2019; Mahon, 2016; The King's Fund, 2020; The Queen's Nursing Institute, 2018) as exemplified by this quote:

> We also heard concerns about the sustainability of local funding, and the instability caused by continual contract renewal, as well as clashing commissioning cycles of the clinical commissioning group and local authorities. Others reflected that the lack of stability from commissioning created particular challenges: when services were 'forever in a state of flux' it was hard to achieve good outcomes for people who need the space and time to recover from being homeless (The King's Fund, 2020).

3.5.2.3 Consolidated CMOC 3: Health system fragmentation and goals

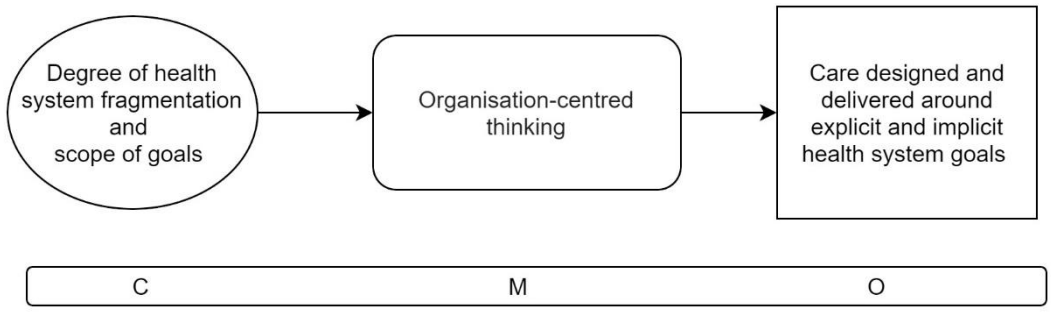

Figure 12: Realist review consolidated CMOC3

CMOC3 (Figure 12) shows that in a context where various parts of a fragmented health system operate in silos with a narrowly defined scope of goals (Cabinet Office Social Exclusion Task Force, 2010b; Gill et al., 2013; Making Every Adult Matter Coalition, 2015; Page & Hilbery, 2011; The King's Fund, 2020), staff engage in organisation-centred thinking, focussing on the needs and operation of their organisation above the needs of their patients. They prioritise the goals of the health system even when they are not suitable for responding to the complex needs of

homeless patients whose care should be organised across a number of domains. This is shown in the quote below:

> People with multiple needs want to be placed at the centre of their own support. However, people felt that their needs and aspirations were not always seen as a priority, and that services' ability to provide support can be limited by the way they are designed and commissioned. People also felt that targets or conditions attached to funding meant that practitioners weren't able to focus on the individual and decide what was best for them (Making Every Adult Matter Coalition, 2015)

Staff often lack knowledge of how to best meet the needs of patients experiencing homelessness and complex needs while health system goals and targets are more clearly defined as part of professional structures and workstreams (Cabinet Office Social Exclusion Task Force, 2010b; Making Every Adult Matter Coalition, 2015; Page & Hilbery, 2011).

Staff and practitioners are not incentivised or empowered to take responsibility for creating holistic, coordinated and flexible ways of organising care around a patient's needs and wishes because they are instead asked to meet narrowly defined targets tied to funding and the expectations of commissioners. As a result, healthcare is organised around explicit and implicit health system goals not the needs or goals of the person (Cabinet Office Social Exclusion Task Force, 2010b; Gill et al., 2013; Homeless Link and St Mungo's, 2012; Making Every Adult Matter Coalition, 2015; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Page & Hilbery, 2011) as reflected in this quote:

> Commissioners are focused on outcomes which are narrow and specific to their sector. The approach of government departments filters down to local commissioners. This leads to them and the services they commission replicating the 'silo culture', focusing on a narrow range of outcomes rather than on the wider set of issues that contribute to multiple needs and exclusions. Joint commissioning has grown over the past decade but needs to go further, with a specific focus on this group (Page & Hilbery, 2011).

3.5.2.4 *Consolidated CMOC 4: Care organised around the person*

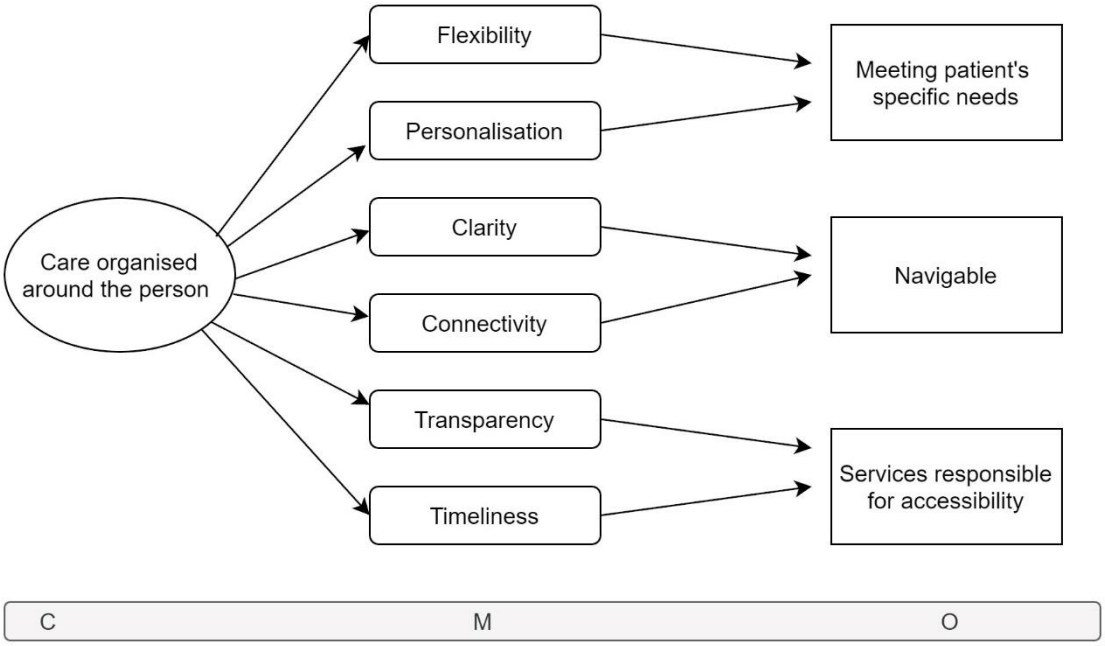

Figure 13: Realist review consolidated CMOC4

In contrast to CMOC 3, CMOC 4 (Figure 13) shows that when care is organised around the person and their needs, resulting outcomes produce conditions that promote healthcare accessibility. In this context, the mechanism of flexibility and personalisation is triggered, allowing patients to feel that their particular needs are understood and met (Harris & Rhodes, 2013; Hudson et al., 2016b; Klop, de Veer, et al., 2018; Lamb et al., 2012; Making Every Adult Matter Coalition, 2015; Robards et al., 2018; Sumalinog et al., 2017; The Queen's Nursing Institute, 2018) as shown in this quote:

> One of the ways people suggested this could be achieved was through a central point of contact, responsible for linking all of the different services together on behalf of the person concerned. One person spoke of how using the MEAM Approach developed by Making Every Adult Matter has fulfilled this role in their local area, and the benefits it has brought.
> Sharing risk and decision making is always better than just one service trying to go it alone and people are getting access to services because they don't feel isolated any longer. So when we get someone into a service where people used to be dumped before and everyone used to run and think "you're it!", now everyone else stays around the person, so besides the fact that the person's got a better outcome because they've got lots of people supporting them (Making Every Adult Matter Coalition, 2015).

Additionally, health system navigability is enhanced through having coordinated and co-located care (Crock, 2016; FEANTSA, 2019; Hudson et al., 2016b; O'Toole, Buckel, Bourgault, Blumen,

Redihan, et al., 2010; Robards et al., 2018; The Queen's Nursing Institute, 2018; J. Weber et al., 2017; White & Newman, 2015), through having clear and intuitive patient pathways managed by staff and practitioners who create connectivity between services by bringing patients along to any subsequent treatment, scan, consultation etc in the given patient pathway (Elliott, 2013; Hamilton et al., 2018; Hudson et al., 2016b; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Robards et al., 2018), and through accompanying patients either by link workers or peer advocates (Brown et al., 2016; Hamilton et al., 2018; Harris & Rhodes, 2013; Hudson et al., 2016b; Luchenski et al., 2018; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Wallace et al., 2018) as reflected in the quote below:

> Multicomponent interventions with coordinated care are most effective and should include both health and non-health services. Partnership working and service design around the whole person is necessary to achieve the best results (Luchenski et al., 2018).

Having this kind of support helps patients by providing extra motivation and confidence in seeking health services when needed and navigating institutional locations such as hospitals and clinics, and negotiating patient pathways which may be complex (Gill et al., 2013; Hamilton et al., 2018; Hudson et al., 2016b; Robards et al., 2018). Peer advocates have a unique understanding of the experience the patient is having and have the ability to meet patients where they are and provide emotional and practical support (Brown et al., 2016; Dawson & Jackson, 2013; FEANTSA, 2019; Hudson et al., 2016b; Luchenski et al., 2018; Wallace et al., 2018) as seen in this quote:

> 'It's easy to get to because they [key workers] come and collect you, and bring you to A, and get you back here. Because that's a big part of stopping you from getting there as well as the, is trying to get there so you know what I mean. It's easier to be picked up and brought … so you have your [addiction] counselling or whatever, the doctor there and your one to ones [needle exchange] all in the one.' Drug using participant 2. The roles of peer advocates and key workers serve as important facilitators to reengagement with the primary healthcare system. It is not surprising then that the homeless group, drug users, sex workers and Traveller participants all mentioned these types of support as priorities (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016).

And finally, when care is organised around the person it is inherently respectful of other demands on their time and their particular goals (or lack thereof) for their own health. Services are characterised by timeliness and openness. For example, if as many services as possible are carried out in one clinical encounter and a course of treatment is chosen through shared and transparent decision making, then responsibility is placed on the service to make itself fit with the patient's life circumstances and to share knowledge and decision making to promote initial

accessibility and beyond (Brown et al., 2016; Crock, 2016; Elliott, 2013; Hamilton et al., 2018; Harris & Rhodes, 2013; Hudson et al., 2016b; Luchenski et al., 2018; White et al., 2016) as reflected in the following quotes:

> In three studies in which arrangements were made for same-day assessment, or participants were escorted, supported or incentivised to attend, uptake was 70% to 92%. The other three studies reported following the usual referral pathways, and uptake of the diagnostic pathway was lower, at 44–57% (Hamilton et al., 2018).

And:

> Suggestions for overcoming the complex needs and irregular lifestyles of homeless people in the delivery of palliative care included taking a pragmatic, person-centred approach, setting goals that are realistic in the context of homelessness and removing discrimination and stigma from health care interactions (Hudson et al., 2016b).

3.5.2.5 Consolidated CMOC 5: Inclusive culture and leadership

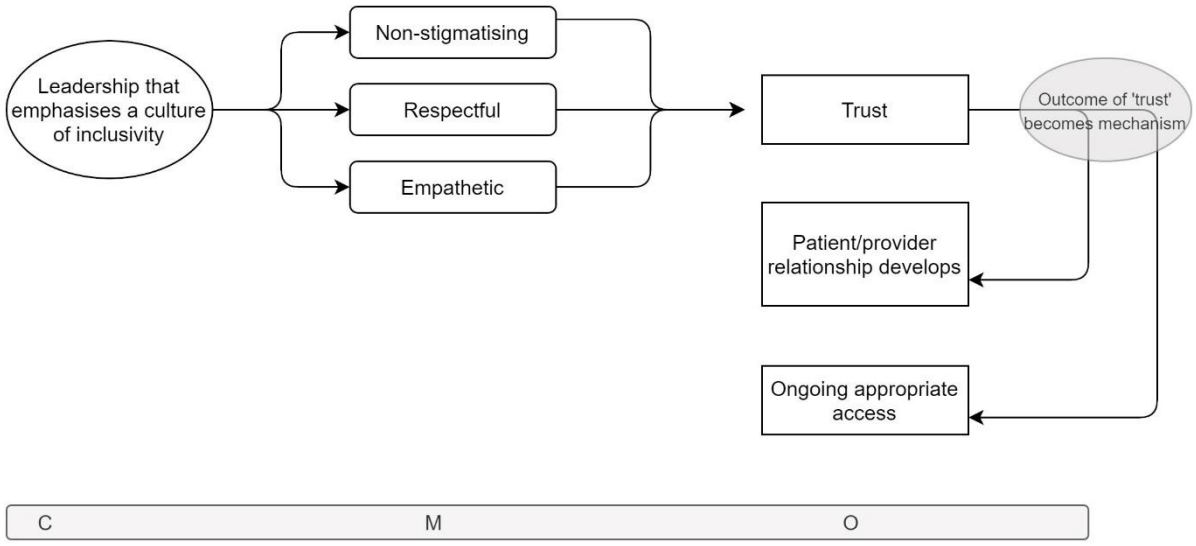

Figure 14: Realist review consolidated CMOC5

CMOC 5 (Figure 14) examines the importance of culture and leadership in creating inclusive health system contexts. Through the dominant culture the value assigned to people from stigmatised groups contributes to their experience of poorer care because of prejudice and stereotypes commonly held about them. Populations experiencing homelessness face stigma when engaging with all areas of society including healthcare settings (Harris & Rhodes, 2013; Klop, de Veer, et al., 2018; Luchenski et al., 2018; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Rural and Regional Health and Aged Care Services, 2009). Creating the right

cultural context depends on leadership and management through explicit commitments to values of inclusivity and whole organisation policies and processes (Cabinet Office Social Exclusion Task Force, 2010b; Davis & Lovegrove, 2016; Gill et al., 2013; Homeless Link and St Mungo's, 2012; McMillan, 2013; Rural and Regional Health and Aged Care Services, 2009; Seeleman et al., 2015; The King's Fund, 2020) as reflected here:

> Leaders should work to gain political buy-in and support. The problem of rough sleeping evokes a range of views about how individuals should be treated. As a group, they may not be afforded the same sympathies as other groups of patients who also have poor health outcomes. Local leaders can play a crucial role in developing a shared narrative – and a common purpose. This framing can set powerful expectations about how the local area will respond to meet the needs of people experiencing rough sleeping (The King's Fund, 2020).

In the articles reviewed, stigma is a crucial mechanism which keeps individuals experiencing homelessness from accessing healthcare (Brown et al., 2016; FEANTSA, 2019; Harris & Rhodes, 2013; Hudson et al., 2016b; Jones et al., 2009; O'Carroll & Wainwright, 2019; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; The Queen's Nursing Institute, 2018) (the impact of stigma on the patient experience is explored above in CMOC1). On the other hand, when individuals experience an environment that is non-stigmatising, respectful, empathetic, accepting, sensitive, and understanding of their life experience and particular needs, trust develops between the patient and the practitioner(s) and a positive feedback loop is created leading to a productive patient/practitioner relationship developing over time. Still operating in a context which explicitly values and promotes inclusivity, trust becomes a reinforcing mechanism whereby deepening trust facilitates ongoing engagement which leads ultimately to ongoing appropriate access to health services at the right time and right place (Brown et al., 2016; Crock, 2016; Hudson et al., 2016b; Klop, de Veer, et al., 2018; Lamb et al., 2012; Luchenski et al., 2018; Robards et al., 2018; Wallace et al., 2018; White & Newman, 2015) as shown here:

> In facilitating access to palliative care, building or rebuilding trust between homeless people and health care professionals was considered vital by homeless people and those supporting them. It was recognised though that this would not be easy:
>
> > "You have to earn it. You have to show that you want to do something for them [homeless people]. You have to be respectful and treat people with the same kind of treatment that you would want. It's often word of mouth. One client will say, "Listen, you can trust her" - Harm reduction outreach worker (Hudson et al., 2016b)

And here:

> 'I personally deal with a man called B and he's just great, he knows all about the addiction; why would you start on it [heroin] and I mean he meets me and we'd go anywhere for a cup of coffee, sit down. And I notice when you leave [the meeting] then … it's kind of like a breath of relief you

know; you say to yourself– that was really nice.' Sex working participant 2 (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016)

3.5.2.6 Consolidated CMOC 6: Flexible healthcare delivery

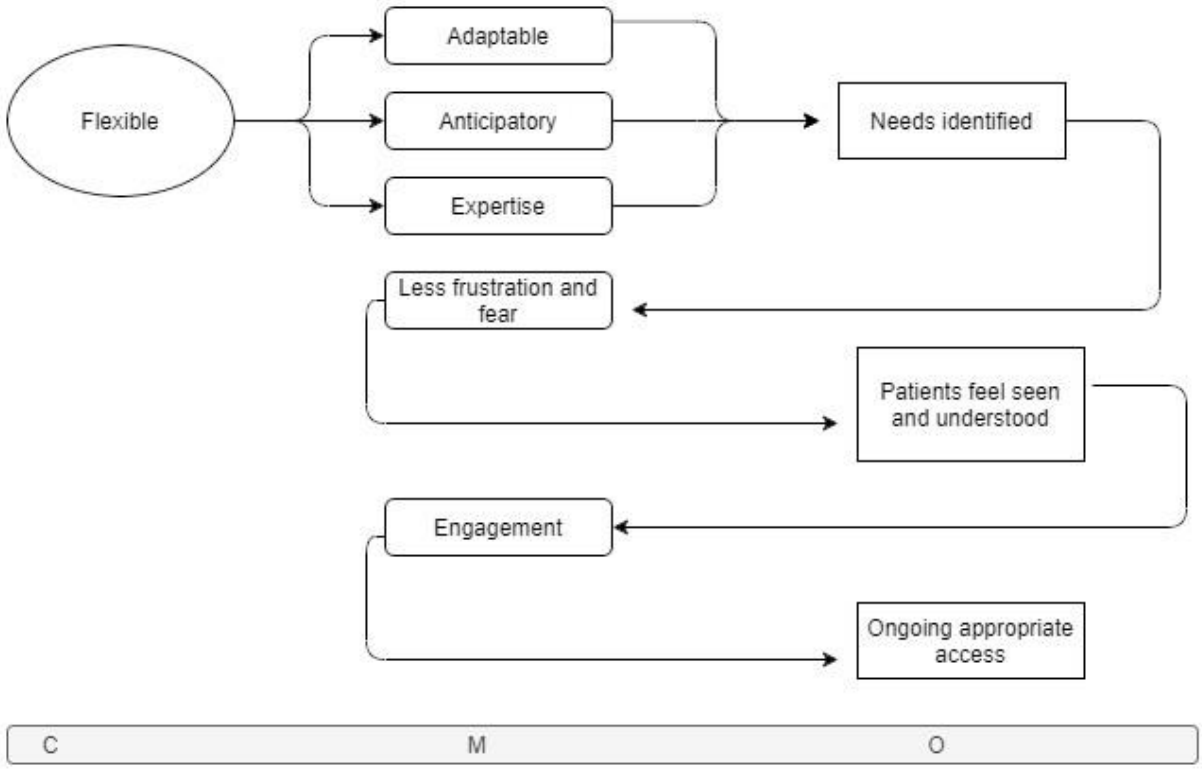

Figure 15: Realist review consolidated CMOC6

CMOC 6 (Figure 15) explores the context of flexibility in healthcare services delivery in terms of appointment length, availability of walk-in appointments and self-referral, opportunistic add-on services such as vaccinations and screenings, allowing dogs, trauma-informed practice and understanding of behaviours that trauma can result in, and more (Brown et al., 2016; Crisis, 2002; Crock, 2016; Elliott, 2013; Harris & Rhodes, 2013; Homeless Link, 2014b; John & Law, 2011; Kaduszkiewicz et al., 2017; Klop, de Veer, et al., 2018; Robards et al., 2018; The Faculty for Homeless and Inclusion Health, 2018; The King's Fund, 2020; J. Weber et al., 2017) Flexibility is also a mechanism in CMOC 4, while here it is acting as a context characterising the approach to and design of care delivery. The importance of flexibility is reflected in this quote:

> Health care practitioners need to provide anticipatory guidance to reduce harm, prescribe medications at no or low cost, choose simple treatment regimens, and ease follow-up by offering walk-in appointments and care during evening hours. Health care workers should administer applicable vaccines at any available opportunity. Ask all youth about their immunization status. Advise how to access 'catch-up' or new vaccines. Better yet, be prepared to provide them 'on-the-spot' in any office setting. Keep treatment regimens as simple and straightforward as possible. Make follow-up procedures easier by having some walk-in appointments and evening

hours (Elliott, 2013).

In this context, practitioners and staff with expertise and experience with the population group are able to anticipate the common interventions that may be needed, to adapt to the particular needs of the patient in front of them, and to use their expertise to provide the treatment that is most needed in the current situation. Communication is tailored to the patient with awareness of potential literacy issues common in the population (Dawson & Jackson, 2013; Elliott, 2013; Hamilton et al., 2018; Hudson et al., 2016b; Islam & Conigrave, 2007; Lamb et al., 2012; Luchenski et al., 2018; White et al., 2016; White & Newman, 2015). This stands in contrast to what happens when services do not have proper resources and when practitioners and staff do not have expertise and experience as explored in CMOC1. The importance of communication and projecting a high level of understanding is reflected in this quote:

> Findings raised the importance of talking to somebody else who would listen, and be understanding. Trust and confidentiality were often considered paramount. Less explicit though perhaps equally important was that the person who was listening respected the boundaries set by those disclosing. This was linked to the perception that health professionals were unable or unwilling to engage with the patients' understanding of who they are and how they relate to the worlds they inhabit. This emerged as fundamental to people's understanding of aetiology, the way they framed their problems, their decisions to seek help and the behaviours they adopted in living with chronic mental health issues (Lamb et al., 2012).

In the context of flexible healthcare delivery, patients' needs are identified and if met in the manner described in CMOC4, this experience forms a new context. In this new context ('needs identified'), experiences of lowered frustration and fear is engendered in patients because they do not have to fit into a mould of a health service which is difficult to navigate and not likely designed with them in mind (Brown et al., 2016; Crock, 2016; Dawson & Jackson, 2013; Klop, de Veer, et al., 2018; M. Weber et al., 2013; White & Newman, 2015). Resulting from that, patients feel seen and understood which becomes a new context ('patients feel seen and understood') in which ongoing engagement from both sides is possible and pathways can be created with high levels of flexibility and assistance (Brown et al., 2016; Dawson & Jackson, 2013; Klop, de Veer, et al., 2018; Lamb et al., 2012; Robards et al., 2018). Patients are able to follow these peer, key-worker and/or health staff assisted pathways and ultimately this leads to ongoing appropriate access to services over a course of treatment or on an ongoing basis as needed. A cyclical nature of an ongoing and trusting relationship is established and reinforced over multiple interactions (Brown et al., 2016; Dawson & Jackson, 2013; Harris & Rhodes, 2013; Hudson et al., 2016b; John

& Law, 2011; Luchenski et al., 2018; W. H. Martens, 2009; Wallace et al., 2018) as shown in the quotes below:

> Community based staff may also be in a position to advocate for homeless people in health care situations, due to their longer term relationship and thereby understanding of the individual's needs;
> "Three or four of these clients since I've started working here have been recognized by the workers at [harm reduction program]. They know to call us and that we'll follow through with helping with appointments and referrals to the [EoLC]" – Health care professional (Hudson et al., 2016b).

And:

> The ability to develop an ongoing personal connection involved rapport with service providers, continuity of therapeutic relationships, and a usual source of care (Robards et al., 2018).

3.5.3 Full programme theory

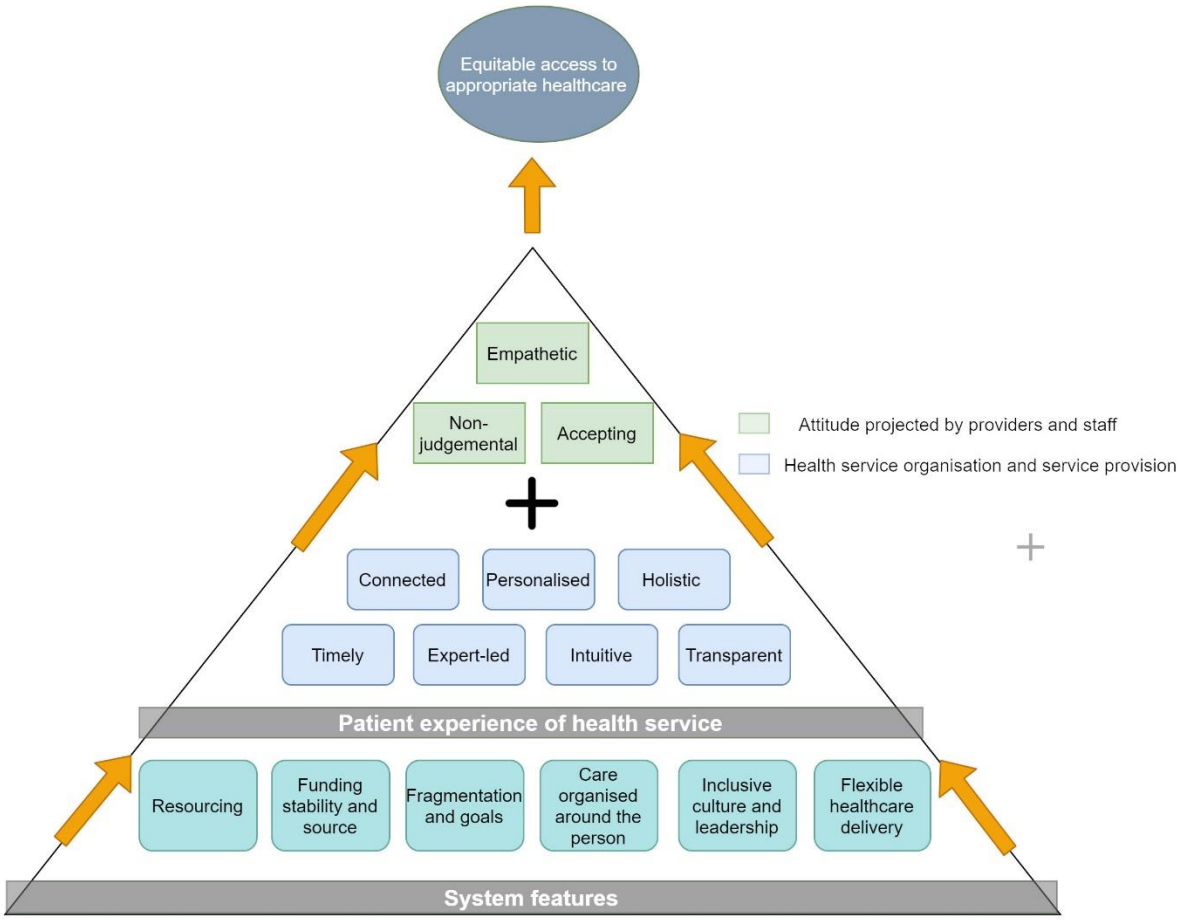

Figure 16: Realist review overarching programme theory

The overarching programme theory synthesising the full set of findings from this review (Figure 16), shows that a set of interlinking factors must all be in place for healthcare access to be successful for populations experiencing homelessness.

It shows that the combination of resourcing, funding stability, health system fragmentation and goals, the degree to which care is organised around the person, the degree to which leadership promotes an inclusive culture, and the flexibility of healthcare delivery set the stage for accessibility.

When resources (funding, expertise, experience of patient group) are adequate, when funding cycles are long and stable, when there is a low degree of fragmentation and health service goals support integrated working, when healthcare is organised around the patient and delivered flexibly, and when services are provided in an inclusive culture championed by leadership, then services can be provided in the way explained in the blue and green boxes. That is that healthcare services are organised and provided (as explained in the blue boxes) in a manner that is: connected to and collaborating with other practitioners and services; personalised to the needs and desires of the patient; holisitic in looking at the patient as a full person; timely in that services are available when needed and take into account the patient's lifestyle and other commitments; expert-led where staff and practitioners have adequate expertise and experience of populations experiencing homelessness, allowing them to anticipate and opportunisitcally act on multiple healthcare needs in one encounter; intuitive in that patients can undestand and easily follow patient pathways, with staff/peer-advocate assistance as needed; and transparent in that confidentiality is clear and decisions are made between patient and practitioners in an open and honest way based on patient desires and not the needs of practitioners. Additionally in an inclusive culture with flexibility and autonomy allowed, staff with the right experience and expertise are enabled to project an attitude of non-judgement, acceptance and empathy as described in the green boxes.

On the other hand, when those system features are not in place or not fully in place, the patient experience of health services is impacted negatively. For example, when health services are provided in a fragmented way, it is not possible to provide timely care because each service operates on their own schedule and each step on a patient pathway depends on a referral from the last.

3.5.4 Statement of principal findings

Health systems influence healthcare accessibility for populations experiencing homelessness in a number of ways as described in the six CMOCs explained above. The analysis has shown the following:

1. When healthcare practitioners have limited experience, training and resources to meet the particular needs of populations experiencing homelessness, they feel professionally inadequate and project unwelcoming attitudes. As a result, patients have a poor experience in the care environment and choose not to seek care until they experience their situation as desperate, resulting in exacerbated need and poorer outcomes to follow.
2. When health services have short funding cycles and diverse sources of income, staff and practitioners perceive their employment situation to be unstable and unsustainable and as a result hiring and retaining qualified and experienced staff is jeopardised.
3. When health systems are fragmented and operate in silos with a narrowly defined scope of goals, practitioners and staff focus on and seek to meet the goals of the organisation they work for rather than those of the individual patient.
4. Conversely, when care is organised around the person, it can be provided in a manner that is personalised and flexible which results in meeting the particular needs of the patient; services work together connecting around the patient's needs and providing the patient with clarity of what their next steps are and give assistance in reaching those next steps, leading to the patient journey being easier to navigate; and services take responsibility for accessibility by seeking to understand the full needs of the patient, respecting their time and other commitments, and being transparent about the reasons why a given treatment is needed.
5. When healthcare leadership and management support and champion inclusive cultures, it allows services to be delivered in a non-stigmatising, respectful and empathetic manner which leads to trust developing between patients and staff. Over time, the experience of trust in a context of an inclusive culture, reinforces and strengthens the patient/practitioner relationship and ultimately allows for ongoing healthcare accessibility.
6. When health services are delivered in a flexible manner, practitioners can use their expertise to anticipate, and adapt care to, the needs of the patient. As a result, the patient's needs are identified, and if met, the patient experiences less frustration and

fear which leads them to feel seen and understood, which promotes ongoing engagement with services and ultimately leads to ongoing access taking place.

Making healthcare accessible for populations experiencing homelessness who have complex needs requires stable funding for sustainable staffing, coordination of services which should be delivered in an inclusive culture championed by leadership, and space to allow practitioners and staff to use their expertise to provide anticipatory, flexible care. Trust and the development of ongoing trusting relationships between patients and staff is key.

3.6 Strengths and limitations

This study has several strengths. First, we have used the RAMESES publication standards (Wong et al., 2014) to guide us in rigorously and systematically reviewing and synthesising the literature included here. Second, the analysis has taken a high-level view of systematic factors across a breadth of data not focused on specific interventions or disease areas. Our findings have uncovered modifiable health system and service contexts that are applicable and transferrable among high-income countries. And third, the analysis has been informed by the involvement of content experts and stakeholders who have confirmed and challenged findings resulting in further refinement.

The study also has a number of limitations. Like any review this one relies on the available literature. A potential limitation of this study is that the initial search of peer-reviewed articles included only literature reviews which may mean that we missed some articles. The risk with this search strategy is that not enough of the rich detail of how, why, for whom, and in what circumstances interventions work or do not work will not be present in reviews. However, with iterative searching and citation tracking, I was able to gather enough information to build CMOCs and my programme theory in chapter 3. Additionally, our search did not identify studies from low-and middle-income countries and we cannot therefore say whether our findings are transferrable in such contexts. More research is needed to explore how the contexts outlined here are applicable or not to low-and middle-income countries, how, for whom and why.

Second, a further limitation was the difficulty in using the initial programme theory in guiding the initial steps in the study. Much like a majority of the literature on access to healthcare for populations experiencing homelessness the initial programme theory took the perspective of an individual seeking to access healthcare services. However, as the goal of this review was to explain health system factors impacting healthcare access for populations experiencing homelessness, the initial programme theory did not provide a helpful framing for the goals of

the study and we did not use it in the search, data extraction or analysis phases as is often done in realist work.

Third, this review did not utilise patient and public involvement (PPI). The research team felt that PPI would not have added sufficiently to this system-level analysis to warrant the use of potential participants' time and resources. Furthermore, we felt that appropriate 'PPI-like' engagement for a study like this should be with frontline staff who function at the intersection of the patient experience with health system goals, culture and operational procedures. To capture this perspective, we held a formal expert panel meeting with a number of stakeholders representing professional groups working with populations experiencing homelessness. More similar engagement during the design phase of the study would likely have been helpful and could have added to the initial programme theory building, searching and analysis phases of the study.

Fourth, none of the included peer review studies specifically analysed health system features. Some analysed service/programme level features that promote or impede access (Wallace et al., 2018; White & Newman, 2015) but the majority of reviews synthesised and described the accessibility of particular individual level treatments such as for TB, diabetes, palliative care and cardiovascular disease (Hamilton et al., 2018; Hudson et al., 2016b; Jones et al., 2009; Klop, de Veer, et al., 2018; Lutge et al., 2015; Tankimovich, 2013; White et al., 2016). However, grey literature sources added substantially to the set of findings about high-level health system contexts and mechanisms (eg resourcing, expertise, funding cycles, fragmentation and goal setting).

Fifth, the included data sources did not differentiate between health access outcomes specifically in response to health system features within subgroups among long-term single homeless individuals with complex needs. Therefore the 'for whom' part of the analysis was not as fully developed as it might have been with more research needed.

Sixth, there was wide variety in the quality of the reviews themselves with some being transparent and following the guidelines of their particular review methodology closely (eg search string and list of databases provided, appropriate quality appraisal tools used, systematic approach, using appropriate reporting standards, etc) while others did so to varying degrees and a few not at all. A majority of reviews were based on qualitative, descriptive, and small-scale quantitative studies using a variety of methods eg RCT, cohort and case-control studies. The majority of included studies evaluated a particular aspect of healthcare access eg association between having health insurance and having a usual source of care (White & Newman, 2015).

3.7 Comparisons with existing literature

We are aware of no other realist reviews examining healthcare accessibility for populations experiencing long-term homelessness and complex needs and of no other reviews of any approach that have examined high-level health system features that impact healthcare accessibility for the same population group. Other reviews have focused on specific healthcare interventions and most take the point of view of the patient navigating services or systems. This review differs in that we have analysed the upstream health system and service contexts that promote healthcare accessibility and have found generalisable features not specific to a particular intervention or the treatment of particular illnesses. These uncover causative relationships between how healthcare is organised and delivered at a systems and service level and its accessibility for populations experiencing homelessness and complex needs.

A realist review by Ford et al (2016) of factors that impact access to primary care for socioeconomically disadvantaged older people in rural areas focused on the patient journey in accessing healthcare and not on health system features. However, there were similarities between its' findings and ours: at the service level, both studies found barriers related to ease of booking, clarity of information, system and service navigability, practitioner responsiveness to patient needs, patient empowerment, social status, trust, and clinician empathy and capacity.

There are similarities between our review and Aday and Andersen's 'A framework for the study of access to medical care' (Aday & Andersen, 1974). Our CMOCs all explain aspects of the two first boxes in their Framework: health policy (eg financing, education, manpower and organisation) and characteristics of health delivery system (eg resources, organisation).

Our CMOCs also hold some similarities with Levesque et al's 'Patient-centred access to health care: Conceptualising access at the interface of health systems and populations' (Levesque et al., 2013) although it is focused on the individual patient journey. Concepts including acceptability (eg professional values, norms and culture) as well as appropriateness (eg technical and interpersonal quality, coordination and continuity) are important to CMOCs 1, 4, 5 and 6.

3.8 Meaning of the study

As in other realist works, our analysis has uncovered demi-regular patterns of outcomes resulting from mechanisms being activated in the specific contexts described in the literature. Mechanisms are not always activated in a given context. Outcomes are occurring at both a system level and individual level. The topic of access to healthcare for homeless populations is a complex one in and of itself but it sits within an area of much more complexity: the general treatment of homeless and socially excluded populations in all areas of society including health,

housing and social care. The narrow focus on access to healthcare here is due to the specificity needed to conduct sound research, however, this focus is not meant to be seen as an argument for siloed thinking and service provision.

In fact, population groups on the extreme margins of society, such as populations experiencing long term homelessness, are in particular need of comprehensive, joined up strategies in their care. These populations tend to exist at the intersection of multiple disadvantages in life (eg substance use, childhood trauma, poor mental health, contact with criminal justice systems) which can amplify each other. At the same time, these people also have a high risk of falling into gaps between service and policy areas each focused on their particular goals and targets. For example, housing and health policies are often not joined up (Bramley et al., 2015).

It is likely that many of the findings in this review can be applied more broadly to all socially excluded populations and form a basis for thinking about how to make a health system fully responsive to populations experiencing a variety of deprivation or differentiation from 'the norm' and thus truly universal, informed by existing approaches such as Universal Design (HSE and the National Disability Authority, 2014). A non-judgemental, flexible and empathetic approach should be applied to all services for all socially excluded populations and beyond, in conjunction with a joined-up approach to health and social care (HSE and the National Disability Authority, 2014; Luchenski et al., 2018; W. H. Martens, 2009).

The first three CMOCs above (CMOC 1-3) were generated almost exclusively from grey literature sources and the other three (CMOC 4-6) were generated primarily from peer reviewed literature. The grey literature included many high-level systems topics including resourcing, funding cycles, the siloed nature of healthcare, health system goal setting and more, as well as describing patient level factors. The majority of the peer reviewed literature described patient level healthcare interactions. In these interactions, contexts are often reflective of systematic or at least service-level planning, management, culture and leadership decisions and practices but they were not explicitly examined. There is a need for more research exploring healthcare access for people that experience homelessness from a health systems perspective.

3.9 Conclusion

3.9.1 Realist review conclusion

Access to healthcare for populations experiencing homelessness depends on adequately resourcing and training practitioners to meet the particular needs of patients in a welcoming and attentive setting without stigma and judgment. Services should be closely linked, and staff and

practitioners should be empowered to take responsibility for providing flexible, responsive, and opportunistic care in adaptable settings. For patients, having a good experience and getting one's needs met sets a precedent for future appropriate healthcare access. The contexts in which this is possible, arise in a respectful, empathetic culture which is created when managers and leaders value and champion it.

3.9.2 Chapter summary

This chapter is based on a realist review study which was published in March 2021 in the BMJ-Open (Siersbaek, Ford, Burke, et al., 2021). Here additional detail has been provided to more fully explain how the research was undertaken. Representative pieces of data have also been incorporated into the text to further illuminate the CMOC analysis which there was not room for in the journal article. The full data are provided in appendix 4.

The chapter has described the methods, analysis and findings of the realist review resulting in six consolidated CMOCs and one overarching programme theory. These findings provide an explanation of how health systems impact healthcare accessibility for populations experiencing homelessness, based on published data sources. It sets the stage for the following study, a realist evaluation which will use primary data to further explore a subset of findings from the realist review.

Chapter 4 Realist evaluation

4.1. Chapter outline

This chapter will explore the second study in this thesis, a realist evaluation taking as a starting point two of the overarching CMOCs which were the product of the first study, the realist review discussed above in chapter 3. Using these two CMOCs as the initial programme theory, this study produces fuller and more in-depth explanations for a subset of findings of the realist review.

The steps in a realist evaluation were used, as described in chapter 2. First, guided by the initial programme theory, data were collected, using qualitative and realist interview methodologies, from Irish healthcare practitioners, healthcare managers, and homelessness advocates working within the Irish health service, the Health Service Executive, and for NGOs that provide a range of services to people experiencing homelessness including housing, health, and addiction services and supports. These data were coded using both inductive and deductive coding. Focusing on the particular data that informed exploration of the initial programme theory, context, mechanism and outcome labels were assigned using a realist logic of analysis. Then explanatory CMOCs were iteratively constructed and refined resulting in a total of 14 CMOCs which were then combined into four higher level consolidated CMOCs, and finally, those were combined into an overarching programme theory at a transferrable level of abstraction.

4.2 Overarching realist evaluation methodology

Simply put, realist evaluation is a realist study using primary data. Realist evaluation is a theory driven approach using a realist logic of inquiry to establish a research question, collect data, analyse data, and establish findings. The approach is theory driven in that the researcher theorises about underlying generative causal mechanisms at play in a given complex social programme or area of research which produce a given outcome but only in the right context.

The process of research using realist evaluation is iterative (see Figure 17) meaning that the analysis can go back over the same areas multiple times with more data collected as needed as the analysis develops and findings are made and potential gaps exposed. The process does not need to go through all the steps before going back a step or several. The iterative nature of the approach allows for moving back and forth as dictated by the needs of the study.

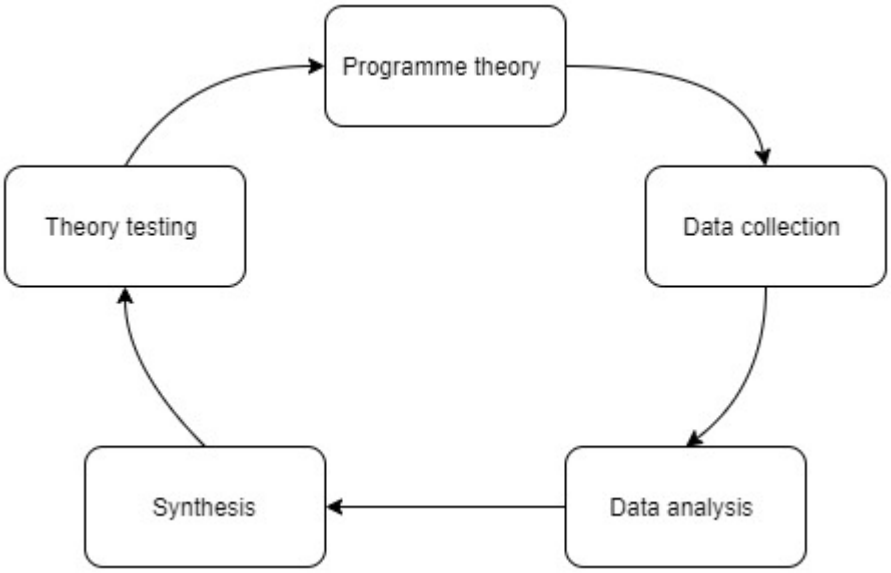

Figure 17: Stages of a realist evaluation

Along with my supervisors, I published a protocol with the title 'Making healthcare accessible for single adults with complex needs experiencing long-term homelessness: A realist evaluation protocol' (Siersbaek, Ford, Ní Cheallaigh, et al., 2021) in January 2021 to guide this study. The protocol sets out the steps which the study followed.

The steps for this study in brief were:

1. Identifying CMOCs from realist review study to further investigate and to act as the initial programme theory
2. Data collection. Two pilot interviews and 11 realist interviews were undertaken.
3. Data analysis. Inductive and deductive coding of interviews in NVivo 12, organising pieces of data into conceptual groupings.
4. Synthesis. Building CMOCs from the coded and grouped data.
5. Theory testing. Iterative testing and refining of CMOC with discussion with supervisors, two content experts, and checking against the data.
6. Synthesis. Integration and description of findings in overarching programme theory.

4.2.1 Ethical approval

Ethical approval for this study was granted by the Trinity College Dublin Health Policy and Management and Centre for Global Health Research Ethics Committee (application 22/2019/01). See ethics application in appendix 11.

Approval was provided for interviews with key informants and for focus groups with experts by experience, eg service users with lived experience of homelessness. However, with the onset of

the global COVID-19 pandemic in March 2020, the data collection plan had to be amended as data collection had to be done remotely. As a result, interviews carried on as planned, through shifting online after a few had been completed in person, while focus groups had to be cancelled as it was not possible to convene a group of people safely in a room together.

4.3 Study aim and research questions

The aim of this realist evaluation is to understand how funding procedures and health system performance management impact service settings, staff, and practitioners, and their ability to make services accessible to populations experiencing homelessness.

As described in the study protocol (Siersbaek, Ford, Ní Cheallaigh, et al., 2021), the study takes as a starting point the following two CMOCs from Chapter 3:

Figure 18: Realist evaluation initial programme theory CMOC1: Funding stability

CMOC1 (Figure 18) suggests that when funding for health services comes from multiple sources in short and unreliable cycles, eg grant funding to meet a specific need (Gill et al., 2013; Page & Hilbery, 2011; The Faculty for Homeless and Inclusion Health, 2018; The King's Fund, 2020), it leads to a lack sustainability and stability for services (Cortis & Blaxland, 2017; Focus Ireland, 2021b; Mahon, 2016; The King's Fund, 2020; The Queen's Nursing Institute, 2018) which face difficulties hiring and retaining skilled and experienced staff members as a result (Cortis & Blaxland, 2017; Focus Ireland, 2019; Mahon, 2016; The King's Fund, 2020; The Queen's Nursing Institute, 2018).

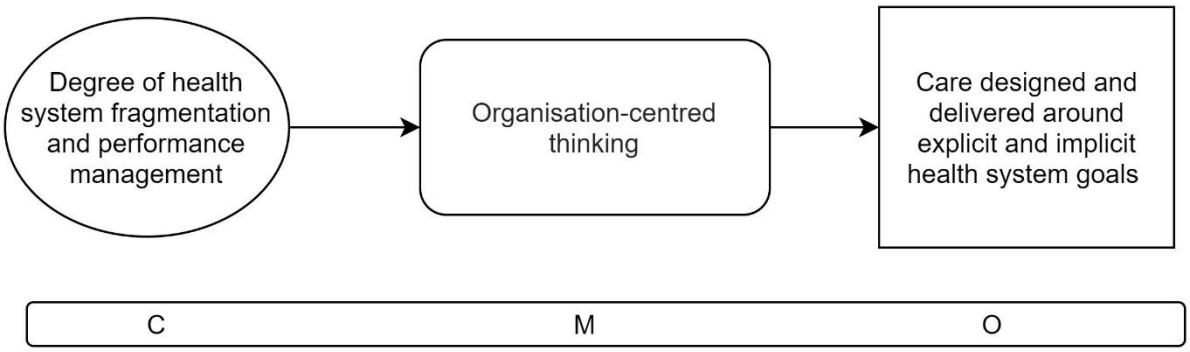

Figure 19: Realist evaluation initial programme theory CMOC2: Health system fragmentation and performance management

CMOC2 (Figure 19) suggests that when individual parts of a health system operate with narrowly defined goals in silos (Cabinet Office Social Exclusion Task Force, 2010b; Gill et al., 2013; Making Every Adult Matter Coalition, 2015; Page & Hilbery, 2011; The King's Fund, 2020), performance management measures become focused on meeting those goals and staff prioritise them even in cases they do not align with the needs of their patients (Cabinet Office Social Exclusion Task Force, 2010b; Making Every Adult Matter Coalition, 2015; Page & Hilbery, 2011). These performance management practices may inhibit the delivery of services in holistic, coordinated and flexible ways. As a result, healthcare is organised not around the needs of the person seeking care but around the needs of practitioners and the system (Cabinet Office Social Exclusion Task Force, 2010b; Gill et al., 2013; Homeless Link and St Mungo's, 2012; Making Every Adult Matter Coalition, 2015; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016; Page & Hilbery, 2011).

Using these two CMOCs as the starting point, this realist evaluation analyses further the underlying causative relationships they describe between funding procedures and health system performance management, and the ability of service settings, staff, and practitioners to make themselves accessible to populations experiencing homelessness.

The following research questions are under consideration:

- How are health services for homeless populations funded?
- For whom do funding arrangements work and not work, and why?
- How is health system performance management intended to translate into service design and delivery for populations experiencing homelessness?
- In what circumstances are health system performance management and organisational targets useful for creating healthcare accessibility for homeless populations and when are they not?

- Who (patients, staff, practitioners, the system) does health system performance management work for, to what extent?

4.4 Data collection

At the outset, the plan for this study was to collect data through interviews with key informants working in, managing and planning healthcare services used by populations experiencing homelessness, and through focus groups with experts by experience who have lived experience of homelessness and have used health services. However, with the onset of the COVID-19 pandemic in March 2020, plans had to be changed.

Three face-to-face interviews had taken place by March 2020. The rest moved online using Zoom for video-conferencing and transcribing subsequently took place using audio recordings made by Zoom during each call with the permission of the interviewee.

Focus groups were planned to take place in the autumn/winter of 2020 with the goal of recruiting members of the Depaul Dublin Homeless Health Peer Advocacy programme, a group of people with lived experience of homelessness who are trained to support people currently experiencing homelessness when accessing healthcare services ('HHPA Dublin', 2021). When COVID-19 arrived, initially plans were made to move the focus groups online. However, the peer advocate programme, which was launched in 2019, did not commence as planned for the year 2020-2021 and so there was no panel of people to consult. Conducting focus groups with other people with lived experience of homelessness was deemed unsafe and unfeasible taking COVID-19 restrictions and cautions into consideration.

As a result, data for this study were collected solely through interviews. Two semi-structured pilot interviews were conducted early in the study, before the protocol was published. Later a total of 11 realist interviews took place to specifically test and further develop the initial programme theory.

4.4.1 Pilot interviews

Two pilot interviews took place in the summer of 2019. The goal of these interviews was to get a sense of the types of questions that might yield useful information, to help with the decision of which CMOCs to bring forward from the realist review into the realist evaluation, and to get some practice interviewing study participants.

4.4.2 Realist interviews

Eleven realist interviews took place from May 2020 to March 2021. The first round of seven interviews took place in May and June of 2020. After the first rounds of data analysis, as it

became clear that more data were needed to further develop aspects of specific CMOCs, four more interviews were conducted in February, March and April of 2021. The interviews were 30 minutes to an hour in length with most being on the longer side.

The majority of interviewees work in health service roles in Dublin actively engaged with managing the COVID-19 crisis at the time of data collection. However, all graciously and quickly agreed to be interviewed and generously provided me with their time and expertise. It was a privilege to be able to engage with these people even though they were extremely busy and under a lot of pressure. Their interest in and enthusiasm for my research speaks to the general dedication of the professionals working in homeless healthcare and advocacy who one and all were thoughtful, open and helpful.

Below is a table (Table 3) with an overview of the interview participants for both pilot and realist interviews. One participant was interviewed twice, once for a pilot interview and later again for a realist review. For this reason, a total of 13 interviews were conducted but the number of interview participants is 12.

These interviewees represented a number of professional roles within health services for populations experiencing homelessness with perspectives ranging from physical healthcare, mental healthcare, health service planning, and advocacy. The interviews yielded sufficient key data for the analysis.

Professional	**Count**
Doctor	3 (one hospital consultant/two GPs)
Nurse	3 (two hospital/ one community)
Senior healthcare manager	2
Social worker	2 (one community/one hospital)
Health service planner	1
Homelessness advocate	1
Total	**12**

Table 3: Interviewees for Realist Evaluation

4.4.2.1 Teacher learner cycle

Like other aspects of realist work, data collection through realist interviews is a theory-driven endeavour. The researcher sets out to explicitly test theories and to answer questions about the how, where, when and why of the intervention or area under consideration. Unlike qualitative interviews, realist interviews are not driven by what the participant wants to share but by the

theory which the researcher seeks to develop, refine, or reject (Greenhalgh, Pawson, Westhorp, et al., 2017).

The realist interview is ideally a cyclical procedure whereby the interviewer explains something about the programme theory to the interviewee. Typically, this is not done by laying out the programme theory in full but by 'telling a story' about it or an aspect of it and going through a cyclical process where the interviewer and interviewee take turns being the 'expert.' This cycle is called the 'teacher-learner cycle' (Greenhalgh, Pawson, Westhorp, et al., 2017).

The 'teacher-learner' cycle works by the interviewer asking a question by telling a story and giving some context and thereby acting as the 'teacher' but they then hand off to the interviewee to become the teacher and assume the role of 'learner' while the interviewee answers the question. They may then stay in the 'learner' role with further follow up questions to probe deeper and pick up on interesting information. The next step happens when the interviewer moves on to the next aspect of a theory to test and again becomes the 'teacher' introducing the next 'story' (Greenhalgh, Pawson, Westhorp, et al., 2017).

For example, in this study, one of the interview questions I asked of several interviewees was a version of the following: 'I have read in some articles and other practitioners have also told me that when funding cycles are short it can give staff a feeling of insecurity in their jobs. Do you think that is correct based on your experience?' In this instance, I was testing an aspect of CMOC1: Funding stability, discussed above in section 4.3. I was investigating the relationship between the length of funding cycles and feelings of job insecurity but without saying what I think or what my analysis had shown. I was 'teaching' briefly about what I have previously found about the topic and the interviewee then would take on the job of 'teacher' by sharing their particular experience which supported, questioned, or refined my theorising.

This kind of questioning leaves the interviewee with enough room to answer positively or negatively and to bring the conversation on to a different aspect of the topic if desired because the researcher is not offering their opinion of what is going on but providing a neutral explanation of a piece of information. Doing so should help minimise the risk of confirmation bias and a potential social desire to be kind and agreeable to the interviewer (Manzano, 2016).

4.4.2.2 Theory testing

According to the RAMESES Project guidance on realist interviews (Greenhalgh, Pawson, Westhorp, et al., 2017) they can be used to develop programme theory but typically they involve testing theory that has been developed, which means that before doing interviews the

researcher should have developed theories to test. The guidance also suggests that interviewers have a good understanding of what happens in the natural setting of the intervention or area they are researching.

In this study, both preconditions were met through the previous realist review study which had involved in-depth study of the topic at hand and the development, testing and refinement of theories. It allowed for rigorous testing and questioning of the theories under consideration and with a confidence and ease that comes from a thorough understanding of the topic. It was helpful also in putting interview subjects at ease and establishing rapport which ultimately led to successful theory testing and collection of many relevant data. The results of the analysis building on the theory-testing in the interviews are explored in the Results section (4.5) below.

4.4.3 Coding

Coding was done both inductively and deductively. First, for the first few interviews, codes were created inductively as coding took place using NVivo software version 12. Second, those codes were applied deductively to subsequent interviews with new codes created along the way if a new concept came up.

The approach to coding was in line with the way Geoff Wong teaches coding on his University of Oxford Department of Continuing Education course on realist evaluation and realist review which I undertook in November 2019. The same coding style is described by Papoutsi et al (2018, pp. 13–14) and Tierney et al (2020).

This approach, as shown in Figure 20, uses a conceptual approach to coding rather than coding using context, mechanism and outcome labels. This approach is useful because it is often difficult to know exactly where in a CMO configuration a particular concept captured in the data will sit, especially at the relatively early phase of a realist study when the first round of coding takes place. Additionally, it is often the case that the same concept could act as context, mechanism or outcome depending on the particular CMO configuration and therefore labelling a concept with C, M or O is potentially not helpful early on before one is actually configuring the data.

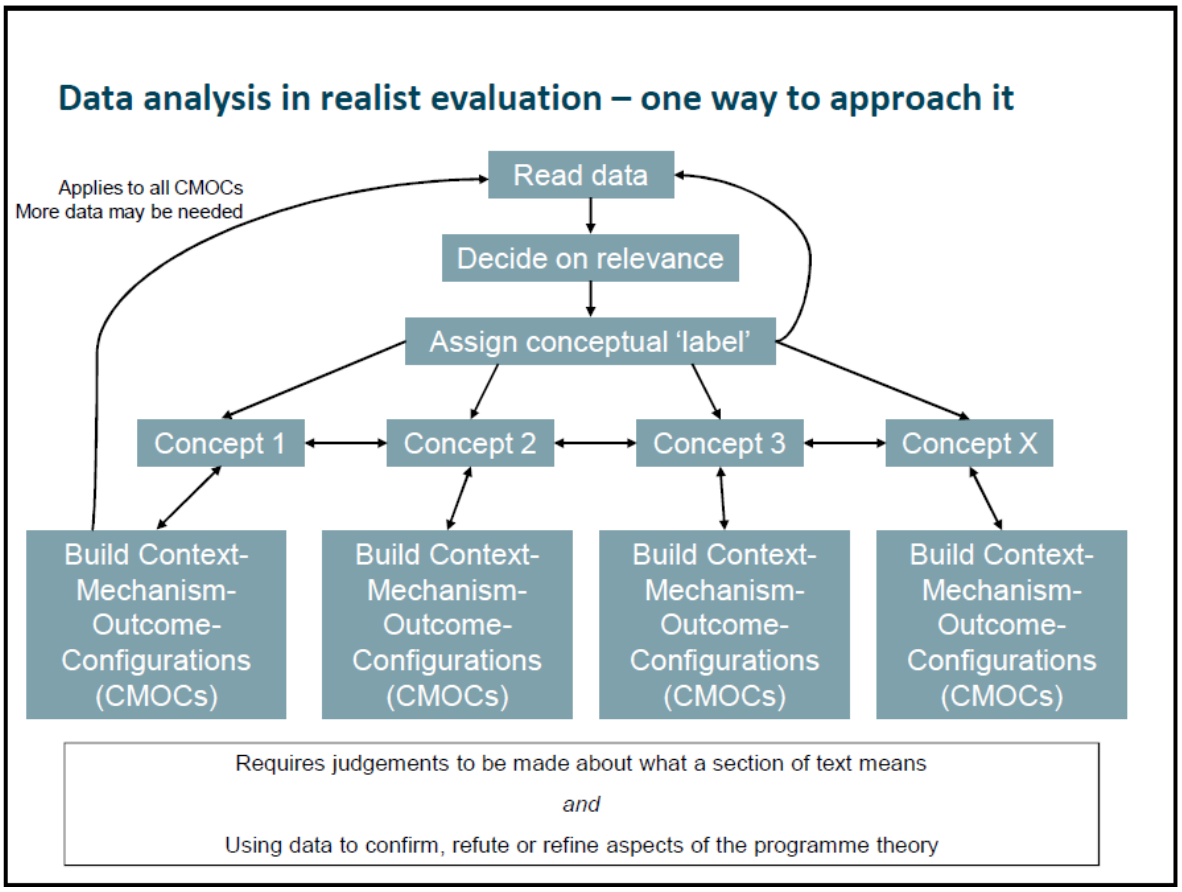

Figure 20: Data analysis in realist evaluation (reproduced from Dr Geoff Wong with permission)

In this approach, codes are assigned under conceptual labels that capture what the concept is about. Eg in this realist evaluation, codes included 'governance', 'hierarchy', 'incentives', 'individually driven', 'fragmentation', 'culture', 'pathways', 'person-centredness', 'policy', 'service design' and many more. See full list of codes in appendix 8.

After assigning conceptual labels, the next step was to pull out the most important concepts which would answer the research questions as listed above in section 4.3. A number of concepts were identified through the coding which were not directly relevant to answering the questions under examination so these were disregarded and the others brought forward with their accompanying data. With this narrower set of data, the next step then began with the examination of the relationships between aspects of the data looking for conceptual, mechanistic and outcomes data and also the analysis of underlying generative causative relationships between mechanism and outcomes. This step of analysis was done by making handwritten lists and a list in MS Word of the important concepts and key related data.

4.4.4 Analysis and synthesis

The next step was to start building CMOCs which was done using MS Excel. Based on the analysis and deep thinking of the prior step, CMOCs were crafted to describe the relationships observed in the data starting from whichever part of the construction 'jumped out'. In other words, I did not use a particular direction in the CMOC eg moving backwards from the outcome as is a practice some realist researchers utilise.

The analysis step was iterative and each CMOC was refined at least three times after discussions with my supervisory team and checking against the data. At times this led to changes to the CMOC or the combining of CMOCs that were similar.

For each CMOC, all the data in the form of direct quotes from the interviews were listed in an excel sheet in columns next to the CMOC itself. These data provide the evidence to support each of the CMOCs. The data from each CMOC comes from multiple sources.

A total of refined 14 CMOCs resulted from the first analysis step. These were then later combined into four higher level CMOCs that brought the analysis to a higher level of abstraction. Finally, these were combined into one overarching programme theory.

4.4.5 CMO construction

A total of 14 CMOCs were constructed (see Table 4 below), all based on several data sources through numerous rounds of analysis and refining. To show the process of arriving at a CMOC, I will provide the data that was used to construct CMOC1. For this CMOC, data came from six quotes in four different interviews and taken together they resulted in this causal explanation: *In a context where health and social care services serving populations experiencing homelessness are fragmented (C) and where each health service manages one problem at a time (C), staff and practitioners are left to act individually (M) and have to rely on their own networks, relationships, communication skills and persuasive abilities (M) to take responsibility for filling gaps and making connections (M). As a result individual staff and practitioners create adequate access for their patients on a one-to-one basis where possible (O) and the quality of service access is precarious and dependent on whether the patient happens to reach a service with dedicated, knowledgeable practitioners and staff (O).*

Data that were used to build this CMOC:

- 'I think that's probably the hardest aspect for our client group, **because they have so many systems, so many agencies involved with**, like, so a lot of the time, like if, if I'm working with a client on the general mental health team they'll know me, they'll build

up a relationship with me - I'm [name of interviewee], I'm their [health professional] . . . **That doesn't happen with homeless people that you work with because they have so many people involved, they don't know, like sometimes they will, like oftentimes they will, but there'd be a portion of them that will get confused - who are you again?**' – Interviewee 9

This quote contributed to my understanding of the context of fragmentation in demonstrating that homeless clients experience a reality of having to navigate and encounter many systems and individual agencies which they have to keep track of.

- '**I think that the way we structure . . . our service delivery model is based on what's good for, what works for the 70% of society, who go to work, and, you know, can keep appointments. Erm obviously, the people who design things come from that cohort. . . appointment times, 10 minute consultations, type of clinic, the way even clinic looks is built for the 70% of society. It's not built for the drop-outs of society**. So obviously, it doesn't meet their needs. Erm they can't keep appointments, don't prioritise healthcare.' – Interviewee 12

This quote contributed to my understanding of what happens to the minority when a system is designed for the majority. It provides information about the expectations embedded in a health service designed by people who may not understand the needs of socially excluded populations.

- "I think the whole health and housing [is] not really being really combined as a policy point of view . . . I don't feel like it's a healthcare system, I think they're happy to have people that are doing the system pieces. **You know they can get outcomes, even better, and if we don't have to finance much, even better. And we can show improved health, great, but if those people aren't there you'd wonder, are the systems there to keep it going?**' – Interviewee 5

This quote provides pieces of data about the realities of working as a clinician in a system that is not designed with the needs of socially excluded populations in mind. The notion that individual clinicians and staff have to figure things out on their own without adequate systems in place to guide their work, that the health system relies on these individuals to fill gaps, and that work-arounds are not just tolerated but encouraged, is clear. It also contributes to the understanding of the outcomes regarding the quality of service-access being precarious and dependent on the dedication of individual people, not the system. And shows that if those people are no longer there, high quality healthcare access and delivery for homeless people would likely leave with them.

- "**So I do think that the whole system probably doesn't work together**. I think we like to think we do but it's not probably an area of focus. Yeah, I mean, drug and alcohol related attendances and I think [major Dublin teaching hospital], was studied recently in a European study and I think it was pretty high up there in terms of overall attendances erm . . . and I think if you can show that then maybe you can show that **these patients need extra resources which means you need extra staffing because it takes a lot of staff to look after. You could spend two or three hours looking after somebody and you just don't have the time. . .** I mean I really didn't want to be a [advanced clinical role], like I had no interest. it was really just, I would rather somebody else did it and I would be floating around in the background and my friends helping out but **I suppose I just felt it was a really good opportunity to really show and make a difference in, you know, the actual patient journey**, erm, and, like, for what the hospital wants as well I think it would be definitely beneficial and beneficial for the patients as well because, you know, in [the] emergency [department] you end up seeing three or four people before you actually get a decision **whereas if somebody can make that decision early on, who knew all about, and it is a really specialist area. Which [name of doctor] shows like loads. It is a really specialist area.** You can't treat somebody with pneumonia who's going to rough sleep the same as somebody who's going home to their cosy home, you know." – Interviewee 5

This quote speaks about the context of fragmentation where this practitioner says that the whole system does not work together. The quote also contributes to an understanding of the mechanisms that arise in this context of fragmentation where this person felt the need personally to get extra training to be able to take on a more senior role in their hospital to be able to have expanded responsibilities to allow them to expedite the care of homeless patients coming to the emergency department.

- 'So okay, so systems like that. I find the MDTs [multi-disciplinary teams – used here to cover inter-disciplinary meetings across a number of services including health, housing and social care in Dublin city], I find what it is, is that you have a lot of likeminded various experiences around a table. And I find it works and I've kind of adapted that, we've adapted that to other areas. So like what I was saying like the diabetic foot service, like we have a little MDT every week. **And it's not that we're going to change the world with it but all our eyes on this particular person for that, for that be it five to 10 people in various circumstances, opportunistically. So eventually when that person lands in the ED [emergency department], there's a note on the system, it's like**

you know, get the podiatry service over to them you know, as when you can because they've been trying for it and then if they can, at that point, they'll come over'. – Interviewee 6

This quote shows that clinicians with an interest in meeting the needs of patients experiencing homelessness are taking the initiative to create professional relationships and networks to allow them to carry out their work with the necessary input of a number of multidisciplinary colleagues even if the systems are not set up for this type of working.

- 'Erm, you know, and one way that they change around the system in the hospital, at the time was, you know, they made COVID wards and COVID testing wards, or, you know, life changed as we knew, but teams would stay on the ward for the day, and that's where they would be. **And it was actually really interesting, because I think it was a really good learning curve for lots of them to see exactly what I do. Erm because they would see me coming back a few times, you know, and they're all valuable things. You this woman who comes and gets them out of the place with one note, like, has actually interacted with them a lot, I meet them on corridors, I meet them outside. And that's their chance just to say things, you know, and you have to have that adaptability as well as flexibility that we were talking about**'. – Interviewee 6

This quote points out the specialist nature of inclusion health work and the extra time and effort which this practitioner was putting in but which was only fully recognised by their colleagues when they were all forced to remain together on a ward due to COVID-19. This points to the ad-hoc nature of the work and lack of systematisation, and it points to the high level of expertise (eg flexibility, adaptability, knowing when to talk to the patient, knowing what to ask) that is present but again is deployed by the individual clinician on their own initiative and not necessarily as part of their official duties.

Taken together, these pieces of data each contribute to a causal explanation of the enabling context of fragmentation in which underlying mechanisms of staff acting individually, relying on networks and skills, and taking responsibility are triggered and lead to the outcome of service access being precarious. This careful process of analysis and synthesis was followed to construct each of the CMOCs in Table 4 below in section 4.5.1.

4.5 Results

Using the process just described in section 4.4.5 above, 14 CMOCs were constructed. The analysis then moved on to take findings to a higher level of abstraction by combining and

condensing the CMOCs, resulting in the crafting of four consolidated CMOCs. This section of the thesis will explain all the findings of the realist evaluation analysis at each level of the analysis from CMOCs to overarching programme theory.

4.5.1 CMOCs

Based on the coded data and through a process of CMOC building, 14 CMOCs were constructed from the data in the semi-structured and realist interviews. These are listed in Table 4 below.

Full list of Realist Evaluation CMOCs	
Number	**CMOC**
1	In a context where health and social care services serving populations experiencing homelessness are fragmented (C) and where each health service manages one problem at a time (C), staff and practitioners are left to act individually (M) and have to rely on their own networks, relationships, communication skills and persuasive abilities (M) to take responsibility for filling gaps and making connections (M). As a result individual staff and practitioners create adequate access for their patients on a one-to-one basis where possible (O) and the quality of service access is precarious and dependent on whether the patient happens to reach a service with dedicated, knowledgeable practitioners and staff (O).
2	In a context where health and social care services serving populations experiencing homelessness are fragmented (C) and where each health service manages one problem at a time (C), complex needs do not fit within service structures (M) and as a result the coordinated, complex care population experiencing homelessness need is compromised (O).
3	In a context where staff and practitioners arrange for healthcare access on a one-to-one basis for each patient (C), they are responsible for making services work for populations they are not designed for (M) and must create work-arounds because health system structures do not exist (M). And as a result, staff navigate multiple concurrent processes (O) and the health system as a whole does not need to change to accommodate the needs of homeless people (O).

4	In a context where specialised homeless services are very responsive (C), they meet the psychological safety and health needs of homeless populations in specialised settings or by providing assistance navigating mainstream services (M). As a result, mainstream services do not become adequately experienced with or flexible enough to accommodate the needs of homeless populations (O) and health systems are not required to take responsibility to meet those needs (O) because specialised services fill the gaps.
5	In a context where mainstream services are not required or enabled to accommodate the needs of homeless populations (C), services are unwelcoming to homeless populations and adhere to and place great value on rules and guidelines that are incompatible with homeless people's situations (M) and as a result, services become segregated and exclusionary and punitive (O).
6	In a context where a national funded strategy for homeless health is absent (C), there is no expectation that healthcare access for all populations should be the responsibility of the entire system (M) and as a result, people with particular vulnerabilities such as drug addiction, illiteracy, lack of family support, past experiences of trauma, previous unwelcoming and unhelpful healthcare interactions, and more, do not have their needs met (O).
7	In a context where a national funded strategy for homeless health is absent (C), individual NGOs lack financial security (M) and as a result raise independent funds to meet their own goals (O) and therefore there is no system-wide understanding of what services are being created and provided and what the needs are that those services meet (O).
8	In a context where a national funded strategy for homeless health is absent (C), health services express support for and ownership of values and best practice guidance and policies which enable populations experiencing homelessness to access healthcare (M) but do not consistently act on those values and best practices (O).
9	In a context where health and social care services are designed to suit the practical, professional, clinical and personal/psychological needs of practitioners and staff (C), patients' needs are not valued as much as the needs of those providing the service (M) and as a result, patients face complicated treatment pathways and delays (O).

10	In a context where health systems are focused on narrow metrics like costs and bed days (C), healthcare practitioners and staff focus on meeting goals that improve those metrics (M) and as a result, healthcare settings are not suitable for populations experiencing homelessness(O).
11	In a context where healthcare practitioners prioritise providing care strictly according to clinical guidelines and hospital rules, or due to their own needs while not taking into consideration the priorities of a homeless patient (C), patients feel their needs are dismissed and they feel unfairly treated (M) and as a result engagement with homeless patients is not cooperative and productive (O).
12	When mainstream health service key performance indicators focus on short-term and single specialty outcomes which are easy to measure and count (C), a life-course perspective is ignored and complex needs not understood (M) and as a result, services are not fit for purpose when it comes to preventing and treating health outcomes related to long-term homelessness (O).
13	In a context where funding cycles are short and attached to short term goals (C), returns are expected on a short time scale (M) and as a result services are not designed based on a life-course approach or to meet very complex needs (O).
14	In a context where there is a number of funding streams and where funding cycles are short (C), services experience funding insecurity (M) and as a result, projects that rely on a long-term engagement with clients cannot be sure of sustainability (O) and have to pitch their needs on a regular basis with success depending on whether their services align with current political priorities (O)

Table 4: Full list of Realist Evaluation CMOCs

4.5.2 Consolidated CMOCs

Four consolidated CMOCs were constructed by combining and consolidating the findings in the 14 CMOCs to create more generalisable, high level causal explanations. The iterative process of analysis which resulted in the four CMOCs shown graphically below took place with the input of my supervisors, as well as one-to-one zoom calls with one interviewee and two people with lived experience of homelessness who now work in homeless services. These consultations acted as an approximate, virtual 'expert panel' at an advanced stage in the research process which helped to further confirm, challenge and refine findings from the realist evaluation. All data that fed into the consolidated CMOCs are listed in appendix 9.

4.5.2.1. Consolidated CMOC 1: Health System Fragmentation

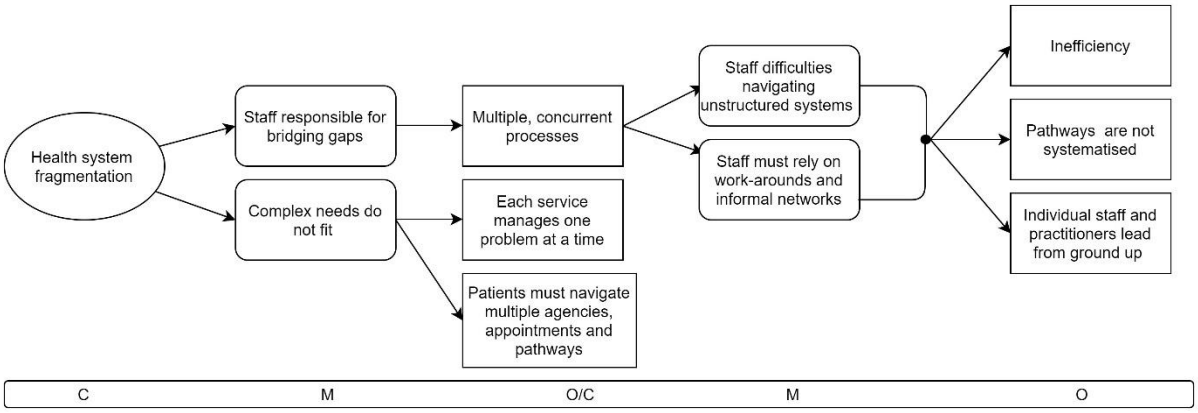

Figure 21: Realist Evaluation consolidated CMOC1

Consolidated CMOC1 (Figure 21) brings together the findings from CMOCs 1, 2 and 3 (see Table 4). It provides an explanation of what happens in the context of providing healthcare services to populations experiencing homelessness in a fragmented manner and in fragmented settings, typically a larger mainstream healthcare organisation like a hospital or within a mainstream health system with multiple settings.

Fragmentation here is both across different systems and services, and within the same system eg across different departments of a hospital and it creates a number of difficulties for both patients accessing care but also for healthcare practitioners seeking to provide the best care possible for their patients. Some of the data used here include:

> Erm I found that by following [in research work], you know, the primary care practitioners, public health nurse, GP, the different services by hanging around I actually saw the same person, that's how I know you know, when I say to the person who looks like seven people to the system I saw the same person coming in, in this domain. And then I was in another domain, the actual same person, and the two services had never spoken, and the three services and then in another domain, so that the problem of that homeless person or the drug user looked far more complex from the fragmented service because it was fragmented – Interviewee 12

And

> And usually, I think that's not intentional, but it's unintentional, but just that their complexity and the way that we think I suppose the biomedical model where it's one disease that you're treating doesn't fit in very well with social exclusion, where people have multiple diseases, multiple things going on, I would actually argue that that one disease at a time fits very few cases that very few people, but but particularly in socially excluded people – Interviewee 1

In these contexts, staff and clinicians are responsible for bridging the gaps in a system where interventions are typically intended to resolve one problem at a time with a focus on biomedical

health and disregarding the complexity of health conditions that are often the result of a combination of physical and mental health factors along with addiction behaviours.

The notion that the responsibility for filling gaps is left to individual practitioners came up in several interviews, including this from Interviewee 5:

> As much as it like has seen huge amazing, amazing progress in terms of awareness and things like that but, it is very much based on individuals, and those individuals when they're not there, you know. . And I suppose it shouldn't be like that because that's how it fails, you know. Because it's. . maybe I'm being too harsh, but I feel like if it's based on me or [name of nurse] or [name of nurse] or [name of doctor], I think you know I think there has to be driving forces in leadership. They should be able to function without us and I worry that wasn't the case. Because the healthcare hasn't really taken it on as part of their system. It relies a lot on going okay, would you fix that grand, push it over there. . . – Interviewee 5

A concrete example in Dublin of bottom-up leadership taking responsibility for improving services is a weekly multi-disciplinary meeting of clinicians from hospital and community settings, housing providers, addiction services, the Health Service Executive and more, which was started several years ago by a hospital consultant and a manager at an addiction service. It has since grown on a grassroots basis to now include 25-30 people representing different services meeting each week. The meeting is run by participants who add a name to a list if they have a particular concern about a given person and then the whole group share any information they have to solve the given need, often coming up with a solution during the meeting or at other times being alerted to the need so if a person arrives at a given service they will know to take action. This model of staff convening and coordinating with colleagues was mentioned in several interviews as being extremely useful and it has been replicated within individual service settings.

As a result of front line staff having to take responsibility for creating healthcare access, patient needs are met piecemeal and patients must navigate multiple pathways, agencies and keep a variety of appointments. Meanwhile, clinicians and staff have to manage multiple concurrent processes on their own inititaitve which is difficult and time-consuming in a system that is not structured to support the navigation of complex needs. Clinicians and staff have to come up with work arounds and leverage their professional networks to fill the gaps in the systems which leads to the system being inefficient with pathways that are not systematised but forged on a on-to-one basis in each circumstance and which is the responsibility of staff and clinicians to lead and manage from the ground up.

These outcomes were discussed widely in the interviews, as in the following example from Interviewee 6 who talks about the bio-medical model of dealing with one health concern at a

time and that patients sometimes do not get their various problems treated because the treatment model does not look at the full person:

> But also I suppose the system as it stands is somebody comes in with one particular, some people go to a GP, one medical condition. Now it's great, you know, when teams will say, oh, I see he has Hep C - certain teams will do that and others won't. I mean, they're coming for a surgical, they're just dealing with the surgical issue. And it's expected because this is what happens in life is that letter will go back out to their GP, they're attending their outpatient appointment for these other conditions. And what is the problem? Where it isn't specialised, because you have someone coming in who fracturing their jaw, they haven't been seen maybe by epilepsy service for so long. Are they engaging with their meds? Are they not? And it's, he's someone who's going to run so I'm going okay, so [name of doctor] can you see this person before they go, a lot of the team particularly medical team will link them in with say hepatitis and stuff like that or make sure' – Interviewee 6

4.5.2.2. Consolidated CMOC 2: Mainstream and specialised services

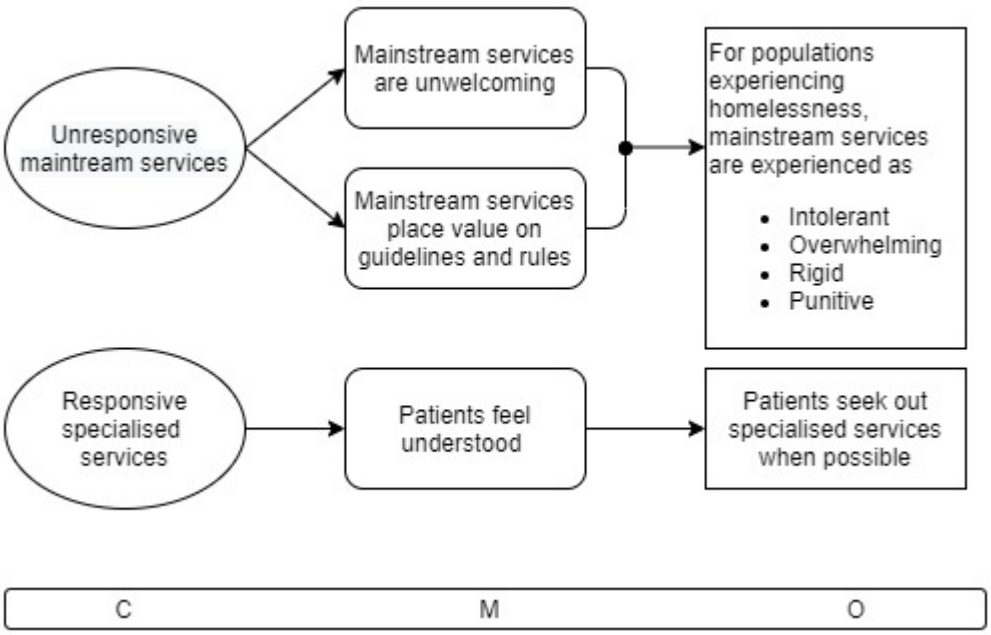

Figure 22: Realist Evaluation consolidated CMOC2

Consolidated CMOC2 (Figure 22) combines the findings from CMOC 4 and 5 (see Table 4). It provides an explanation of the role of specialised homelessness health services in making health systems accessible for populations experiencing homelessness. It shows two sides of the same coin – where mainstream services are unresponsive to the needs of populations experiencing homelessness and specialised services are responsive.

The contexts are based on data which came up a number of times in the interviews to show that generally speaking, specialised services for homeless populations are more responsive to their

needs than mainstream, non-specialist services. These specialist services can be standalone health practices eg a primary care centre or GP practice that primarily cater to socially excluded populations, a dedicated inclusion health service within a hospital setting or a clinic within a homeless accommodation setting.

Responsive specialised health services are more likely to employ people with exposure to and experience with socially excluded populations who understand their particular needs than mainstream services. Therefore, when accessing specialised services or when encountering a specially trained staff member in a hospital setting, patients are more likely to be understood and listened to which means that they experience feeling a degree of psychological safety, and that their full set of needs at that moment in their life are understood and will be acted on. This leads to the outcome that patients prefer to access specialised services instead of mainstream ones.

At the same time, unresponsive mainstream services are often experienced as unwelcoming by homeless populations. Both staff and patients experience mainstream services as being rule-bound and focused on meeting guidelines. Interviewee 4 explained how this happens:

> It has cost me a lot of fall out professionally with other clinicians trying to access care for my population because mainstream services follow the guidelines and they follow strict appointment times and well you didn't show up three times so now you have to go back to the doctor and I'm like, grand, I'm writing the referral right now, no you give them another appointment like you're just making me go through a process that doesn't need to happen because somebody said that you needed to do it. But why are you doing it? What's it based on? Does it affect the behavior of the person, does it actually increase the availability of the service, or your waitlist to be addressed. Like, it's just an arbitrary rule. And I think that more mainstream services that do that continue to exclude our population and what we try to do, is we adapt the guidelines. You know, we consider the guidelines and use them to the best of our ability to meet the needs of a population that the guidelines aren't written for. – Interviewee 4

The outcome that follows is that people experiencing homelessness find mainstream health services to be intolerant of their appearance or other characteristics, overwhelming because they are not designed with vulnerable populations in mind and can be difficult to understand and navigate, rigid in the rules and the narrow scope of behaviour that is accepted, and punitive when one does not understand or is not able to follow the rules.

Regarding the design of mainstream health services Interviewee 2 said:

> The mainstream services are not designed for homeless people, they're designed for housed people. And they suit the needs of housed people. They do appointments, they do, you drive in parking places, you keep regular times, people whose behaviours are not chaotic. And anyone who goes into that system who feels out of that system, outside that system, will automatically find it difficult. – Interviewee 2

Interviewee 6 said the following about the fact that complex needs do not fit in traditional hospital structures:

> If we're trying to get someone up for ages and then the plan is like that I can go and meet them in ED, again it's a bit hit and miss because there's only one person [who regularly contacts the Inclusion Health Team]. They tend to ring me a lot about people coming up to ED, there isn't a fast track way of getting through ED. . . you've heard many examples of people leaving for things like that. Erm and it's the way they come across as well, trying to get their needs met that they just, again don't fit in the system. But somewhere sometimes it does work. – Interviewee 6

Additionally, juxtaposing the two CMOCs indicates the reliance of the mainstream system on specialised services to provide quality care for populations experiencing homelessness. The existence of this parallel system enables the mainstream system to rely on knowing that there is the safety net of specialised services who will pick up patients who fall through the cracks. Interviewee 5 touched on this aspect:

> I don't feel like it's a health care system I think they're happy to have people that are doing these system pieces. You know they can get outcomes, even better, and if we don't have to finance much, even better. And we can show improved health, great, but if those people aren't there [the mainstream practitioners with a specialist interest in inclusion health] you'd wonder, are the systems there to keep it going? – Interviewee 5

4.5.2.3 Consolidated CMOC 3: National strategy

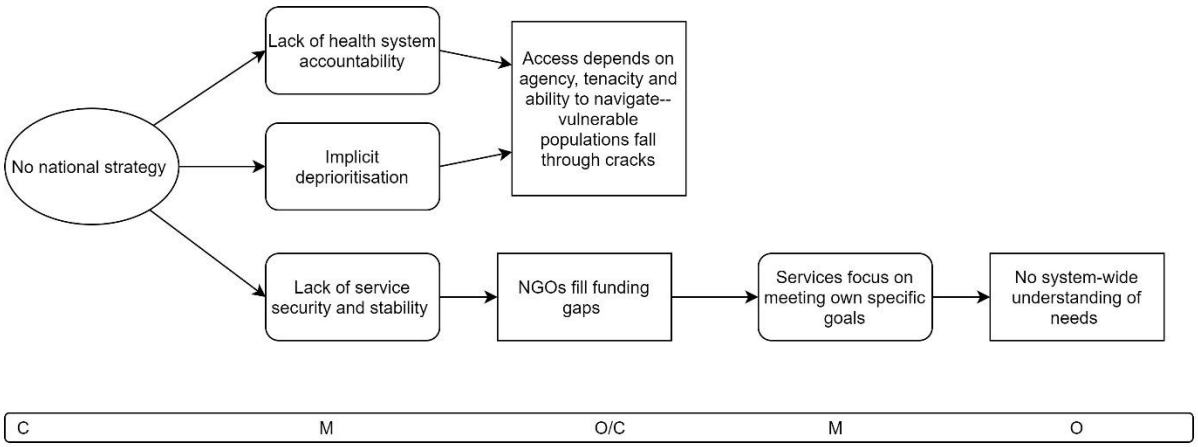

Figure 23: Realist Evaluation Consolidated CMOC3

Consolidated CMOC3 (Figure 23) combines the findings of CMOC 6, 7 and 8 (see Table 4), and explores the importance of national strategic leadership in setting expectations and accountability. In the Irish context there is currently no national strategy for homeless health or the health of socially excluded populations. In this context there is a lack of high-level accountability for the system to provide quality healthcare access, services, and outcomes for

socially excluded populations, and there is an implicit message from policy makers that other areas of society are valued higher. This topic will be examined further in study 3/chapter 5.

The outcome is that access to health services depends on individual patients and their families' ability to navigate the systems and use their agency, skills, connections and tenacity to ensure adequate access. But for population groups who may not have contract with family and/or are not always able to or interested in advocate for themselves in a hostile environment, such as homeless populations, access is impaired.

Interviewee 8 explained:

> So in the hospital at the moment, what I've seen in terms of the homeless population is that it's very challenging for someone that does not see themselves as worth any care to then be able to engage in a care system that is individual. That is the individual that needs to attend for an appointment once or twice, and then they're off the list. Erm or it's the individual that needs to understand the language that is used by the doctor or the nurse or the caregiver who are looking after them. Because unfortunately, a lot of the people in homelessness have very low levels of education, very low levels of literacy, have high levels of early childhood neglect which results in different areas of the brain not functioning as well as they might need to, to be able to take on that level of information – Interviewee 8

The same context, where there is no national strategy for inclusive healthcare, also negatively impacts the stability of sources of funding and dedicated resources coming into the area which means that services do not have permanent and stable resourcing. Interviewee 7 discussed this issue:

> The issue here is that we haven't had secure kind of recurring funding. It's been once off funding. So it hasn't been mainstreamed, which is it does create uncertainty for organisations and it does create that instability, I think in the system. . . So it kind of, I think the system is getting a sense, it's not going away. But it still is once off. – Interviewee 7

The result is that homeless service NGOs, who are at the front line of providing services for ongoing and emerging needs in Ireland, observe and prioritise filling the gaps in the mainstream services. Within the mainstream services, individual specialists and specialist teams may also apply for special funding or to hire more staff to be able to provide care in a more holistic, inclusive way. However, providing specialist care from within a large system takes more time and effort as the system is slow to change. Interviewee 7 shared their experience:

> I think there's a big gap in terms of accessing mainstream services, because the homeless sector is very responsive. And there are some really, really good people doing really, really, and really good teams doing really good work. Yes, I think that there could be more coordination across the system. And I think with the resources and the secure funding, we can get there. . . [but] often . . . if there's an issue, and it's related in any way to homelessness, it's lumped on Social Inclusion. So

> what you have is then the other parts of the HSE [Health Service Executive], not responding to certain minority groups. – Interviewee 7

In a new context then, where NGOs primarily take on the responsibility of filling service gaps and to fundraise to meet these needs, then their independent services will identify and prioritise the needs that they observe. And the final outcome then is that when services are provided in a decentralised manner by fragmented services without feedback loops, there is a lack of a system-wide understanding of the current needs being met on the ground and as such the system as a whole at a Department of Health or Health Service Executive level cannot adequately plan for or meet the needs that exist. Something of a vicious cycle can arise from the lack of mainstream prioritisation of specialist needs where specialist services then step in to fill gaps but then inadvertently mask parts of the full picture of the need that exists. Interviewee 7 explained:

> . . the majority of our [Health Service Executive] funding will go to . . . section 39 [agencies], which is voluntary agencies. And . . . our funding so to some extent, you have you have some oversight about how the system is coordinated, so to speak. But having said that, you know, these some of these organisations now, like, [Name of NGO], I don't want to name names, but you know, some of the . . . bigger homeless agencies, they have really good fundraising. So there's naturally going to be additional resources in the system. And we don't have any understanding of where that, you know, where what kind of services will be set up. It's entirely independent . . . of the public health system. – Interviewee 7

4.5.2.4 Consolidated CMOC 4: Health system values

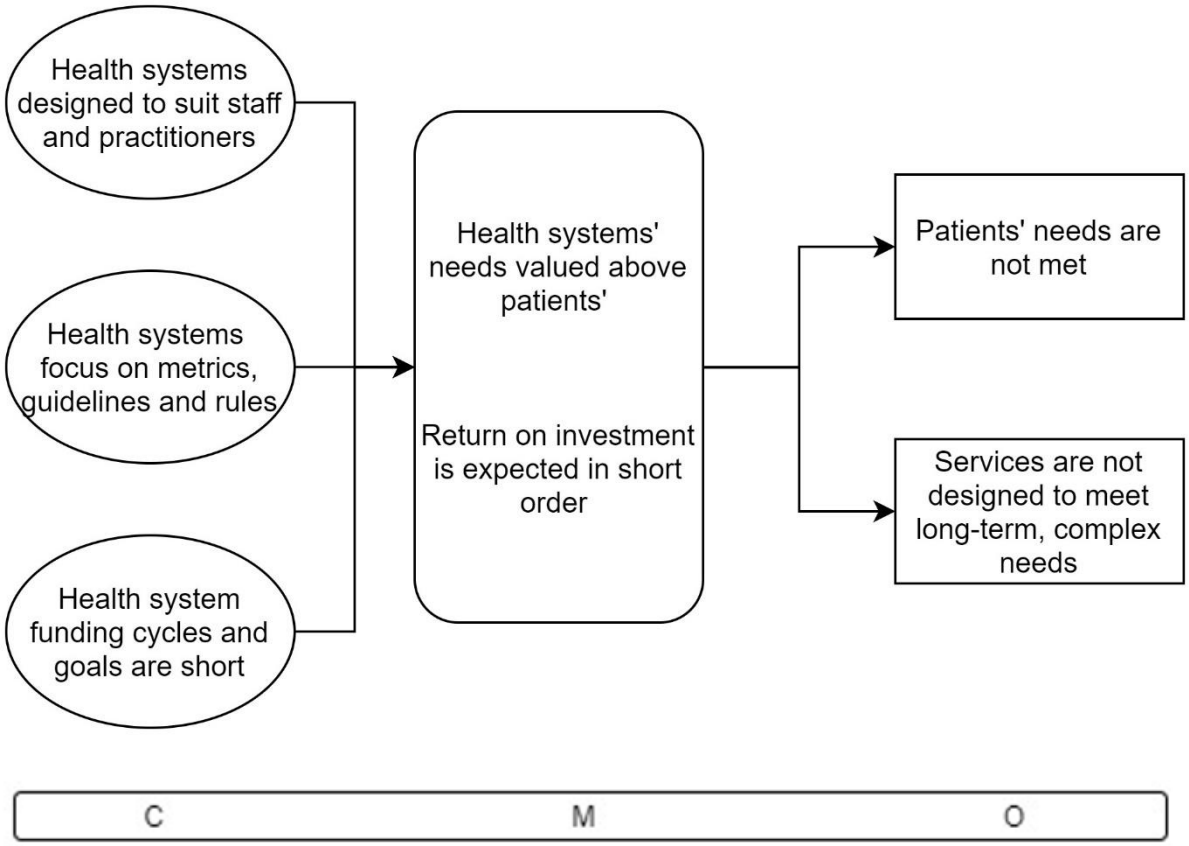

Figure 24: Realist Evaluation Consolidated CMOC4

Consolidated CMOC 4 (Figure 24) combines CMOC 9, 10, 11, 12, 13 and 14. This consolidated CMOC brings together three contexts which trigger the same mechanisms namely the fact that health systems are generally designed to suit the needs of practitioners and staff with regards to their service locations, appointments times, clinic set ups that are suited to clinical work rather than patient comfort, etc. A second context is the focus that health systems put on particular metrics like bed days, length of stay, costs, etc and the guidelines and rules that everyone must follow in healthcare settings. The third context is one which is common in Ireland where health system funding cycles are short and goals are to be implemented over a short time horizon to demonstrate their success in hopes of gaining continued funding. These contexts are explored in the following quote:

> And usually, I think that's not intentional, but it's unintentional, but just that their complexity and the way that we think I suppose the biomedical model where it's one disease that you're treating doesn't fit in very well with social exclusion, where people have multiple diseases, multiple things going on, I would actually argue that that one disease at a time fits very few cases that very few people, but particularly in socially excluded people, and it goes right through so in terms of service delivery, how the services are delivered, to what time the clinic is at where it is, how you accesses it how you make appointments, health workforce, in terms of training in terms of who, from which social groups doctors come . . . frequently you'd see that maybe the catering staff or the porters who would be from a poorer background will that the socially excluded patients are

> much more comfortable with them and will already feel that there's a power imbalance when they're dealing with the people that are in the health workforce. – Interviewee 1

The mechanisms that arise in these contexts are twofold: First, health systems' needs are valued above those of the patients – the ability for clinicians to practice how they see fit in the interest of making their patient well, comes before the comfort and security of patients and the other needs in a patient's life that may be of greater concern to them in the given moment. Interviewee 5 spoke about this conflict:

> . . it's a lot of like patting ourselves on the back I think, you know and you hear it at the moment, more than ever. . . So I think if people feel like that about themselves before, you know, I think before they even go into a patient. If you're really focusing on what, what do you think is important . . . and your needs, and [that] I need to be able to discharge the person without any problems and I don't want to get into a report and don't have to call the guards. And I don't want to have to do all of those things. And if [the person leaves] I have to do all of those things. And that's like that's your focus, which is crazy. So, I don't know - person centred care is very abstract, isn't it? . . . I think identifying [patient] needs is massive. And it's not what we think their needs are. You know, I think we're really good at that as nurses and doctors. We're really good at saying this is what you need but actually maybe it's not. It goes against your instincts. – Interviewee 5

Second, return on investment is expected in short order and complex cross-discipline health and social care investments such as education or stable housing in childhood that take years of investment to pay off do not fit. Interviewee 1 spoke about the consequences of the short-term nature of funding for services:

> And then financing is a huge part of it . . the way that budgets are set up so that health is in one place and social care is in another, the way that erm decisions are made on financing based on very short term erm recuperation, whereas . . . you might invest now in early childhood interventions erm and you might see the benefit of that in terms of health 40 years down the line, and we don't capture that. And we look at health as a unit of a person rather than the health of the community, which is probably another really important way to be able to look at it. And then that all feeds into there's, it's a system that isn't fit for purpose, I would argue, in treating people, let alone people who are complex. – Interviewee 1

Interviewee 8 also spoke about viewing patients through the lens of their life experiences and the critical importance of understanding the effects of trauma:

> So what I see in terms of in the healthcare side of things is because for me, everything is very much embedded on top of each other. So I can't talk about healthcare without thinking about early childhood care and what was received for the person because no matter whether you're homeless or housed, your early childhood care and attachment with your caregivers will predicate how you're were able to look after yourself. So for me, it's more so about people that aren't able to engage in a system that don't take into account where they're coming from, where they're at. And everything around social work is dealing with people where they're at and social work has always been at odds with the medical system. . . If we can get system to understand

> where people are coming from, and have a system that meets people's needs, instead of the person having to fit into the system. – Interviewee 8

The outcomes are that patients' needs are not met because systems and services are not ultimately designed with their complex, long-term needs in mind. This is particularly important for populations experiencing homelessness or other social exclusion but it is also important for other populations who typically can navigate mainstream health systems with success because all humans have complex needs and have health outcomes that result from myriad factors that develop over the life course.

4.6 Overarching programme theory

Figure 25: Realist Evaluation overarching programme theory

The overarching programme theory (Figure 25) resulting from a synthesis of the data collected via semi-structured and realist interviews shows the high-level, transferrable findings from the realist evaluation study. It shows that when health systems are fragmented both between and within services, then health service delivery is complex. In this complex, fragmented setting mainstream health systems focus on prioritising its own needs and as a result more specialist needs have to be provided for elsewhere. As a result of the default outsourcing of some needs, the system as a whole miss out on information as feedback loops do not provide full information

for system planning. Incomplete information is fed into high-level policy decisions about whether or not to officially prioritise the needs of homeless and other socially excluded populations. If these needs are deprioritised it supports the maintenance of a fragmented healthcare system.

4.7 Discussion

4.7.1 Statement of principal findings

Health systems characterised by fragmentation are designed to meet their own needs above the needs of patients and rely on practitioners with a special interest and specialised services to fill the gaps in the system.

Key contexts identified in the study include: health system fragmentation; health service fragmentation; bio-medical, one problem at a time model; responsive specialised services; unresponsive mainstream services, national strategy; short health system funding cycles; and short-term goals.

Key mechanisms identified in the study include: staff taking responsibility for system failings and creating work-arounds; complex needs not accommodated; patient experience of not being understood; mainstream services valuing guidelines and rules; mainstream services projecting unwelcoming attitudes; lack of health system accountability; importance of health system prioritisation; lack of security of funding; and expectations of short-term return on investment.

4.7.2 Strengths and limitations

A strength of this study is the in-depth analysis of findings from the realist review (chapter 3) utilising CMOCs from that study as the initial programme theory to further uncover causal patterns within a subset of the review findings. The interviews represented a range of perspectives from individuals with high levels of expertise in working with and planning the care for populations experiencing homelessness in healthcare settings.

A sufficient level of data saturation was reached to inform the development of CMOCs. The perspectives of the interviewees represent those working in Dublin specifically and the data therefore represent a particularly Irish experience. However, this is common for realist research where causal patterns based on specific data are brought to higher levels of abstraction which apply more widely than the particular setting in which they were gathered. The findings in this chapter likely apply to similar settings in high income countries where healthcare is predominantly provided by the state.

Additionally, another strength is that while populations experiencing homelessness are the focus of this study, these can be seen as a stand in for other socially excluded populations and the findings in this study also illuminate challenges which populations groups such as drug users, sex workers, migrants, and others, experience in accessing healthcare. Some of these are also experienced by mainstream populations when seeking to access healthcare in a health system that is fragmented.

Limitations include the lack of data collected from service users with a lived experience of homelessness which had to be abandoned because of the impact of the COVID-19 pandemic. I had planned to collect data from the Depaul peer advocacy programme but as discussed in section 4.4 that became impossible because the programme was paused during the COVID-19 pandemic. I discussed other options for collecting data from other people with lived experiences of homelessness with my supervisors but felt that, at the time in the autumn of 2020 when vaccines were still not available, it was too risky to try to convene people in person. Similarly, the likelihood of organising data collection online with very vulnerable people was not high and would ask a lot of potential participants and gatekeepers.

Additionally, I had ethical approval specifically for contact with the Depaul peer advocates because of the protections that programme offers its participants and the levels of gatekeeping around them. This group are ideal representatives for very vulnerable people experiencing homelessness because they have had similar life experiences while themselves no longer being in a state of extreme vulnerability. They are vetted by Depaul and receive training in how to advocate for others. For that reason, I felt comfortable asking them for their participation without risking inflicting harm on them.

When it was clear I would not be able to speak to the peer advocates, I discussed other options with my supervisors. We considered recruiting other participants but ultimately decided that it was potentially unethical and harmful to try to recruit people who were not necessarily vetted in the same way as the peer advocates. It might have been possible but it was difficult to ascertain whether it would be possibly to move forward at a stage in the pandemic where homeless charities and the health services were under great strain.

Another limitation is that this study relies entirely on interview data in crafting the CMOCs without other data to challenge or support the claims made by interviewees. This limitation is present within the realist evaluation as a standalone study, but is mitigated by the bringing together of the three individual studies in chapter 6 of the thesis which provides an integrated analysis of the three studies which each rely on different data sources.

A further limitation is the lack of a robust expert panel process which was again not possible due to the pandemic. In the place of convening a group together and discussing the findings with a number of expert voices in the room, two individual consultations took place with people who have personal experiences of homelessness and who work in homeless services so have a similar dual perspective to those of the Depaul peer advocates but also significant professional experience and expertise. And one individual consultation took place with one of the interviewees.

The COVID-19 pandemic presented a challenge to the study in several other ways. First, it meant that interviews had to be moved online which might have changed the dynamic between interviewer and interviewee. There were more interruptions during the remote interviews with people working from home such as dogs barking and deliveries being made. Clinical staff were interrupted by co-workers who did not realise they were in the middle of an interview because they were in their usual workspace seemingly working on their computer. The pandemic also meant that all interviewees were especially busy. However, in all cases they made the time to speak with me which was a welcome surprise as I had expected that might not be the case due to increased workloads.

Another challenge of the pandemic has to do with the data collected. It is difficult to know to what extent the experience of working through such a disruptive and unexpected set of circumstances meant for the perspectives and opinions offered by the interviewees. While the interview questions did not specifically ask about the pandemic, some answers were coloured by the experiences of providing care during it. I do not know to what extent interviewees told me about what happens in regular conditions versus in pandemic conditions. Nor does anyone know to what degree things will 'go back to normal' after the pandemic.

4.7.3 Comparison with existing literature

I am aware of no other realist evaluations examining healthcare access for populations experiencing homelessness or for any other populations. Realist evaluations have been published which examine an aspect of improving healthcare access such as a study by Doi et al (2017) which found that a health visiting programme for families with children under the age of five enhanced access to healthcare in Scotland through the development of trusting relationships and early identification of health concerns. These findings are similar to those of the realist review (chapter 3) which also found that trust and ongoing engagement are key to promoting access to healthcare for populations experiencing homelessness as explored in CMOCs 5 and 6.

A realist evaluation by Hamon et al examined both supply and demand side factors in the delivery of family planning and childhood immunisations in routine outreach clinics in Malawi (Hamon et al., 2020). On the supply side, of relevance here, important mechanisms included health practitioners' empowerment through training and their confidence based on their abilities. They experienced motivation through the recognition they received for their work and through the experience of teamwork. These findings underscore the importance of resourcing healthcare practitioners through professional and skills development which is similar to consolidated CMOC2 in this study (section 4.5.2.2) which shows what happens when practitioners do not have adequate expertise and when a health system does not seek to have experience with and enable expertise to develop in how to best provide services to a given population group.

Goodman and Gatward (2008) found that deprived populations are underrepresented in epidemiological surveys potentially introducing bias and making them less valid. Their findings are in line with consolidated CMOC3 (section 4.5.2.3) in this study which shows that health system planning is not based on adequate data to fully understand healthcare needs in socially excluded populations. Goodman and Gatward's study shows that this phenomenon exists internationally and that bias is introduced into the health system at such foundational levels as understanding basic information about population need.

Several realist evaluations have examined aspects of how health systems function. Kwamie et al studied the implementation of the Leadership Development Programme, an intervention with the goal of enhancing management and leadership within health district teams in Ghana. They found that the intervention worked in the short term to enable individuals using systems thinking tools but in the long term the health system rejected the intervention and went back to its prior centralised decision making because the tools were not embedded into the organisational culture, practices and processes (Kwamie et al., 2014).

Prashanth et al published a realist evaluation of a capacity building intervention in two sub-units within a district health system in India. The study found that health systems strengthening interventions such as capacity building works through 'aligning or countering existing relationships between internal (individual and organisational) and external (policy and socio-political environment) attributes of the organisation' (Prashanth et al., 2014) and that programme designers should identify opportunities for alignment at the design and implementation stages. These lessons would likely be key were a national strategy to make healthcare accessible for populations experiencing homelessness and social exclusion to be

implemented in the Irish setting because the current system is inward-focused and fragmented and not prone to systematising solutions developed at the frontline.

4.8 Chapter conclusion

This chapter has described the methods, analysis and findings of the realist evaluation resulting in four consolidated CMOCs and one overarching programme theory. These findings provide an explanation of how fragmentation and health systems' funding arrangements and goal setting impact healthcare accessibility for populations experiencing homelessness, based on data collected from 13 interviews with 12 people (as one participant was interviewed twice).

Findings show that there is a cyclical relationship, explored in the overarching programme theory in section 4.6, where health system factors that have a negative impact on healthcare access for populations experiencing homelessness reinforce each other in a vicious cycle. Fragmentation leads to complexity in service delivery and in response a health system focuses on its own needs to the detriment of patients. Specialist services and specialised practitioners must fill the gaps and lead the provision of care from the ground up. Due to the fragmentation and reliance on NGOs to fulfil central health system functions, key information is not fed back to the health system as a whole for planning and resourcing purposes. As a result priorities are made without adequate information and the needs of homeless and other socially excluded populations do not rise to the top of the agenda.

Chapter 5 Policy analysis

5.1 Chapter overview

This chapter accounts for the third study in the thesis, a policy analysis of major Irish policies that influence healthcare access for populations experiencing homelessness. The chapter contains three parts which makes up a unified policy analysis:

1. A historical analysis of the Irish healthcare system focusing in particular on aspects that shape current day healthcare access for socially excluded populations
2. An analysis of relevant current health policies
3. Discussion of findings from the two analyses

Following on the realist review and realist evaluation, I wanted to place those findings in an Irish policy setting to understand the broader context in which healthcare is delivered to populations experiencing homelessness in Ireland. The realist analyses in the two previous chapters have uncovered causal mechanisms which operate in health system contexts and this study places those findings in the Irish setting to understand how those mechanism may play out there, and to produce recommendations (in chapter 6) of particular relevance to the Irish health system.

The policy analysis undertaken below built on the prior realist studies to answer specific questions about how health system factors affect healthcare access for populations experiencing homelessness in Ireland. It was selected as the method for this study because it is suited to analysing how the Irish health system came to be as it is, came to embody certain values and priorities, and how those play out in the current policy landscape.

Historical analyses and policy documents were selected using purposive and snowball sampling. Documentary analysis was employed to construct an overview of the Irish policy landscape in this area and to analyse how healthcare access for homeless populations is conceptualised in Irish policy documents.

The study seeks to answer three questions:

- What is the historical background to the policies and practices that have led us to the current situation of inequitable healthcare access?
- What motivated the creation of these policies and practices (or lack thereof) and who were the major players?
- What is the current policy landscape and how does it maintain or refute past priorities and practices?

5.2 Methods

This chapter is based on two bodies of literature (see figure 26) . The first analysis builds on secondary literature discussing the history and development of the Irish healthcare system, and the second analysis uses primary sources in the form of current major health and housing policy documents governing healthcare for populations experiencing homelessness in Ireland today.

The first set of literature was synthesised into a narrative literature review, thematically building on the findings from the analysis of the policy documents to tell the background story to the key policy themes present in current day policies. It is presented below starting in section 5.3.1. The second set of literature was coded and analysed using inductive coding and documentary analysis.

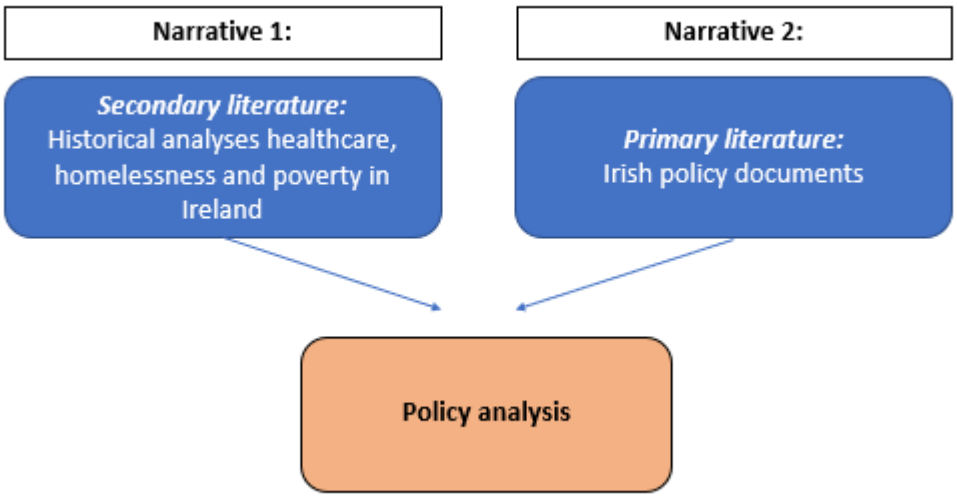

Figure 26: Policy analysis data sources

5.2.1 Search strategy

The secondary sources, consisting of analyses of historical Irish health, homelessness and poverty policy actions and inactions, were identified using google scholar, the Trinity College Library search function, citation tracking and through expert recommendation (particularly from my co-supervisor Dr Sara Burke who is an expert on Irish health policy).

The primary sources, consisting of recent health and homelessness policy documents, were collected via a search process which started with a review of the three most relevant high-level, national policies. Relevant policies that were cited within these documents were then reviewed and further snowball searching took place from there. I also undertook google searching, searching of the websites of the Department of Health, Department of Housing, Local

Government and Heritage, Department of Social Protection, and the Health Service Executive, and asked my supervisors and study 2 interviewees for key documents. Two internal Health Service Executive documents were given to me by an interviewee who works there with permission to cite in this research.

5.2.2 Coding

The secondary literature sources were not formally coded. Documentary analysis was used to construct a non-systematic narrative literature review (Green et al., 2006) based on a variety of sources through a process of writing focused on themes and key concepts identified in the coding of the policy documents. While the historical analysis is presented first in the narrative below, it was completed after and guided by key themes identified in primary policy documents.

The primary policy documents were read and coded in NVivo 12 using content analysis (Mayring, 2000) creating conceptual codes as the coding went along. The coding was specifically focused on content related to key high level health systems features identified in the realist studies. Codes include: 'Integrated care', 'inter-agency care', 'information flows', 'case management', 'funding', 'infrastructure', 'pathways', 'leadership' and 'governance'. The full set of codes can be found in appendix 10.

First, the three national policies *Rebuilding Ireland*, *Sláintecare* and *Healthy Ireland* were coded inductively. Subsequently, as more documents were identified using snowballing, citation tracking and expert recommendations, these were then also coded inductively using the codes which had already been created and with new codes added as needed. Key data were extracted into Table 5 in section 5.3.2 below which provides a high-level overview of the core aspects of each of the policies.

The goal of the coding was not to exhaustively code the policy documents from start to finish but to rather code sections that were relevant to the particular areas of interest. For example, the housing policy *Rebuilding Ireland* (Government of Ireland, 2016) has few sections covering health and homelessness, and is predominantly focused on measures for expanding and securing an adequate housing supply in Ireland. These aspects of the policy were not relevant to this thesis and were not coded.

5.2.3 Health policy analysis

Health policy analysis adds a different lens through which to view the previous research carried out in this thesis. The two realist studies in chapters 3 and 4 focus on providing causal explanations adding to our understanding of how, why, and in what circumstances health

systems can make healthcare accessible for populations experiencing homelessness. The policy analysis places those findings in the Irish historical and political context which supports the overarching goal of the thesis to understand how health systems can make healthcare more accessible because health systems of course exist in historical and political contexts which impact their development.

This study uses policy analysis because it is a good method for examining how the broader Irish context in which healthcare is delivered to homeless people came to be what it is. Additionally, it set the stage for the integration of findings in chapter 6 where the policy aspirations (discussed in this chapter) and the realities of practice at the front line (as highlighted in chapter 4) are brought together to show how they match up (and do not).

According to Gilson (2012):

> Policy analysis specifically considers: (a) the roles of actors who influence policy change at different levels –from individual, organizational, national to global – and their interests; (b) the influence of power relations, institutions (the rules, laws, norms and customs that shape human behaviour) and ideas (arguments and evidence), over health system operations and policy change within them; and (c) global political economy issues. It also seeks to understand the forces influencing why and how policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated, including how researchers influence policy-making. The latter includes considering whether and why routine practices differ from, and may even contradict, formal policies, and generate an implementation gap between policy intentions and routine practice (p29).

The approach to policy analysis in this study uses both a historical and contemporary lens to consider the historic actors, historic power relations, institutions and ideas that have shaped and influenced the development of the Irish health system into what it is today and which still shape the assumptions, values, policy intent, and priorities evident in current day policies and their relationship to the provision and accessibility of healthcare for populations experiencing homelessness.

The notion that conditions established and choices made many years prior impact policies and systems that exist later builds on the idea of 'path dependency' per Wilsford in his paper 'Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way' (Wilsford, 1994). Wilsford says:

> 'While very early on a number of different paths may be equally plausible and probable, once a given path has been laid, perhaps as the result of quite random variables initially, each

> subsequent decision making episode at the individual level in this decentralised decision making network reinforces the path which characterizes collective decision outcomes' (Wilsford, 1994, p. 253).

Similarly, Kriznik et al (2018) argue that employing a 'historical perspective in policy and research informs a clearer understanding of the longer-term intertwining causes, construction and maintenance of health inequalities'. They also state that 'bringing a historical perspective provides a richer understanding of causation that recognizes the 'layered' nature of how the past leaves its mark on the ways health inequalities are reproduced over time. This perspective helps to illuminate the tools available to policy-makers and the interventions which could have a lasting impact' (Kriznik et al., 2018). These perspectives support the idea in this study of examining the historical understanding of poor people and their interaction with healthcare in Ireland.

This study uses documentary analysis discussed in the next section (5.2.4) to draw out themes in the historical accounts (section 5.3.1 onward) and then in the policy analysis discussion (section 5.4 onwards) to trace those themes in current policies described in section 5.3.2 onward with the goal of linking the historical background with the modern-day health policy landscape.

I considered using an existing health policy analysis framework such as Walt and Gilson's policy triangle framework or Kingdon's multiple-streams theory (Walt et al., 2008). However, after discussions with my supervisors, none of the existing frameworks I reviewed felt like a good fit because I was interested in providing a historical analysis spanning generations which would tell us something about today's policy landscape. The predominant health policy frameworks, rather, are designed to analyse how a particular policy came about or how a particular issue rose to prominence. Whereas I wanted to know how and why the past decades' health policies inform today's policy making and implementation.

The policy analysis in this chapter draws specifically on the findings of the realist evaluation in chapter 4 in the same way that the realist evaluation builds on the realist review in chapter 3. I designed the full thesis to intentionally have each study build on the one before it, and to together contribute answers to the overarching question of the research here: how health systems impact healthcare accessibility for populations experiencing homelessness.

For this reason, and due to the diversity of the policies and the large timespan of the analysis, and because this study builds so specifically on the previous two studies, I decided it would be best to use 'thematic' documentary analysis (Bowen, 2009) for this study (further description in next section 5.2.4). To build on the previous studies, the 'thematic' documentary analysis is

informed by the frameworks used in the two previous studies, namely the WHO Building Blocks (WHO, 2007) and the Aday and Andersen (1974) frameworks to maintain internal logic within the thesis.

5.2.4 Documentary Analysis

The policy analysis was carried out using documentary analysis as described by Bowen (2009) and Dalgliesh et al (2020):

Bowen says:

> The analytic procedure entails finding, selecting, appraising (making sense of), and synthesising data contained in documents. Document analysis yields data - excerpts, quotations, or entire passages - that are then organised into major themes, categories, and case examples specifically through content analysis (Bowen, 2009).

And:

> Document analysis involves skimming (superficial examination), reading (thorough examination), and interpretation. This iterative process combines elements of content analysis and thematic analysis. Content analysis is the process of organising information into categories related to the central questions of the research (Bowen, 2009).

The analysis also kept in mind Bowen's suggestions that the 'absence, sparseness or incompleteness of documents' says something about the area of investigation, for example that little attention has been given to it, and the researcher should 'consider the original purpose of the document' and who it was produced for (Bowen, 2009).

Dalglish et al propose the READ approach consisting of four steps: '(1) ready your materials, (2) extract data, (3) analyse data and (4) distil your findings' (Dalglish et al., 2020). They further describe the actual analysis phase as such:

> As in all types of qualitative research, data collection and analysis are iterative and characterized by emergent design, meaning that developing findings continually inform whether and how to obtain and interpret data. In practice, this means that during the data extraction phase, the researcher is already analysing data and forming initial theories—as well as potentially modifying document selection criteria. However, only when data extraction is complete can one see the full picture (Dalglish et al., 2020).

This approach fit with the iterative nature both data collection and data analysis of the realist approach used in the previous studies and allowed this study to proceed in a similar vein.

Based on these principles from both Bowen and Dalgliesh, the documentary analysis in this study focused on finding and reading relevant sections of policies and identifying passages and content related to healthcare access for populations experiencing homelessness. In the interpretation phase of the analysis, particular attention was paid to how policies describe the health needs of homeless populations and the solutions proposed in them. Attention was also paid to how high-level health system factors such as those outlined in the WHO Building Blocks (WHO, 2007) and the Aday and Andersen (1974) frameworks were conceptualised and how the policies engaged with those factors. Additionally, threads from the historical background (section 5.3.1 onward) were followed into how current policies discuss key concepts such as deprivation and its causes, entitlement to care, and how care should be organised.

The advantage of using documentary analysis is that it suited the crafting of the kind of narrative I wanted to construct to place health policies today in a historical context and allowed flexibility for sense making which fit well with the other two studies in the thesis.

5.3 Results

The results of the analysis consist of two narratives. The first narrative (starting in section 5.3.1) describes the history of the Irish healthcare system. The second narrative (starting in section 5.3.2) analyses current policies that govern healthcare accessibility for populations experiencing homelessness in Ireland.

A total of sixteen recent health and homelessness policy documents were reviewed for the study. Out of these, nine policies were deemed most pertinent and were included in the policy review below. The inclusion criteria for the policies were that they were: 1. high-level national policies with direct relevance to healthcare access and homelessness, or homeless healthcare specific policies at any level, and 2. current policy being used to govern their specific policy area now.

5.3.1 The Irish health system

Unlike residents in all other Western European countries, those residing in Ireland do not have universal entitlement to healthcare (OECD/European Observatory on Health Systems and Policies, 2019). Attempts have been made to establish a health system similar to the National Health Service in the UK, most notably by Noel Browne, TD, who was minister for health from 1948 to 1951. Browne introduced the progressive Mother and Child Scheme which would have provided free healthcare to mothers and children up to the age of 16 but the proposal was

unsuccessful, in large part due to opposition from the Catholic Church and the medical profession (Adshead et al., 2003; *Mother and Child Scheme*, n.d.).

In contrast with the ethos inherent in universal healthcare, the Irish health system builds on the idea that the state should provide publicly funded healthcare to individuals on low incomes but that those who can afford to pay should be responsible for doing so (Geary et al., 2018; Wren, 2003, pp. 11, 27).

The Irish health system has roots in both British laws and practice before independence, and in the political priorities and practices of Irish governments which have governed since. The Catholic Church has heavily influenced Irish healthcare delivery, indeed it is considered one of the main influences on the evolution of the Irish health system (Daly, 2012). According to Adshead et al: 'The integration of Church and state in post-independence Ireland was such that the teachings of the Catholic Church governed most aspects of state policy, including social policy' (Adshead et al., 2003).

The Church had a vision of families as being self-supporting units with a breadwinning man and a woman taking up her so-called natural role as wife and mother within the home. The idea of the family as the centre of society meant that the state should only intervene if a family had proven unable to take care of itself and as a last resort (Adshead et al., 2003; Heavey, 2019; Wren, 2003, pp. 26–28).

5.3.1.1. Deserving and undeserving poor

Historically, being poor was not seen as enough of a reason to seek assistance. In fact, in the 17th and 18th centuries, in Ireland as in many other countries, assistance to the poor was not provided for their own sakes, as Dukelow and Considine (2017) explain:

> Initially, the maintenance of social order superseded the meeting of needs, despite the existence of large-scale poverty in Ireland. The primary purpose of early provision was to group together people who were considered undesirable to impose some kind of order and control. Undesirability was associated with moving from place to place and being without work if one was physically capable of working or 'able-bodied' (p10).

If a person was poor and also 'able-bodied', the prevailing logic of the day was that they should be fit to work and thereby take care of themselves. These people thus were considered 'undeserving poor'. 'Deserving poor' people by contrast were ones who were sick and unable to work. Such people could officially be allowed to beg and be recognised as a 'deserving poor' person by being granted a badge (Dukelow & Considine, 2017, pp. 11–12; Malone & Millar, 2020).

In the 19th century, the British colonisers in Ireland introduced new ways to manage the poor, building on experiences in Britain with providing 'out-door' relief to the poor such as giving them food or clothing outside of the workhouse as had been the practice for several hundred years. However, by 1838 that approach was deemed too expensive and too lenient, and it was thought that providing assistance to 'able-bodied' poor people was encouraging them to stay poor and rely on alms rather than find work (Dukelow & Considine, 2017, p. 8).

Poor 'able-bodied' people were seen to be poor because of character flaws rather than due to factors outside of their control such as a lack of work available (Dukelow & Considine, 2017). This belief was compounded by the view of the Irish as an inferior and uncivilised people compared to the English. Having conceived of poverty as caused by character flaws, approaches for combatting poverty became increasingly punitive. A new Poor Law Act came into effect in 1838 and a key feature of the Act was that for anyone deemed 'able-bodied', poor relief could only be accessed within the workhouse (Dukelow & Considine, 2017; Geary et al., 2018).

According to Geary et al, the Poor Act of 1838:

> did not provide the Irish poor with a legal entitlement to assistance. Relief was discretionary and dependent on the availability of workhouse places. The refusal to provide outdoor relief meant that public assistance to the poor was limited to the number of inmates the workhouses could contain, approximately 100,000 (Geary et al., 2018).

Work houses were funded by a compulsory property tax and were run in ways that stigmatised and degraded its residents. Standards of accommodation, food and clothing were intended to be inferior to the living conditions of labourers of the day, making the prospect of the workhouse unappealing – the 'ethos underpinning poor relief, its very philosophy, was punitive and degrading' (Geary et al., 2018).

Medical services for the poor were provided by voluntary hospitals, county infirmaries, fever hospitals and health dispensaries. These services, established in the 18th and early 19th centuries, were intended 'not for the destitute but for the deserving or working poor, individuals who could support themselves and their families, however marginally, through their own labour and productivity but who would have been reduced to penury if prevented by serious illness from working for any length of time'. Free access to medical care for the poor was paid for by philanthropic contributions from upper- and middle-class individuals. Such individuals paid privately for their own medical care (Daly, 2012; Geary et al., 2018).

The workhouse and public healthcare became associated as many people without means received health services from within workhouses, as Geary (2018) explains:

> The workhouse infirmaries and fever hospitals were originally intended for the sick in the workhouses but, following legislation in 1862, they were converted into general hospitals for the sick of each poor law union. Despite the broadening of their remit, the poor were reluctant to avail of these hospitals' services because of their association with the workhouses, pauperism, and
> social degradation. Hospital inmates had to endure the same conditions as paupers in the workhouse; they wore the same clothing, lived in the same unattractive buildings, and were governed by the same restrictive rules and regulations (p19).

5.3.1.2 Advent of the Irish Welfare state

The understanding of poverty changed at the beginning of the 20th century and a number of welfare laws were passed including the Old Age Pensions Act of 1908 and the National Insurance Act of 1911 which provided protection to working classes against poverty in the case of illness, unemployment and in old age. However, the medical system was not reformed and the need for reform was later overshadowed by the World War I and the Irish War of Independence (Geary et al., 2018). When the Irish Free State was established in 1921, there was no Department of Health or a Department of Social Welfare. Neither was established until 1947. In the meantime, from independence onwards, most gaps in social, health and educational provision were filled by the Catholic Church (Heavey, 2019).

In the first half of the 20th century, the majority of the population paid for health services while poor people received care for free at county and district hospitals paid for by a national lottery, the Hospital Sweepstakes. A programme of social insurance for workers but not their families was introduced in the 1940s (Wren, 2003, p. 30).

Public healthcare improved in independent Ireland but no universal system was introduced and there was no unified strategy for the development of the health system to match population need. New hospitals were built in the 1930s funded by the Sweepstakes programme (Daly, 2012). Historian Professor Mary Daly argues that the Sweepstakes drove healthcare provision toward secondary care because of its success in raising money:

> . . the medical market place in Ireland pushed medical care and patients towards hospitals to a greater extent in Ireland than in the UK or other developed countries for two reasons: firstly, the Irish Hospitals' Sweepstake provided a substantial amount of money that was available to fund

> the construction of hospital beds and to subsidise the running costs of voluntary hospitals; money that was not available to support out-patient or general practice services (Daly, 2012).

In the 1940s and early 1950s, several serious attempts were made by senior government figures to promote the idea of a national health service, inspired by the Beveridge Report and the establishment of the National Health Service in the UK in 1948 and similar developments in many other European countries (Daly, 2012; Wren, 2003, pp. 30–31).

The Health Act of 1947 included reforms to make healthcare free at the point of use by introducing a Mother and Child scheme set to provide free healthcare to all mothers and children. The scheme, spearheaded by Minister for Health Dr Noel Browne TD, was intended to be the first step in a subsequent introduction of free healthcare to the whole population but was met with staunch opposition from both the Catholic Church and the medical profession (Heavey, 2019; Wren, 2003, pp. 32–33, 36–37).

The medical profession was concerned that the state with lay people at the helm would control their domain and would introduce socialised medicine gradually and by stealth, and that their incomes would go down (Adshead et al., 2003; Heavey, 2019). The Church was afraid that the Mother and Child Scheme would undermine their social teachings by giving women and children direct access to a doctor, and that particularly family planning and abortion services could be offered contrary to Catholic values. The service was also incompatible with their preferred idea of the family with the husband and father holding personal responsibility for taking care of the needs of his dependents, including paying for healthcare. Additionally, the Church saw state-provided medicine as a road to communism and to be avoided for that reason too (Adshead et al., 2003; Daly, 2012; Heavey, 2019; Wren, 2003, pp. 32–33).

The Mother and Child scheme initially enjoyed widespread support among politicians. However, with the opposition of the powerful medical profession and Catholic Church, the support fell away. Cabinet members professed their loyalty to the Church above anything else and the scheme as initially envisaged was abandoned. Noel Browne eventually resigned his position as Minister for health and soon left national politics (Heavey, 2019; Wren, 2003, pp. 35–39).

With the passage of the Health Act of 1953, the only key feature of the Mother and Child scheme that was maintained was that women received free ante-natal and post-natal care. The rest of the scheme was watered down with general practice remaining private, and all but the very poorest still had to pay to see their family doctor (Wren, 2003, p. 41).

Means testing became a key feature of healthcare in Ireland. Medical cards gave entitlement to outpatient and hospital care without charge for all but the highest 15 percent of earners who

were personally responsible for paying for their own healthcare. For this population, a voluntary health insurance programme was established in 1957 (Geary et al., 2018). Ultimately, the direction of travel for the Irish health system was set, and without universal access to healthcare (Wren, 2003, pp. 42–43).

In the following decades, various small adjustments to healthcare eligibility were made but predominantly the status quo prevailed. In 1970 a new Health Act was passed which followed the same approach. It introduced the General Medical Services scheme to replace the prior dispensary system which gave access to free family doctor visits for poor families and which again maintained the status quo of providing free access only to those on a low income. Under the new scheme, those who met the means test could choose their own private doctor. The 1970 Health Act also introduced a new eligibility: expenditure on drugs over a certain threshold could be refunded for anyone regardless of level of income (Wren, 2003, p. 48).

Another scheme launched in 2005, added further to the complexity of the system. The GP visit card is available to a cohort of people who do not qualify for the General Medical Services scheme because their income is too high but whose income is still low enough to qualify for the higher threshold of this programme. It makes GP-visit card-holders eligible to access general practice care without charge but those with GP visit-cards still have to pay for essential medications and other primary care services (Malone & Millar, 2020; Thomson et al., 2014, pp. 38, 42).

This landscape of shifting eligibilities, a mix of private and public services and sources of payment, powerful stakeholders, and a lack of fundamental organising principles of solidarity have remained defining features of the Irish healthcare system (Wren, 2003, p. 139).

Within this system, socially excluded populations face a number of difficulties accessing healthcare even in the current era because the charity model of care still plays a large role in Irish healthcare delivery and brings with it a casting of people into ‘deserving’ and ‘undeserving’ categories. Similarly, because there is no legal entitlement to care, vulnerable people are left to navigate confusing categories and levels of eligibility. The following sections will explore how this history of the Irish health system still has a major impact today on the whole population.

5.3.1.3 Contemporary Irish health system

Ireland’s contemporary health system is characterised by a complex tapestry of eligibility requirements and means tested programmes available to various population groups. Officially there are two tiers of healthcare in the Irish system: Category 1) Those with a medical card (or GP-visit card) and Category 2) Those without a medical card.

Those with a medical card or GP-visit card can access GP and primary care services without being charged. Those with a medical card (but not those with a GP-visit card) can attend both outpatient and inpatient hospital treatment without charge, and they are charged €1.5 per prescription medicine up to a total of €15 per month per individual or family (Citizens Information Board, 2020b; Nolan et al., 2014).

Those without a medical card are not entitled to the same services free of charge. For GP visits they pay the full market rate of €40-60 per appointment and they pay up to a total of €114 out of pocket for pharmaceutical drugs per family per month if they register for the Drugs Payment Scheme. They pay €80 per night as an inpatient in hospital up to a total of €800 per year per person as a public patient. Additionally, there is a charge of €100 for attending the emergency department without being referred by one's GP. With a referral, emergency department attendance is free of charge. Other outpatient hospital attendances in public hospitals are free of charge (Citizens Information Board, 2020a, 2021; Nolan et al., 2014).

Many people in category 2 who are not eligible for a medical card, take out private health insurance to cover both primary care and hospital charges as well as a variety of allied health and mental health services, depending on their level of cover. A key motivation for having private health insurance is that it gives preferential access to consultants and treatments which may have a long waiting period in the public system. Typically, these services are provided by the same practitioners who work in the public system in the same public facilities because Irish consultants can choose a type of contract which allows them to practice both public and private medicine at an 80/20 split. Additionally, those with private insurance cover may choose a plan which provides private or semi-private hospital accommodation (Nolan et al., 2014).

The complexity of eligibility within the Irish health system is evident in the figure (Figure 27) below from the 2017 Sláintecare report, adapted from Burke et al (2016). Some of the charges have changed over the intervening years but the complexity remains.

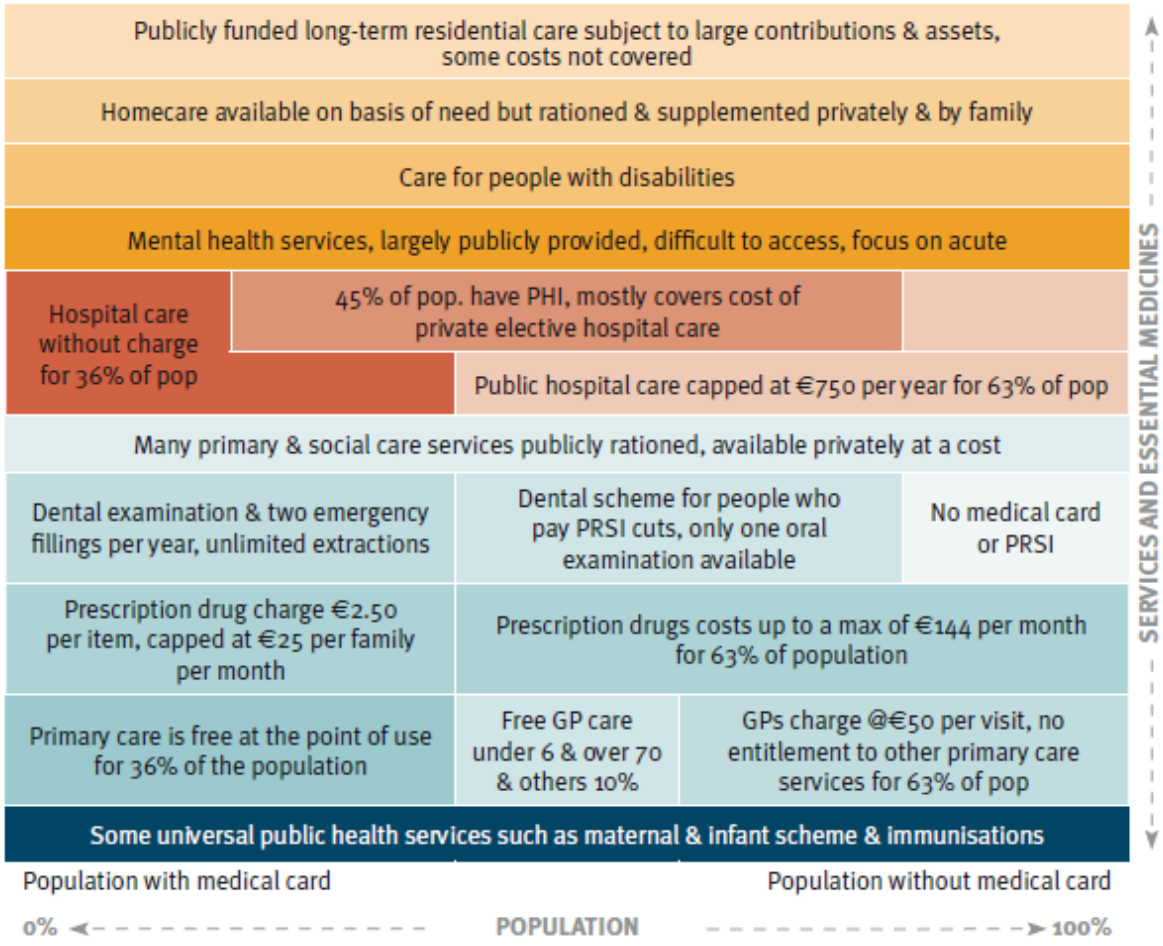

Figure 27: Overview of Access to Health and Social Care in Ireland (Houses of the Oireachtas, 2017, p. 45)

There are significant waiting times of up to several years for many kinds of 'elective care' such as knee and hip replacements and cataract surgery (Brick & Connolly, 2021). A parallel private hospital system exists where individuals with private insurance or with the means to pay directly can access these 'elective' services with much shorter waiting times. This two-tier system is underpinned by hospital contracts which allow doctors to work in public and private settings at the same time (Connolly & Wren, 2019).

Health has been an important political issue in several recent elections based on the recognition among the population that the current way health services are organised is not efficient nor equitable (Bowers, 2020; Neville, 2020). In 2017, a cross-party committee published a ten-year reform plan entitled Sláintecare which sets out a costed, phased plan for changing the Irish health system into one that would provide universal entitlement to health and social services for the full population (Houses of the Oireachtas, 2017). The reform plan was adopted as the official policy of the government in 2018 and remains the official policy of the current government at the time of writing in 2021. However, its implementation is taking longer than set out in the

original plan and key parts of the reform have yet to be tackled so it remains to be seen whether universalism will be fully implemented (Thomas et al., 2021).

This health service with so much complexity built in is difficult for most people in Ireland to access because of the confusing categories of eligibility and the significant wait times (Burke et al., 2016, 2018). And it is even more difficult for anyone who does not have a strong network or family to support them, or who has poor literacy (Barrington, 2004; O'Carroll & Wainwright, 2019; O'Reilly et al., 2015). Many people who experience homelessness do not have a network to fall back on for help to apply for a medical card or for help navigating a hospital appointment. And many have problems with basic skills such as literacy due to a lack of education in their childhoods or acquired deficiencies such as brain damage or cognitive decline as a result of being homeless (de Sousa et al., 2018; O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016).

5.3.2 Overview of Irish policies with relevance to populations experiencing homelessness and their health

This section provides an overview of the policies that link the domains of the Irish health system and homelessness. While there are a number of services providing both specialist and non-specialist healthcare to homeless populations, there is no single national homeless health strategy or policy in Ireland. However, there are a number of policies which spell out the vision for the direction of housing and healthcare broadly, which are therefore relevant to access and the provision of healthcare for populations experiencing homelessness.

Three major national policies, *Rebuilding Ireland*, *Sláintecare* and *Healthy Ireland*, outline national strategy in the domains of housing and health. However, each policy is mainly focused on its own area with little evidence of integration between policies or a whole of government approach eg there is little focus on health in the housing policy and vice versa.

Three specialised health policies, *Sharing the Vision: A mental health policy for everyone*, *Reducing Harm Supporting Recovery*, and the *National drugs rehabilitation framework*, focus on domains of care which many people who experience homelessness often have a need for, namely addiction treatment and mental healthcare. These policies, like the national policies, are mainly focused on their particular area and not on integrated, multidisciplinary solutions to complex problems.

Only two policies are specific to homelessness and health and both of these are internal Health Service Executive policies. One is an internal Health Service Executive model of care (the *Model of Care for the health of people experiencing homelessness in Ireland*) which guides the flow of

funds from the national Health Service Executive Social Inclusion Division to nine community healthcare organisations across the county which then each distribute the funds locally to NGOs providing health services to individuals experiencing homelessness in their locale via service level agreements (Health Service Executive Social Inclusion Division, 2018). And the second is a regional hospital discharge protocol (the *Dublin Homeless Hospital Discharge Protocol*) developed via a pilot programme specifically for Dublin hospitals. It sets out the steps that all acute hospitals in Dublin are supposed to take when an inpatient is discovered to be homeless in order to prepare them to leave hospital when appropriate with a plan for housing and follow up care in place so they can continue to recover and will not need to be readmitted (Dublin Homeless Hospital Discharge Oversight Committee, 2019).

Finally, one policy, *the Housing First National Implementation Plan 2018-2021* spells out goals for providing specific support needs, including health supports, individuals exiting usually prolonged homelessness have in conjunction with entering suitable housing.

Each of these policies are listed in Table 5 below and will be analysed further in the following sections.

Irish policies with relevance to populations experiencing homelessness and their health				
Policy domain	**Title**	**Author**	**Year**	**Key items**
Homeless healthcare	Model of Care for the health of people experiencing homelessness in Ireland	Health Service Executive Social Inclusion Division	2018	-Guiding internal policy for HSE Social inclusion building on principles of 1. Intersectoral policy, research and service-delivery, 2. Integrated and person-orientated ways of working; 3. Involvement of service-users in service planning and development - Details the distribution of €32.6 million HSE budget for homelessness services, mainly to independent NGOs who provide a majority of housing, health and social care services for homeless populations - Calls for a national homeless health policy - Calls for expansion of current services and programmes providing health services to better meet the needs of service users through care provided with an integrated approach to improve the quality and standardisation of care across the service system.
Homeless healthcare	Dublin Homeless Hospital Discharge Protocol	Health Service Executive	2019	-An operational document which sets out guidelines for in-patient and Emergency Department discharges of persons experiencing homelessness to ensure that they are discharged to appropriate accommodation and with necessary supports lined up. -Procedures include each hospital crating internal pathways to coordinate the work related to the discharge of homeless persons as well as the liaising with local the local authority. -The document lists the staff roles that must be represented, the specific steps they must take in relation to each patient,

				the patient data that must be collected, and the multi-disciplinary coordination to be undertaken within hospital during an in-patient stay and after discharge to connect with needed community healthcare and housing providers after discharge -Key performance indicator data must be collected, monitored and reported to the Health Service Executive on a monthly basis. Its purpose is to improve social and health for
General health policy	Sláintecare Implementation Strategy and Action Plan 2021-2023	Government of Ireland	2021	-High level reform framework with two Reform Programmes: Reform Programme 1: Improving Safe, Timely Access to Care and Promoting Health & Wellbeing, and Reform Programme 2: Addressing Health Inequalities — towards Universal Healthcare. Each have a number of associated projects and workstreams. -Deliverables for 2021-2023 are spelled out along with timelines, budget allocations, and reporting and oversight mechanisms.
General health policy	Healthy Ireland Strategic Action Plan	Government of Ireland	2021	-Theme six focused on reducing health inequalities (p29-30) -Recognition of the need to provide targeted health promotion effort to deprived populations who are not effectively reached by the whole population approach of previous Healthy Ireland initiatives (p4) -Goal (in alignment with Sláintecare implementation) of providing dedicated funding to deliver health, mental health and wellbeing supports to address the complex needs of people experiencing homelessness (p27)
General health policy	Sláintecare report	Committee on the Future of Healthcare, Houses of the Oireachtas	2017	-Report spells out the impact of social determinants of health on population outcomes (section 1.3-1.5) -Makes the case for and sets out a ten-year plan for reorientating the Irish health service toward universal entitlement to health services regardless of ability to pay
Specialist health policy	Sharing the Vision: A mental health policy for everyone	Government of Ireland	2020	-Sets out catchment area-based, four tier (from community to specialist) approach to organising mental healthcare -Recognition of the complex needs of populations experiencing homelessness and the additional care they may need
Specialist health policy	Reducing Harm, Supporting Recovery	Department of Health	2017	- Whole-of-government, health-led approach to problematic drug and alcohol use - Draws upon a range of government policy frameworks, incl the national drugs Rehabilitation framework (with the same four-tier coordinated integrated, inter-agency treatment and rehabilitation pathways based on case-management model) -Recognition of the complexity of life circumstances which makes recovery challenging but with strong focus on individual factors over systemic factors -Mention of both dual (mental health and substance use) diagnosis and the particular needs of people who experience

				homelessness as groups with particular needs. Housing First suggested as key initiative
Specialist health policy	National drugs rehabilitation framework	Health Service Executive	2010	-Framework for a four-tier coordinated integrated, inter-agency treatment and rehabilitation pathways based on case-management model (pp12-14) -Recognition that people with problematic substance use are diverse and have multiple needs which need the involvement of multiple agencies and are at risk of falling between the cracks between different areas of responsibility (p5)
Housing Policy	Housing First National Implementation Plan 2018-2021	Government of Ireland	2018	-Provides evidence of the prior success of the Housing First model in Ireland -Sets out goals for placing a total of 663 long-term homeless people with high support needs in Housing First tenancies across Ireland in the period 2018-2021
Housing policy	Rebuilding Ireland: Action plan for housing and homelessness	Government of Ireland	2016	-High level goal to address 'unacceptable' level of families in emergency accommodation and deliver interagency support for people experiencing homelessness (p13) -Goal to provide enhanced supports for homeless people with mental health and addiction issues (p17) - Goal to triple the tenancies to be provided by Housing First teams in Dublin and extend the housing-led approach to other urban areas (p17) -Recognition that there has to be a whole-of-Government approach to homelessness due to its complex nature (p36) -KPI: Improve mental health and primary care services for homeless persons with increased budget allocation (p91) -KPI: address the rehabilitation needs of homeless people with addiction issues through the National Drugs Strategy (p91)

Table 5: Current health and housing policies Ireland

I will now discuss each policy in the sections below starting with the two with most direct relevance to the healthcare provided to populations experiencing homelessness.

5.3.2.1 Homeless healthcare policies

5.3.2.1.1 Homeless healthcare policy: Model of Care for the health of people experiencing homelessness in Ireland

The *Model of care for homeless health* (Health Service Executive Social Inclusion Division, 2018) is an internal guiding policy document developed by the Health Service Executive's Social Inclusion Division. This Division holds 'the remit for improving health outcomes and access to

health services for vulnerable groups including health service users experiencing homelessness or at risk of homelessness' (p3).

The *Model of care for homeless health* specifies that 'joint responsibility and commitment to a long-term, coordinated and integrated response to delivering homeless services to a growing group of homeless people which involves the provision of suitable housing together with a set of appropriate health supports that assist the service user in maintaining a tenancy together with ensuring optimal physical and mental health' (p3) is with the Health Service Executive and local authorities. This is all in line with Rebuilding Ireland (described in more detail in section 5.3.2.4.2 below) actions 1.13, 1.15 and 1.16.

The *Model of care for homeless health* sets out a research-informed approach to providing healthcare, social care, temporary housing, and addiction services for populations experiencing long-term homelessness and complex needs. The document has two parts. First, it describes the current (as of 2018 when the document was written) funding arrangements and service programmes for homeless services. Second, it sets out plans for improvements to the service area to provide

> 'integrated assessment and care planning processes between homeless and addiction services, establish and formalise networks in the homeless health sector, enhance opportunities for shared information, research, training and service user involvement, and; enhance the standardization, reporting and delivery of best-practice and evidence-based health care across the service sector' (Health Service Executive Social Inclusion Division, 2018).

Three principles underpin the *Model of care for homeless health*:

- Intersectoral policy, research and service-delivery
- Integrated and person-orientated ways of working
- Involvement of service-users in service planning and development (p3)

It cites research which points to significant overlapping mental and physical health needs along with in the Irish homeless population: 'around 80% of homeless people experience some type of physical health condition, 78% report illicit drug or alcohol use and around 60% report a mental health condition' (p6).

The *Model of care for homeless health* policy explains the funding arrangements for the provision of homeless health service. In 2017 the Health Service Executive allocation to homeless services was 32.6 million euro. This allocation funded three high level areas of services: accommodation supports (supported temporary accommodation and long-term temporary accommodation) which accounted for 81% of the budget; specialist multi-disciplinary

supports (nursing, social work, mental health, occupation therapy, addiction treatment) which received 8% of the budget; and other services including day services, advocacy, in-reach health and addiction treatment in homeless accommodation and staff training which received 11% of the budget.

The funding is distributed through nine Community Healthcare Organisations in Ireland who are responsible for overseeing and funding homeless services in their geographic area, which are largely carried out by NGOs such as Depaul, Novas, Simon, Focus Ireland and Peter McVerry Trust. The funding equates to approximately 650 whole time employees at an average salary of €50K per year. Funding to NGOs is allocated on an annual basis in response to applications to their local Community Healthcare Organisation (p10).

The *Model of care for homeless health* sets out several planned future initiatives for improving homeless services. A key programme here is an integrated services pathway which the policy describes as such:

> the HSE [Health Service Executive] plans to lead the development of an integrated approach to improve the quality and standardisation of care across the service system. The proposed model will aim to enhance integrated assessment and care planning processes between homeless and addiction services, establish and formalise networks in the homeless health sector, enhance opportunities for shared information, research, training and service user involvement, and; enhance the standardisation, reporting and delivery of best-practice and evidence-based health care across the service sector (p17).

As of summer 2021, the new model of care has not been published.

Another proposed initiative of the *Model of care for homeless health* policy is a plan for 'the development of a national Inclusion Health Strategy to address the complex unmet health needs of vulnerable groups within Ireland'. This Strategy is envisioned to be:

> in line with core principles of social inclusion including intersectoral collaboration, joint ways of working and service-user involvement with an overall aim to improve access to mainstream and targeted health services for people from disadvantaged groups, reduce inequalities in health and address social determinants of health. . . The HSE [Health Service Executive] plans to establish processes in 2018 to commence the development of an Inclusion health strategy' (p18).

As of summer 2021, an inclusion health strategy has not been published.

5.3.2.1.2 Homeless healthcare policy: Dublin Homeless Hospital Discharge Protocol

The Dublin Homeless Hospital Discharge Protocol (Dublin Homeless Hospital Discharge Oversight Committee, 2019) was developed via a pilot project in 2018 and was then adopted in 2019 by the Health Service Executive for the following health service domains: HSE Primary Care, Mental Health, Acute Hospitals, and Palliative Care in Community Healthcare Organisations 6 (covering

south east Dublin), 7 (covering west, south-west and south city Dublin) and 9 (covering north and north west Dublin).

Its purpose is to improve social care and healthcare for people at risk of homelessness or experiencing homelessness through planned, coordinated and timely discharges from acute hospitals with onward referral as appropriate. It is meant to be used by all staff members of the health services, local authorities and voluntary agencies working with homeless populations. It sets out clear procedures, roles and responsibilities to ensure that discharges are planned and that health needs and other needs including housing are met upon discharge. It also suggests ways to monitor progress and outcomes via key performance indicators. Expected outcomes include increasing the number of assessments to identify complex needs and planned discharges, increasing the number of people experiencing homelessness going to appropriate accommodation upon discharge, and reducing in readmissions and lengths of stay to ultimately reduce costs (Dublin Homeless Hospital Discharge Oversight Committee, 2019).

5.3.2.2 General health policies

5.3.2.2.1 General health policy: Healthy Ireland Strategic Action Plan 2021-2025

Healthy Ireland is the Irish Government's overarching public health policy framework. It was launched in 2013 and has four top level goals:

- 'increase the proportion of people who are healthy at all stages of life
- reduce health inequalities
- protect the public from threats to health and wellbeing
- create an environment where every individual and sector of society can play their part in achieving a healthy Ireland' (Department of Health, 2021, p. 10)

Various policy documents have been published to guide the implementation of *Healthy Ireland* initiatives, with the current action plan, *The Healthy Ireland Strategic Action Plan 2021-2025*, being the most detailed so far with (high level) measurable goals, deadlines, and responsible government departments assigned. Since 2020, Healthy Ireland implementation efforts have been closely linked with Sláintecare (see sections 5.3.2.2.2 and 5.3.2.2.3 below) in its goals and implementation. It is led by the Health and Wellbeing Programme of the Sláintecare Programme Implementation Office based within in the Department of Health.

The *Healthy Ireland Strategic Action Plan 2021-2025* contains four mentions of homelessness with one specifically being about providing health services to people experiencing homelessness.

This occurs in Theme 4: Sláintecare Health Reform under ref 4.4.4 which promises to 'Ensure that the Health Service Executive provides a dedicated funding line and resources to deliver the necessary health and mental health and wellbeing supports required to assist homeless people with complex needs' (Government of Ireland, 2021b, p. 27).

Homelessness is also mentioned in relation to the 'Healthy Ireland Outcomes Framework' (on page 9 of the *Healthy Ireland Strategic Action Plan 2021-2025*) which consists of three sets of outcomes under the headers of 'Health status', 'Health outcomes' and 'Social determinants'. These are intended to work 'together to create an overall picture of health and wellbeing and will, in time, provide a holistic view of the effectiveness and impact of current policies, as trends become apparent' (Government of Ireland, 2021b).

'Homelessness' is one of the outcomes listed under the header of 'Social Determinants' but with no description of which data are being collected in relation to homelessness. Nor does it explain how these contribute to the tracking or improvement of health outcomes (p9).

Theme 6 of the *Healthy Ireland Strategic Action Plan 2021-2025* is called 'Reducing Health Inequalities' (pp 29-30) and sets out six high level goals with a number of sub-goals. Of particular relevance to the health of populations experiencing homelessness, ref 6.1 promises to 'Develop and implement the Sláintecare Healthy Communities Programme to facilitate an area-based approach to health and wellbeing'. This particular goal and its sub goals are all assigned to the Department of Health and will be accomplished based on ref 6.1.1 'Target specific areas in order of deprivation level and support the implementation of specific, agreed health interventions with greatest potential impact on health and wellbeing in target areas', ref 6.1.2 'Engage across all relevant Government Departments and agencies to develop a collaborative, holistic and comprehensive approach to address the social determinants that impact on health and wellbeing and reduce health inequalities', and ref 6.1.3 'Develop initiatives to address health inequalities in marginalised groups' (Government of Ireland, 2021b, pp. 29–30).

Taken together, the *Healthy Ireland Strategic Action Plan 2021-2025* has a general focus on health inequalities and calls for an integrated, holistic approach to conceptualising health and wellbeing and promoting good outcomes. However, it does not have a specific focus on deep deprivation and social exclusion such as that experienced by homeless populations.

5.3.2.2.2 General health policy: Sláintecare

Sláintecare[1] is the major national health reform plan to deliver timely access to universal healthcare in Ireland which is currently being implemented. The first Sláintecare report was published in 2017 by the Houses of the Oireachtas' Future of Healthcare Committee which was convened in 2016 to produce a ten-year plan to guide health reform in Ireland (Houses of the Oireachtas, 2017). The committee had representation from all parties and groupings in the Dáil (the lower house in the Irish legislature) and their final report was published in May 2017 (Burke et al., 2018).

The 2017 Sláintecare report set out a high-level road map for health reform to ultimately bring about the establishment of a 'universal single tier service where patients are treated on the basis of health need rather than on ability to pay' under the assumption that 'the best health outcomes and value for money can be achieved by re-orientating the model of care towards primary and community care where the majority of people's health needs can be met locally' (Houses of the Oireachtas, 2017). It was produced in response to the programme for government just published by the then newly formed Government and a motion introduced on 1 June 2016 by the Minister for Health to create an all-party Committee on the Future of Healthcare. The motion gained the support of all parties and groupings in the Dáil (parliament) which was a historic instance of unanimous consensus on the need for health reform in Ireland (Burke et al., 2018).

5.3.2.2.3 General health policy: Sláintecare Implementation Strategy and Action Plan 2021-2023

Since the publication of the Sláintecare report, the approach it outlines was broadly speaking adopted as official government policy. Plans for the implementation of its high-level roadmap have been translated in to three implementation strategies since. The first Sláintecare Implementation Strategy (Government of Ireland, 2018b) was published in July 2018. Soon after, an implementation unit was established within the Department of Health in September 2018 which has produced a number of policy documents to guide the further implementation of the reform programme (Thomas et al., 2021).

The most recent Sláintecare implementation policy, the *Sláintecare Implementation Strategy and Action Plan 2021-2023* (Government of Ireland, 2021a), was published in May 2021. It contains two high level reform programmes; 1. 'Improving Safe, Timely Access to Care and

[1] I was a member of the team of academics from Trinity College Dublin who provided technical support to the Oireachtas Committee on the Future of Healthcare along with two of my supervisors Prof Steve Thomas and Dr Sara Burke and other colleagues. We provided content expertise, research support and drafted the report chapters.

Promoting Health & Wellbeing' and 2 'Addressing Health Inequalities — towards Universal Healthcare'. These goals have seven and four projects respectively, outlining the particular actions which will drive their progress (pp10-11).

'Homelessness' is mentioned four times in the *Sláintecare Implementation Strategy and Action Plan 2021-2023* and is associated with one goal (appearing under four subsequent timelines) in Reform Programme 1 in relation to the development, progression and review of 'the delivery of high quality, accessible and safe care for the homeless population in EDs and Acute services'.

Reform Programme 2, as the title indicates, ('Addressing Health Inequalities — towards Universal Healthcare') is focused on improving upon health inequalities. The description of Reform Programme 2's Project 2 'Implement Sláintecare Healthy Communities Programme' includes a strong focus on the social determinants of health:

> The social determinants of health are the non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Research has shown that the social determinants can be more important than health care or lifestyle choices in influencing health. In Ireland, there is a strong link between poverty, socio-economic status, and health.
>
> A concerted focus on addressing health inequalities will be taken in implementing the Sláintecare Healthy Communities Programme which will take a geographical (area-based) population profiling project and segmentation approach. The goal of the Sláintecare Healthy Communities Programme is to improve the long-term health and wellbeing of the most disadvantaged communities in Ireland, objectively selected based on the Social Inclusion and Community Activation Programme (SICAP) areas. 18 of 51 SICAP areas across the country will receive additional investment in 2021, with a rollout to further areas subject to funding and lessons learned. The Programme for Government provided a clear intention to address cross-sectoral inequalities. (Government of Ireland, 2021a, p. 40)

Additionally, Project 3, 'Develop Regional Health Areas,' promises to improve areas of health service provision which are potentially important to making health care more accessible for populations experiencing homelessness. These include improving clinical governance, moving to service planning with a population-based approach, and the integration of acute and community services (p41). This area-based approach to health service planning and provision is in line with *Healthy Ireland Strategic Action Plan 2021-2025* and its goal of targeting specific areas in order of deprivation level (Government of Ireland, 2021b, pp. 29–30).

The title of Reform Programme 2 'Addressing Health Inequalities — towards Universal Healthcare' contains the words 'universal healthcare' and yet the *Sláintecare Implementation Strategy and Action Plan 2021-2023* refers to both 'entitlement' and 'eligibility' to services a number of times which signals a lack of commitment to full universal entitlement to healthcare.

In the section discussing Reform Programme 2, Project 1, workstream 4 (p 39), a listed goal is to 'Develop policy proposals and options for achieving universal eligibility across hospital and community settings' along with the aim to 'consider the current eligibility and entitlement policies, and review how they align with population needs as identified in the above workstreams, with a view to achieving universal eligibility/entitlement' and to consider 'the range of services to be provided on a universal basis', and the 'rationale and methodology for eligibility/entitlement for the services' (Government of Ireland, 2021a).

Taken together, the *Sláintecare Implementation Strategy and Action Plan 2021-2023* has a strong focus on health inequalities and universal eligibility for health services. A move toward population-based service planning signals an intention to provide resources according to geographical need with poorer communities receiving more funding and services.

5.3.2.3 Specialist health policies

5.3.2.3.1 Specialist health policy: Reducing Harm, Supporting Recovery

Reducing harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025 (Department of Health, 2017) is the Irish Government's most recent policy on problematic drugs and alcohol use. The policy sets out a number of strategies to minimise harmful effects of drug and alcohol use based on a public health approach and is included here because of the strong association between homelessness and substance misuse (Cornes et al., 2018; O'Reilly et al., 2015, p. 42).

Reducing Harm, Supporting Recovery also calls for action to 'improve the range of problem substance use services and rehabilitation supports for people with high support needs who are homeless' (strategic action no 2.1.25 – p 48). This is to be accomplished using a four-tier coordinated, integrated, inter-agency treatment and rehabilitation framework set out in the *National drugs rehabilitation framework* (Doyle & Ivanovic, 2010). Other measures include infrastructure investment to increase the numbers of detoxification, stabilisation and rehabilitation beds, as well as through providing treatments using enhanced assessment, key-working, and case management, and through coordinated working between State organisations and non-governmental service providers to ensure linked drugs rehabilitation pathways are comprehensive. These goals are the responsibility of the Health Service Executive and Department of Health in collaboration with NGO sectors.

5.3.2.3.2 Specialist health policy: Sharing the Vision: a mental health policy for everyone

Sharing the Vision: a mental health policy for everyone (Government of Ireland, 2020) published in 2020, is the most recent national mental health policy and is included here because of the

high prevalence of mental ill health among populations experiencing homelessness (Cornes et al., 2018; O'Reilly et al., 2015, p. 49). The general model of care is one based in the catchment area where a client lives and the general patient pathway is outlined as a four-tier 'stepped care approach'. The first tier is community level support from social networks, peers, family, friends, and community and voluntary groups. The second tier is primary care including general practice. The third tier is community and specialist mental health care. And finally, the fourth tier is special inpatient or residential unit services (p35).

With regards to people experiencing homelessness, the policy states that they should if possible, access support through their general practitioner or if necessary be referred to a community mental health team in their area. However, the policy also recognises that for those experiencing long-term homelessness, this may not be possible:

> When those living in long-term emergency accommodation cannot gain access to the mental health services they require, homeless services should provide for their mental health needs. This would include low-level interventions and appropriate referrals to specialist services. Duplication of services should be avoided and, where possible, homeless people should access their local community mental health team. Homelessness should not create a barrier to accessing mental health services. For the rough-sleeping population, a dedicated mental health service operating on an outreach model is required in large urban areas (Government of Ireland, 2020).

5.3.2.4 Housing policies

5.3.2.4.1 Housing policy: The Housing First Implementation Plan 2018-2021

The Housing First Implementation Plan 2018-2021 (Government of Ireland, 2018a) is the plan for the implementation of the Housing First method in Ireland. This method has been shown to better meet the needs of long-term homeless individuals than previous approaches and has been the preferred method of the Irish government since 2011 when it was included in the Programme for Government (p8).

Housing First is an approach targeted at 'people with a history of sleeping rough and long-term users of emergency homeless accommodation with high and complex mental health and addiction needs' which:

> offers the provision of immediate, permanent and affordable housing to tackle homelessness, and then provides the appropriate wraparound housing and health supports, and connections to community-based supports, to ensure people maintain their housing and improve their overall health and well-being. This support is time unlimited and provided for as long as required (p11)

The Housing First Implementation Plan 2018-2021 provides data to show the success of the Housing First model in Ireland with a tenancy retention rate of 85% for the 182 people who had had until then participated in the Irish Housing First programme (p19). It then sets out a plan for

2018-2021 with targets for the numbers of people to be serviced by the programme in each region of Ireland and discusses the anticipated nature and level of needs in the population that could benefit from accessing future Housing First interventions, based on an audit of need carried out with homeless service key workers in May 2018 (p28).

According to the *The Housing First Implementation Plan 2018-2021,* funding for the programme is being supplied by the Department of Housing and the Service Reform Fund, which is an initiative of the Department of Health, Health Service Executive, the Department of Housing, Planning, and Local Government, Atlantic Philanthropies, and Genio to implement service reforms in homelessness, mental health and disability in Ireland (p32).

5.3.2.4.2 Housing policy: Rebuilding Ireland

Rebuilding Ireland (Government of Ireland, 2016) is the current Irish official government policy for housing. It was published in 2016 and was the fourth housing policy published in the 2000s coming after *A Housing Policy Statement* (MerrionStreet.ie, 2011) published in 2011, *Delivering Homes Sustaining Communities* (Department for the Environment, Heritage and Local Government, 2007) published in 2007 and *Housing Policy Framework - Building Sustainable Communities* (Oireachtas, 2006) published in 2005.

Rebuilding Ireland recognises the notion that there is a strong and complex relationship between housing and health. On page 36, it says:

> While the recent increases in family homelessness are primarily related to the housing supply shortage, homelessness among vulnerable individuals has been an enduring societal problem in this country and internationally. Homelessness is a complex phenomenon which is usually the result of a number of inter-related issues, including mental health issues, addictions, relationship breakdown, family issues, domestic violence, financial loss, economic insecurity, rent arrears, tenancy issues, anti-social behaviour, crime, prisoner release and the vulnerability of migrants, among other factors. Consequently, a successful whole-of Government response is required in relation to such issues, if the current homelessness issue is to be tackled effectively (Government of Ireland, 2016).

With the demonstrated understanding of the complexity of homelessness, the policy sets out a general approach to meeting the needs of people experiencing homelessness through an integrated, coordinated service provision:

> There is a need for collaborative and cross-agency working in this regard, with the DoH, the HSE [Health Service Executive], the Department of Social Protection (DSP), local authorities and NGOs with expertise in the area all playing a vital part. For example, the HSE Service Plan for 2016 commits to ensuring that arrangements are in place and working effectively to ensure homeless persons have access to primary care services where required, and that in-reach services are provided to emergency accommodation settings and long-term supported accommodation for people with high-support needs. Additional funding of €2m is being provided to the HSE this year

> for the provision of case management and support for homeless people with chronic and enduring health needs, in collaboration with mental health services. This will be increased to €6m next year and the HSE will identify appropriate Pathfinder projects to help guide the delivery of these services into the future. In addition, there will also be a particular emphasis on significant projects providing drug and alcohol detoxification programmes and enduring services supporting long-term recovery. (p37)

5.4 Policy Analysis Discussion

The goal of this analysis is to explore how policies and their historical background impact on health system design to provide healthcare access for populations experiencing homelessness and complex needs in Ireland. It follows the historical threads to understand the roots of current policies, and it examines what present day policies tell us about the priorities and intentions that govern the Irish health system at a high level, and how these impact healthcare accessibility for homeless populations.

Having recounted the historical influences which have shaped the modern-day Irish health service and then described the key policies that govern housing and health, I now discuss and analyse the implications of these sets of data for current and future policy. Six key themes derived from the analysis are presented below: fragmentation; charity model and health inequalities; deserving and undeserving; entitlement and eligibility; governance; and funding. These are discussed in turn below in sections 5.4.1-5.4.5.

5.4.1 Fragmentation

The history of the Irish health system is characterised by a lack of both unified strategies to support the public's health and strong centralised leadership. Services were historically provided via a number of public and private providers representing strong ideologies and interests such as the Catholic Church and a conservative medical profession. Healthcare has been fragmented in planning, funding and delivery (Adshead et al., 2003; Heavey, 2019; Malone & Millar, 2020; Wren, 2003, pp. 18–21).

Despite the policy intent found in all policies to provide cross-departmental responses and integrated care, fragmentation is characteristic of the Irish health system to this day. This is reflected in policy documents which across the board call for services to become more integrated and coordinated. The *Model of care for homeless health* (Health Service Executive Social Inclusion Division, 2018) points out the specific need for integration in homeless services:

> There is an urgent need for strengthened liaison between primary care, secondary care services, ED and other sectors to ensure appropriate, timely, targeted and best-practice service provision

> that aims to prevent and address complex health conditions and support service-users to maintain stable housing. A wide body of research emphasises that housing is a key element to maintaining optimal health and it is critical that the HSE [Health Service Executive] works in close collaboration with the housing sector in health service planning and development.

Mainstream policies also recognise that especially for populations experiencing homelessness, who have complex needs which cut across a number of domains, integration and coordination is key. For example, *Rebuilding Ireland* (Government of Ireland, 2016) states:

> Accommodation alone will not address the underlying problems of the vulnerable grouping of homeless people who have addiction and/or mental health problems. They have particularly complex needs which must be addressed in tandem with the provision of stable housing. The individuals concerned must be given holistic medical and practical supports as required (Government of Ireland, 2016, p. 37).

Reducing Harm, Supporting Recovery (Department of Health, 2017) states:

> People who are homeless are at a far higher risk of problem drug use than people in secure housing, with particularly high levels of use and risk amongst rough sleepers and those using emergency accommodation. While substance misuse can lead to homelessness, homelessness can also contribute to the development of substance misuse problems. This underlines the importance of homelessness services and substance misuse services working together in a collaborative way . . (Department of Health, 2017, p. 45).

The *Sláintecare Implementation Strategy and Action Plan 2021-2023* (Government of Ireland, 2021a) calls for the development of integrated care pathways as ways to promote high quality outcomes and timely access to care:

> The development of integrated care pathways that are based on delivering the best outcomes for patients can help to drive streamlined integration between care settings at a national, regional and local level. Pathways that are agreed between GPs, primary/community care providers, community specialist teams and hospital-based specialists can provide better links across these care settings and will ensure that resources are used to provide the best care for patients and that services are provided in a more timely way (Government of Ireland, 2021a, p. 17).

Sharing the Vision: a mental health policy for everyone (Government of Ireland, 2020) recognises that people who experience co-current conditions alongside mental ill health such as addiction or intellectual disability have overlapping needs but also particular difficulty accessing adequate health services: 'Access to primary care addiction services and existing mental health supports when there is a co-existing mental health/addiction problem remains complicated' (p53). To better meet these needs, the policy calls for integrated services across primary and specialist

care and says that there 'is a need to further develop universal access to primary care addiction services that include associated models of leadership and governance' (p 53). It states that integrated services are necessary because it is often difficult to establish whether a mental health difficulty is the primary complaint or comes secondary to a co-morbid issue (Government of Ireland, 2020).

However, when it comes to people with complex needs which cut across domains, the policies reviewed here show a lack of integration. The policy landscape does not demonstrate an integrated approach to the delivery of health and housing and other services needed for populations experiencing homelessness. Crucially, there is no unified policy or strategy to address the specific health needs of populations experiencing homelessness and other forms of social exclusion.

Instead, health and housing policies are situated in different domains with different ministries in charge of implementing them and meeting the goals articulated within them. They focus mainly on the particular area they are guiding and while they recognise the complex needs of populations experiencing homelessness, each policy offers few specific strategies for the crucial integration and multi-disciplinary collaboration between health, social care and housing that is necessary for making healthcare accessible for populations experiencing homelessness.

The *Model of care for homeless health* (Health Service Executive Social Inclusion Division, 2018) is the only national policy to provide specific goals which cut across domains including health, social care, housing, and addiction. However, it governs the specialist homeless service sector only and is not an official, publicly available policy and as such has limited scope for shaping high level integration between domains in mainstream services. However, the existence of a division within the Health Service Executive tasked with promoting social inclusion indicates a will and intention from the high-level leadership within that organisation to prioritise the needs of socially excluded populations. Additionally, it means that the necessary capacity and expertise to drive the creation of a national policy is present and signals the potential for such a policy to be produced.

5.4.2 Charity model and health inequalities

Historically the Irish health system has been dominated by 'principles of *individualism, self-help*, and the supremacy of the private market' and has developed 'according to the principle of *ability to pay* rather than on the *basis of medical need*' (Malone & Millar, 2020). Those who could not afford to pay could be given access to healthcare if they were deemed worthy but as

an act of charity without ongoing entitlement (Geary et al., 2018). These principles have formed the basis for the development of a system where those who can afford to pay for healthcare are expected to do so and only those who cannot because of low income or life circumstances, are given access to free care. On this topic, Maev-Ann Wren says of healthcare in Ireland in her book *Unhealthy State*: 'Not only the state but also the health care system is unhealthy, an expression of Victorian values in which health care is a commodity to be purchased or, when it is unaffordable, to be given as a charity, never as a right' (Wren, 2003).

Healthcare free at the point of use is not seen as an entitlement that comes along with residency in Ireland unlike other European countries but as something to which some people are granted eligibility, based usually on means testing for low income. For that reason, services have developed in different tiers for those who can pay and for those who cannot (Connolly & Wren, 2019).

While there are officially two tiers within the Irish health service (those with and those without a medical card), as described in section 5.3.1.3, it could be argued that there is a third tier of health access in Ireland for socially excluded people who rely on a host of specialist homeless services. Here the legacy of the charity model is evident in the way primary care, social care and housing services are provided for populations experiencing homelessness in specialised, parallel systems largely funded by the state but carried out by NGOs and charities away from the rest of the population as described in the *Model of care for homeless health* (Health Service Executive Social Inclusion Division, 2018).

While housed low-income people can more readily access entitlements such as medical cards because they have an address where they receive post and often have an established relationship with their GP, transient people often experience barriers applying for a medical card due to their busy, chaotic lifestyles. Therefore, socially excluded populations tend not to have an ongoing link with mainstream services. Additionally, specialised services are often preferred by socially excluded people because of the expertise and attitudes of the practitioners which is no doubt at times appropriate but also allows the mainstream system to avoid developing the same expertise. Instead mainstream services benefit from the stigmatisation which leads socially excluded populations to avoid contact with them unless absolutely necessary (O'Carroll & Wainwright, 2019).

Finally, addressing health inequalities is not accomplished just within health. It requires society-wide economic, social, educational and employment policies, and more, which support the reduction of inequality of all kinds. Today, no recent government in Ireland has adopted such a

full suite of policies, further suggesting that there is a lack of true dedication to the goal of reducing health inequalities.

5.4.3 Deserving and undeserving

With an understanding of the history of the Irish health service, a thread can be traced from the charity model of care before the establishment of the Irish State in 1922 in which private care was better and care provided by the state was available only to the poor (Wren, 2003, pp. 18–21) to today's two-tier system where private care is still seen as better and for good reason. Indeed private care provides faster access to certain procedures even today (Nolan et al., 2014).

Among people needing state-provided care, historically a divide existed between those who were seen as 'deserving poor' and those who were seen as 'undeserving poor'. The 'undeserving poor' who experienced deep poverty and destitution had to suffer the indignities of the workhouse to qualify for food, housing, and health supports, and served as a cautionary tale for anyone considering relying on the state for aid. On the other hand, poor people who were able to look after themselves and their families were seen as being worthy of support such as free healthcare because of a recognition that with supports they would not end up in a worse position and potentially a bigger burden on the state (Geary et al., 2018). Echoes can be heard of the distinction between the deserving poor, now those on a low income with a medical card, and undeserving poor, now socially excluded populations who are stigmatised and made a cautionary tale of.

This individualised view of people as being fundamentally deserving or undeserving builds on the notion that each person is essentially responsible for how their lives turn out (Malone & Millar, 2020). This ethos is still present. For example, *Rebuilding Ireland* presents an understanding that homelessness is multifaceted with many causes:

> Homelessness is a complex phenomenon which is usually the result of a number of inter-related issues, including mental health issues, addictions, relationship breakdown, family issues, domestic violence, financial loss, economic insecurity, rent arrears, tenancy issues, anti-social behaviour, crime, prisoner release and the vulnerability of migrants, among other factors' (Government of Ireland, 2016).

However, the focus is on the individual circumstances, behaviours, and events that can lead to homelessness rather than also discussing structural factors which contribute to and shape individual life conditions (Fowler et al., 2019). For example, financial loss may result from many factors such as growing up in poverty and a lack of educational and employment opportunities. The focus on the micro level in describing these factors may be inadvertent but it indicates the

general orientation among the authors of the report and might result in placing responsibility for the life experiences that lead to homelessness on the person rather than the systems that have failed to keep them housed and well.

There is also a general lack of consideration given across the policies to the particular historical roots of social exclusion which sometimes results in homelessness in Ireland, such as people with a history of institutionalisation in Mother and Baby Homes and Magdalene Laundries and their descendants (Murphy, 2020) as well as those with a history of being in care or spending time in prison (Khan, 2010).

5.4.4 Entitlement and eligibility

The lack of universal entitlement to healthcare means that the Irish health system still allows those with the ability to pay to move ahead in the queue and access is not determined by who has the greatest need. Eligibility depends on a variety of measures and generally requires people to actively apply to a programme or scheme to get access. In some cases, age or having a particular condition provides access to a given scheme but in the majority of cases eligibility is means tested (Nolan et al., 2014). This means that the implementation of, for example, goals to develop, progress and review 'the delivery of high quality, accessible and safe care for the homeless population on EDs and Acute services' as set out in Reform Programme 1 in the *Sláintecare Implementation Strategy and Action Plan 2021-2023* (Government of Ireland, 2021a) builds upon a shifting foundation where eligibility to service can change and service quality and accessibility are not known entities.

The lack of entitlement to healthcare is contrary to stated goals in the 2017 Houses of the Oireachtas Sláintecare report authored by the all-party Committee on the Future of Healthcare which called for legislation to introduce legal entitlement to healthcare services via a 'Cárta Sláinte' (health card). The Cárta Sláinte which would 'entitle all those ordinarily resident [in Ireland] to access care based on need establishment a legal entitlement' (Houses of the Oireachtas, 2017, p. 59).

The lack of universal entitlement to health services is also contrary to the approach in the majority of European countries and to a key recommendation to the WHO's 'Poverty, social exclusion and health systems in the WHO European Region' report published in 2010. The report states:

> 'Health systems have four functions: financing, stewardship, service delivery and resource generation. Action to improve the health of disadvantaged populations should span the four

> functions. It should be grounded in a human rights approach to health and the values and principles of primary health care' (WHO, 2010)

Implicit in the paradigm of universal healthcare is a responsibility of the state to provide healthcare free at the point of use, or to ensure that care is provided free at the point of use via private practises paid by the state as is the case in general practice in Denmark and the UK, for example. According to a conceptual synthesis by Abiiro and De Allegri, in the international literature universal healthcare is:

> 'operationalised in terms of population coverage of health-related social security systems, financial protection, and access to quality health care according to need, and pursued within the framework of health care as an international legal obligation grounded in international human rights laws' (Abiiro & De Allegri, 2015).

Additionally, legal entitlement to care constitutes more than just an extension of coverage of healthcare services to all residents. It is a commitment to ensuring that the various complex parts of the universal system work together (Abiiro & De Allegri, 2015). Further, a legal entitlement provides a basis for holding a state or government accountable for providing healthcare to all (Lau et al., 2021). It is perhaps no coincidence that there is no legal entitlement to healthcare in Ireland as it exempts the State from having to fully commit to providing healthcare free at the point of use even if it was stated as an explicit goal in the original Sláintecare report published by the Committee on the Future of Healthcare in 2017 (Houses of the Oireachtas, 2017).

Without legal entitlement to healthcare all populations, including those experiencing homelessness and social exclusion, lack a clear right to seek healthcare and lack recourse when it is not provided. The two-tier health service in Ireland and the need to actively opt in for certain eligibilities create confusion. Navigating this complex landscape is difficult for most people but even more so for those without social supports and social networks. It creates a basic assumption on both the supply and demand side of the healthcare consumption equation that services can be denied to certain people and that the healthcare system is not obliged to serve all (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016).

Additionally, eligibility to care does not always guarantee that the care is available to be accessed in a reasonable timeframe. In Ireland, access to both inpatient and outpatient hospital procedures are seriously constrained by long waiting times and the existence of the two-tier system which means that individuals who can pay privately out of pocket or through private

health insurance have the ability to gain faster access than in the public system (Brick & Connolly, 2021).

Even when someone meets the income requirements, access to a means-tested Medical Card is not always straightforward, especially for socially excluded populations. Applying for a medical card requires the patient to find a general practitioner to sign their application form and thereby agree to provide care to that patient and add them to their practice. Homeless persons have reported experiencing difficulties in both finding a general practitioner and in navigating the application process (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarlane, 2016).

5.4.5 Governance

The Irish Health system developed in an ad hoc way, first under British rule. The same path continued in a young Irish state, under the strong influence by the Catholic Church and the medical profession which promoted their own interests in organising and providing healthcare above those of the state. A universal, lay health service was rejected by politicians, the clergy and doctors. As a result, healthcare was practiced without national systematic planning for how to meet the population's needs. These roots are still evident in how healthcare is provided today.

With regards to health services for homeless populations, while there is a strong focus on health inequalities and the needs of deprived populations in the national and specialised policies which I have reviewed above, there are very few actual measurable high-level goals to drive the provision of accessible healthcare for these populations.

This is reflected in the *2021 Health Service Executive National Service Plan* (Health Service Executive, 2021b). This is the 2021 edition of the annual master plan for the provision of services throughout the public health service. It is the official document where the Health Service Executive publicly share their clinical and management goals for the type and volume of services they will perform in all domains including primary care, mental health services, disability services, older persons' services, acute hospital care, cancer services, managing COVID-19, and much more.

The *2021 Health Service Executive National Service Plan* has a number of objectives for improving the health of people experiencing homelessness. These include implementing objectives related to homelessness in the current policies governing housing (*Rebuilding Ireland & Housing First National Implementation Plan*), mental health (*Sharing the Vision – A Mental Health Policy for Everyone*), and drugs (*Reducing Harm, Supporting Recovery*). Another priority is

to develop a 'single integrated homeless case management team for Dublin and enhance homeless action teams outside of Dublin that will provide integrated individual assessment, case management, care planning and co-ordination'. Other priorities include the evaluation of current programmes aimed at improving hospital discharges for patients experiencing homelessness and the step-down transitional services for homeless people exiting residential addiction treatment (Health Service Executive, 2021b, pp. 51–52).

The *2021 Health Service Executive National Service Plan* also signals the intention to retain successes experienced during the COVID-19 pandemic where homeless services in Dublin became highly coordinated and integrated through the leadership of the Health Service Executive Social Inclusion division and their convening of a number of important services and stakeholders. A strategic initiative the Social Inclusion division will undertake following on from this, is to: 'Embed the primary care response to homelessness arising from COVID-19 as a model of integrated care for people with complex needs in line with Sláintecare' (p53).

However, the *2021 Health Service Executive National Service Plan* only contains one key performance indicator specifically tied to the health of homeless people with four more that are likely to touch the areas treatment needed by many people experiencing long-term homelessness and complex needs. These are shown in Table 6 below:

Health Service Executive – Social Inclusion – National Performance Indicators			
Number	Domain	Key Performance Indicator	2021 Target
1	Opioid substitution	Average waiting time from referral to assessment for opioid substitution treatment	4 days
2		Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced	28 days
3	Homeless service	Homeless Services % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed within two weeks of admission	85 %
4	Substance misuse	% of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	100%
5		% of substance misusers (under 18 years) for whom treatment has	100%

		commenced within one week following assessment	

Table 6: Social Inclusion Key Performance Indicators, Health Service Executive National Service Plan 2021

The single key performance indicator listed for the 'Homeless service' domain is focused on measuring the number and percentage of service users admitted to homeless emergency accommodation who have received a health needs assessment within two weeks of their arrival. While the *2021 Health Service Executive National Service Plan* lists a number of goals for the Social Inclusion domain, it is important to note that these are not coupled with key performance indicators and therefore their progress is not being measured at a national level.

Similarly, *Rebuilding Ireland* has few tangible actions to support the health needs of people experiencing homelessness. There are four particular actions related to health and with the exception of action no 1.15 there are no measurable key performance indicators included to track improvement or development over time:

- 'We will enhance inter-agency arrangements to ensure that accommodation, welfare and health supports for prisoners are in place prior to their release' (action no 1.10)
- 'We will improve mental health and primary care services for homeless persons using the existing allocation of €2m, and we will increase the allocation to €6m in Budget 2017' (action no 1.15)
- 'We will address the rehabilitation needs of homeless people with addiction issues, through the new National Drugs Strategy which is to be effective from January 2017' (action no 1.16)
- 'We will work with the HSE [Health Service Executive] and local authorities on all issues, including funding supports, for housing people who are transitioning from HSE accommodation and for clients of the mental health services living in community-based accommodation' (action no 2.20). (Government of Ireland, 2016)

Despite policy intent to meet the needs of specific populations, these do not translate into service targets or key performance indicators and therefore are unlikely to be implemented or realised.

5.5 Discussion

5.5.1 Summary of principal findings

There is no government policy specifically dedicated to promoting positive health outcomes for populations experiencing homelessness in Ireland. Homeless health is partially covered in

several policies including the national housing policy published in 2016, *Rebuilding Ireland* (Government of Ireland, 2016), in the policy for population health, *Healthy Ireland* (Government of Ireland, 2021b), and in the ten-year reform programme to redesign the Irish healthcare system as a system with universal entitlement to care, *Sláintecare* (Houses of the Oireachtas, 2017). However, these policies do not include many measurable goals and key performance indicators that set into motion, fund, and evaluate the work that needs to be done in a coordinated, integrated manner to provide better access to healthcare for populations experiencing homelessness, and ultimately better health outcomes.

The only policy which specifically provides a plan for the provision of inclusion health services across domains as needed, the *Model of care for homeless health* (Health Service Executive Social Inclusion Division, 2018), is an internal document situated within the Social Inclusion division. In the document itself, there is a call for a national strategy:

> to provide a framework through which health actions will be recommended to address the complex unmet health needs of vulnerable groups within Ireland . . in line with core principles of social inclusion including intersectoral collaboration, joint ways of working and service-user involvement with an overall aim to improve access to mainstream and targeted health services for people from disadvantaged groups, reduce inequalities in health and address social determinants of health (Health Service Executive Social Inclusion Division, 2018).

The fact that there is no national policy means that there are few national goals and no dedicated funding to this area. This in turn allows the health system to focus on other things. Meeting the needs of socially excluded populations is therefore done in an environment tasked with and measured on other things, first and foremost, and serving them is an afterthought.

5.5.2 Strengths and limitations

A strength of this study is its long view and the exploration of the historical roots of modern political priorities. This kind of analysis helps to uncover the values and ideas we take for granted in daily life. In this study it shows where ideas about poverty and who deserves what in society are a product of historical social constructions that serve particular purposes and are not benign.

Another strength is the use of policy analysis to illuminate policy processes and the complex political, cultural and economic forces that shape the development and implementation (or lack thereof) of health policies. The use of this method brings an understanding of the broader environment in which a health system functions and is a reflection of the society it serves.

Conversely the breath of the scope of the analysis is also a limitation of this study because the analysis covers a lot of ground perhaps to the detriment of covering some of the concepts in more depth.

Another limitation of this study is that no primary data were collected in the form of interviews with policy makers to explore the policy making process and how priorities are made, as well as try to understand the trail from policy formation to implementation, which according to the findings in the realist evaluation (study 2) is lacking in Ireland. Rather than bringing that perspective into this study, the decision was taken to collect data from frontline workers who have a view of both policy intentions and patient outcomes for use in the realist evaluation study. I then bring both sets of findings together in the next chapter (chapter 6) where the integration of findings of all the studies takes place. Nevertheless, this study could be strengthened by adding interview data with policy makers.

5.5.3 Comparisons with existing literature

I am not aware of another policy analysis of policies related to how populations experiencing homelessness access healthcare in Ireland.

Maev-Ann Wren's book *Unhealthy State: Anatomy of a sick society* (Wren, 2003) was published in 2003 and provides an explanation of the roots of the Irish health service which leads to an exploration of how and why the health service as a whole has been organised and services delivered in ways that do not meet the needs of the Irish population as a whole. Building on Wren's analysis, this thesis chapter is focused on current 2021 policies with a much narrower scope of exploring how they impact healthcare access specifically for populations experiencing homelessness and complex needs.

Geary (2018) provides a historical overview of the development of the Irish health service from the early 18th to the mid-twentieth century. He explores how ideas about healthcare eligibility developed and changed, how services were delivered and by whom, how structures developed, and which laws guided the health service first under British rule and later after Independence. This chapter built on that detailed history to explain key developments such as discussions of who deserves healthcare, the role of powerful stakeholders who prevented a unified health service from developing and the practices of means testing, and then drew parallels to the current Irish health system and discussed how historical priorities and values are reflected in health policies and practice.

Malone and Millar (2020) explore why Ireland, in a departure from other European nations, never established a universal health service and points to a reliance on the market and societal values of individualism and self-help as key reasons. Their analysis is a traditional policy analysis of policy actors and their values and motivations and finds that Irish policy makers choose to promote fairness and equity through subsidising services for the most vulnerable while still relying on the two-tier system to provide services. The analysis above in chapter 5 is different in that it is focused on current policies more than current policy actors, and in that it is focussed specifically on policies that impact populations experiencing homelessness.

5.6 Chapter conclusion

This chapter has presented a historical account of the Irish health system, a descriptive review of relevant national and regional health policies, and an integrated policy analysis of them both.

It has found that the history of the Irish health service is one dominated by fragmentation, powerful stakeholders, stigma against the poor, and a lack of strong governance. The policies that govern this area today signal awareness of these problems and shortcomings and are recognising the need to move in a different direction toward a universal health system.

Chapter 6: Discussion and conclusion

6.1 Chapter outline

The overarching aim of this thesis was to examine how health systems impact healthcare accessibility for populations experiencing homelessness. In this final chapter of the thesis, I will synthesise the results from the three studies described in chapters 3-5 and discuss the findings in the thesis as a whole.

Each study in the thesis builds on the one(s) before it (as depicted in Figure 28), and this chapter next arrives at a coherent overarching outline of findings and integrates them into a societal macro, meso, micro-level framework. Resulting recommendations for future policy and practice are made.

Finally, strengths and limitations are discussed and a conclusion to the thesis as a whole is provided.

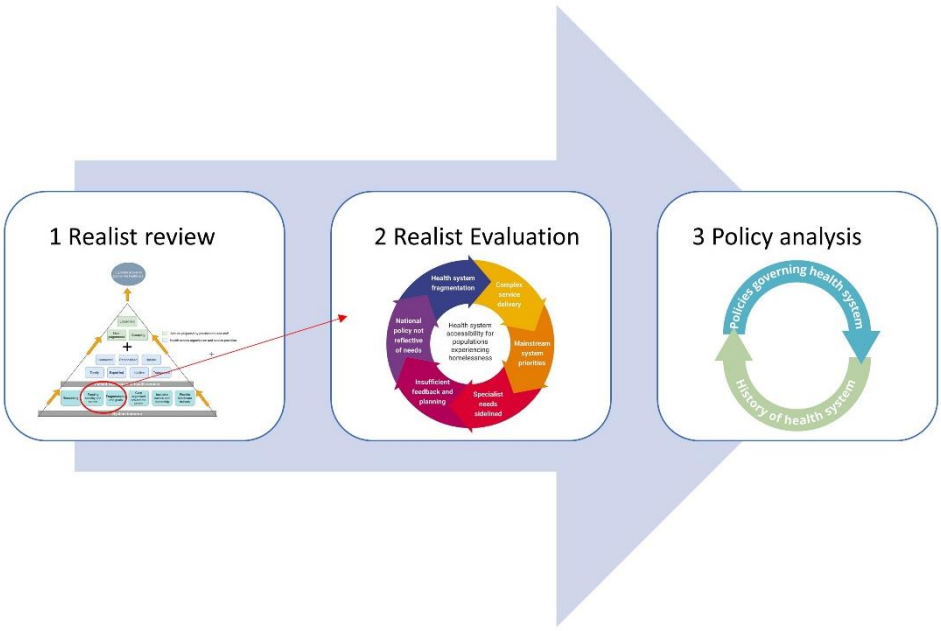

Figure 28: Relationship between the three PhD studies

6.2 Summary of findings

In this thesis, two types of analysis have taken place (realist analysis and policy analysis) of sources of data coming from different orientations and with different goals (peer reviewed published studies, grey literature, interview data predominantly from front line service delivery, and national and regional policy documents). The realist analyses have produced transferrable causal explanations at a high level of abstraction while the policy analysis has provided findings

particularly related to the Irish context. In this chapter, the three individual studies are brought together in a unified synthesis discussing the relationship between policies and the practice of providing healthcare to populations experiencing homelessness by clinicians and staff.

First, the findings of each of the three studies are briefly restated below.

6.2.1 Realist review findings

The realist review found that the following health system contexts impact healthcare accessibility for populations experiencing homelessness:

- Resourcing
- Training
- Funding cycles
- Health system fragmentation
- Health system goals
- How care is organised
- Culture
- Leadership
- Flexibility of care delivery

Key mechanisms which arise in these contexts are:

- Practitioner attitudes
- Practitioner confidence
- Staff and practitioner experience of stability and sustainability
- Organisation-centred thinking
- Flexibility
- Transparency
- Timeliness
- Demonstration of respect and empathy
- Trust
- Adaptability
- Anticipation

The overarching programme theory which brings together the full set of findings (Figure 16, page 79) shows how healthcare accessibility depends on the interlinking of the mechanisms above provided in the right contexts. In other words, healthcare can be made accessible for populations experiencing homelessness when funding sources are stable and dependable beyond annual funding cycles; when services have adequate resources in terms of training, expertise, extended appointment times, and ability to be flexible in the healthcare delivery; when healthcare is organised around the person; when health services are connected within and across organisations; and when healthcare is provided within an inclusive culture championed by strong leadership.

In such contexts, healthcare services can be delivered in personalised ways with practitioners and organisations collaborating and coordinating together; they can take in the full person and provide for their full needs as experienced by the individual receiving care; services can be expert-led, timely

and opportunistic; patient patways can be established which are navigable, with the assistance of peer-advocates or key workers as require by the patient; and services can be delivered in collaboratively, with transparency and an emphasis on confideniality and trust between the practitioner and the patient.

6.2.2 Realist evaluation findings

Building on the realist review, the realist evaluation sets out to further and more fully investigate two of the six CMOCs resulting from the review. The aim of the study was to understand how funding procedures and health system performance management impact service settings, the staff and practitioners that operate in them, and their ability to make services accessible to populations experiencing homelessness and complex needs.

The realist evaluation found a cyclical relationship (figure 25, page 111) springing from the degree of fragmentation in a health system. When health systems are fragmented without tools and means of collaboration and integration both between and within services, health service delivery becomes overly and unnecessarily complex. In a complex, fragmented setting, health systems prioritise meeting their own objectives such as limiting costs, focusing on bio-medical needs over social and mental health needs, and asking patients to fit in with the schedules, locations, and culture of the health system rather than understanding and addressing full patient needs. As a result, patients with complex needs have to be provided for elsewhere, or they go without care altogether, and their care is outsourced to responsive specialist practitioners and organisations leaving the system as a whole unaware of their particular needs and missing pertinent information needed for future, more adequate, service planning. Incomplete information is also fed into high-level policy decisions potentially leading to the de-prioritisation of the needs of socially excluded populations. As these needs are deprioritised, health systems continue to cater for organisational needs resulting in the maintenance of a fragmented healthcare system, and the cycle continues.

6.2.3 Policy analysis findings

The policy analysis found that mainstream health and housing policies in Ireland call for integrated and coordinated solutions for the complex needs of populations experiencing homelessness. However, the same policies are not coordinated across domains and do not provide goals with enough specificity nor adequate resources or accountability to support and enable the right approaches to delivering healthcare to meet complex needs. Rather, policies mirror the fragmented nature of healthcare provision with a focus within each domain on meeting short-term goals which can generally be resourced and completed within a yearly budget cycle.

This current state of high-level government health policy in Ireland has deep roots in the history of the Irish health service which has developed piecemeal without a unified strategy, dictated by powerful stakeholders like the Catholic Church and the medical profession. Stigma against the poor and a preference for the private market have also been important drivers of development of the current system.

6.3 Integration of findings

The sections below discuss how each of the three studies relate to each other and then goes on to discuss seven integrated themes which have resulted from the various analyses in each of the three studies above in chapters 3, 4 and 5.

6.3.1 Relationship between realist review and realist evaluation

The two realist studies in this thesis (study 1 and 2) are closely related because the realist evaluation explicitly builds on the realist review by taking a subset of its findings and further analysing them as discussed in the published study protocol for the realist evaluation (Siersbaek, Ford, Ní Cheallaigh, et al., 2021). The realist evaluation presents a natural progression of the realist review, and because of the design of the studies, their aims, approach and mode of explaining findings are similar.

6.3.2 Relationship between realist studies and policy analysis

The realist review in study 1 explores how health systems should organise healthcare services to make them accessible for populations experiencing homelessness. The realist evaluation in study 2 builds on study 1 and explores in depth how mainstream health system fragmentation, funding, goals, norms and priorities shape healthcare access for vulnerable populations. Finally, the policy analysis in study 3 builds on studies 1 and 2 and explores the policies that govern the Irish health system with a focus on how the factors identified as important for promoting healthcare access in the two realist studies are featured and prioritised.

Where the realist review (study 1) provides an overview of how services should be organised to be accessible for populations experiencing homelessness, the policy analysis (study 3) features a number of policy documents which state that they are informed by similar research in placing value on easy access to integrated services which are welcoming to all. Therefore, the policies should be informed by best practices and their implementation should reflect that. However, the realist evaluation (study 2) shows that the implementation of the policies in Ireland is at best lacking and that more detailed policies are needed along with tools to implement them such as dedicated funding, resources and training, under strong leadership and governance.

It would be reasonable to anticipate that national policies are translated into action on the ground in a given area of practice since that is their stated goal and function. That is after all the purpose of policy, as Gilson says: 'Commonly, health policies are understood as the formal, written documents, rules and guidelines that present policy-makers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health' (Gilson, 2012). Ideally, therefore one might expect that the policy analysis undertaken above in chapter 5 would have identified high-level guidance and goals for the Irish health service which were also experienced at the front line as explored in study 2. However, this is not the case. In fact, the two are highly disconnected as is evident in the discussion of high-level themes which have all been informed by the three studies together which follows next.

6.3.3 Integrated themes

The integrated analysis in this chapter has resulted in the development of seven integrated themes, bringing together the findings from studies 1,2 and 3. These are presented below.

6.3.3.1 Health system goals

The stated intent of the various policies that govern healthcare provision for homeless populations in Ireland is to provide integrated, collaborative approaches to meet complex needs. For example, *The Healthy Ireland Strategic Action Plan 2021-2025* calls for 'all relevant Government Departments and agencies' to engage 'to develop a collaborative, holistic and comprehensive approach to address the social determinants that impact on health and wellbeing and reduce health inequalities' (Government of Ireland, 2021b, p. 27).

The *Sláintecare Implementation Strategy and Action Plan 2021-2023* promises a 'concerted focus on addressing health inequalities' and describes the social determinants of health as 'the non-medical factors that influence health outcomes' while recognising that 'the social determinants can be more important than health care or lifestyle choices in influencing health'. The document signals the importance of these issues by also mentioning that the 'Programme for Government provided a clear intention to address cross-sectoral inequalities' (Government of Ireland, 2021a, p. 40)

However, when comparing these types of statements with the realities for those providing the care at the frontline as evident in the realist evaluation, there is a clear disconnect. That analysis shows that practitioners in the mainstream health services are working within a system that does not prioritise addressing health inequalities, that does not use a collaborative, holistic, or comprehensive approach to delivering care, and that is not resourced (through funding, training, ability to be flexible, etc) to meet complex needs. Rather the goals that are actually measured and prioritised (such as emergency department waiting times, trolley counts, bed-days and costs) do not promote

the delivery of appropriate access to services and resulting good outcomes for populations experiencing homelessness. Instead, those goals directly contribute to poor access and poor outcomes because they focus on and reward actions that promote short term goals.

In other words, there is a dissonance between the stated policy intent and the actions of the health system. According to Imbeau (2009), there is often a dissonance between what policy actors say and what they do. The dissonance arises because policy makers have to straddle different interests not limited to what has been promised in the last election, the principles and values of the politicians in power and what the public want, recognising that it can change from election to election and between elections (Imbeau et al., 2009).

Kriznik et al argue, in addition, that there is a tendency for policy makers to forget about the history of a given policy area quickly, which has a detrimental effect on sustainable policy making:

> There is a form of institutional memory loss evident in policy where similar ideas are rediscovered and recycled over a relatively short period of time, and policies demonstrate historical amnesia about the processes which have led to contemporary health inequalities. This leads to, for example, the assumption that health inequalities can be explained by current societal conditions alone and ignores endemic social arrangements which persist over decades and longer (Kriznik et al., 2018).

Meanwhile, Gilson (Gilson, 2003) argues that:

> the state should not, as is common in health policy discussions, be seen as just a provider, funder, manager or regulator of health services. Rather, in relation to health care, its central role is to manage the processes through which the meaning of the health system to society, and so its contribution to broader societal value, is established.

The dissonance observed in this thesis between policy intention and action with regard to the provision of healthcare for populations experiencing homelessness in Ireland has been based on and contributed to the maintenance of the meaning of the health system to society being of a system that is not for everyone but gives preference to people of a particular class, income or social background. As such, this finding is not only of importance to populations experiencing homelessness. Rather the experiences of this population illuminate issues that affect a much larger section of society, including groups such as frail older people, people with multi-morbidity, people with disabilities, people with severe and enduring mental illness and more.

6.3.3.2 Culture

The culture in healthcare which assumes (usually subconsciously) that patients are of a certain social class and educational level with a strong support network is the high-level context in which health services are designed. As such the culture is not focused on active inclusion of people who are

different and have different life experiences, and the delivery of care is not flexible enough to meet their needs.

In mainstream health services, people who experience homelessness and complex needs are viewed through a lens of stigma which is common in society. The notion that some people are deserving of care and respect and that others are not, is key for how they are treated. Interviewee 4 spoke about this in their interview:

> The people that are homeless or service users that we work with, they're not given the same level of autonomy to make decisions. They're almost, they're, they're looked at as though they're not making informed decisions, they couldn't possibly, they don't have the capacity. . . And you have to say that's okay people are allowed to make bad decisions. We make bad decisions for ourselves, all the time. Vulnerable populations are almost not given the same value to do that, does it make sense? And that's what makes person centred care difficult in the sectors because it's almost like the person's decisions, aren't respected as much as if it was, you know, a 50-year-old lady who's refusing treatment for her breast cancer any longer. – Interviewee 4

Cornes et al argue that the daily lives of people experiencing homelessness and healthcare practitioners are so different that they can become 'cultural strangers' who, in fear of each other, avoid contact. Gaps arise in this cultural distance and specialist care is expected to fill them when mainstream practitioners feel unequipped or unwilling (Cornes et al., 2018).

A qualitative study by Purkey and MacKenzie (2019), using interviews from people experiencing homelessness and various practitioners in Ontario, Canada, found that a culture shift is needed toward delivering healthcare in more creative and versatile ways to make it accessible for populations experiencing homelessness. They call for changes both in the curricula in medical and nursing education and in continuing professional development to break away from stigmatising and shaming practices, as well as for different ways of working in delivering care using team-based approaches (Purkey & MacKenzie, 2019).

The King's Fund published a report in 2020 (The King's Fund, 2020) focused on how to deliver health and social care services to people who sleep rough. They discuss the importance of culture and the crucial role of leaders who can use their influence by 'encouraging and modelling collaborative working across organisations . . . to demonstrate the value placed on relationship-building. They could also use their position to remove administrative and structural obstacles to joint working' (The King's Fund, 2020).

6.3.3.3 Specialisation

When mainstream services do not provide responsive care in settings that allow for more flexibility and a wider range of goals built on an understanding of how people experiencing homelessness access care and what their particular needs are, specialised services fill those gaps. Specialised

services created specifically to cater to the needs of populations experiencing homelessness and other socially excluded groups often operate in ways that suit both the patient and the practitioner better because patients are met where they are and practitioners get to meet their needs and solve problems more efficiently.

In the Irish health system, a number of health services for populations experiencing homelessness are provided by NGOs specialising in the care of socially excluded populations. These arrangements serve patients better in the individual clinical encounter, which is usually primary care, addiction care, or social care, and they serve the health system which does not have to provide for those patients in mainstream settings.

However, this reliance by the health system on specialised NGOs with expertise also contributes to fragmentation in the system as a whole when various parts are disconnected as Interviewee 12 said:

> Erm I found that by following, you know, the primary care practitioners, public health nurse, GP, the different services by hanging around I actually saw the same person, that's how I know you know, when I say to the person who looks like seven people to the system . . . and two services had never spoken . . . so that the problem of that homeless person or the drug user looked far more complex from the fragmented service because it was fragmented. – Interviewee 12

Similarly, Interviewee 7 said:

> So you're always going to have NGOs and services that are responding to other, you know, unmet needs in the community. So I think, to some extent, when you have such a reliance on the voluntary and the NGO sector, there is going to be fragmentation. – Interviewee 7

This means that information is not fed back to the mainstream system but remains within the domain of each NGO. Therefore, the system as a whole does not learn what socially excluded populations need and it does not plan accordingly, which ends up contributing to the maintenance of fragmentation.

Some degree of specialisation is necessary according to Interviewee 1 but not at the detriment of the full system taking responsibility for being accessible and inclusive of all:

> What you're asking the healthcare system to do is to have like basic good manners, and that should happen all across the health system. And you're probably always going to have somebody who that's their special interest . . . [like] there's somebody who's special interest is like, you know, a type of ulcer or, you know, particular type of malaria. But the mainstream it should . . . be as mainstream as possible. But for that to happen, you have to do a huge amount of upskilling. And until then it's probably makes sense to have some, especially in. . actually, it's like palliative care or geriatrics where I suppose everybody needs to have a lot of competence. And then maybe you do need a specialist service at the extreme end to do that and to push that specialty forward, but then that everybody keeps up with a certain amount of it. – Interviewee 1

However, specialist services should not be seen as the cause of fragmentation. Rather fragmentation stems from the way the system as a whole is organised and how it generally fails to meet unusual needs, which creates the need for specialisation in the first place. The solution then is not 'either or' but 'both and'. O'Carroll and Wainwright (2019) argue that creating an accessible, single health system 'while conceptually desirable, may be pragmatically unachievable as it would require a total redesign of our present system addressing the wide range of external barriers and addressing deeply seated prejudicial attitudes as well as overcoming a range of internalised barriers' (O'Carroll & Wainwright, 2019). They further contend that while mainstream services should seek to be fully accessible, specialised approaches should be recognised as needed adaptations of the mainstream services.

Similarly, a report published by the UK's National Health Service (Mehet & Ollason, 2015) in 2015 speaks about the importance of specialist services in building the kinds of relationships with people who experience homelessness that allow them to feel comfortable accessing treatment:

> Ideally, specialist primary care providers would discharge their patients to a mainstream GP once their health issues are being managed. But . . . the attachment processes of homeless people are awry and the required building of trust requires slow engagement. Relationships with patients mean clinicians at specialist centres can convince people to access treatment which otherwise they would not be able to (Mehet & Ollason, 2015).

Healthcare access for homeless populations likely depends not on having good specialised services or good mainstream service but on an appropriate combination of both with core competencies across all services and higher levels of specialisation in certain services.

In this vein, the Health Service Executive published a competency framework in the speciality of palliative care in 2014 (Palliative Care Competence Framework Steering Group, 2014) which specifies the levels of competence that various practitioners should possess in providing palliative care services. The framework is intended to inform health and social care education, as well as care provision. It specifies competencies at three levels of specialisation: 1. the core competencies which all health and social care practitioners should have, 2. intermediate level expertise for general palliative care, and 3. high level of expertise for specialist palliative care. A similar framework could be useful in guiding minimum levels of competence in inclusion health needed across the board among all homeless and health service practitioners, as well as standards for higher levels of expertise where needed to promote increased competence and appropriate practice in inclusion health in Ireland and beyond.

6.3.3.4 Fragmentation

In addition to the fragmentation arising from a lack of integration of mainstream and specialised healthcare, the lack of a unified national strategy for healthcare for populations experiencing homelessness in Ireland also encourages the fragmentation seen in the policy domain. Each of the national policies reviewed in chapter 5 represent their own area with goals narrowly defined to support specific actions within its bounds. The stated high-level, cross-domain goals of policies cannot be delivered by a system which does not enable cross-specialty coordination but rather is focused on each problem in isolation and providing care predominantly using a biomedical model.

This lack of a published, funded national strategy has resulted in the needs of homeless populations not reaching high on the agenda when high level health service planning and funding decisions are made. In their interview Interviewee 7 explained:

> . . . we set our strategy through the National model of care for people experiencing homelessness, but the currently issue is that it's an internal document for HSE [Health Service Executive] planning purposes only. Moving forward, we would like to see a national strategy for homeless health where there is broad consultation with stakeholders right across the systems around what should be included in that strategy. . .without, you know, a strong strategy, with wide input, it's it's difficult to achieve that. For obvious reasons, cross-sectoral collaboration is really important in homelessness, there's a lot of social needs, housing needs, education, employment etc. for those living in homelessness, so you know, a cross departmental strategy is very important. It allows for a lot of other kind of important projects to address social determinants of health that otherwise may not be on anyone's radar. – Interviewee 7

It is clear from this quote that the absence of national strategy is enabling the maintenance of fragmentation because there is no unified, shared model of care, and as a result there is no instrument for setting clear expectations, goals and norms across the full set of services providing care for populations experiencing homelessness. This lack of a national strategy, and funding that comes along with it, translates into the conditions that practitioners are working under and ultimately patient care, as Interviewee 6 explained:

> I think on a national level or even an international level when you look at all the documents and the policies thoroughly, they all talk about homeless population as a vulnerable group . . . And yet, like, what, what do we do about it then? Like if you call something vulnerable and say that their needs need to be met . . . And you know from being on the floor that, you know what the person might need or what you could do for them, but you just don't have time . . . So I do think that the whole system probably doesn't work together. – Interviewee 6

These health system failures represent a lack of concerted leadership contrary to an important context uncovered in the realist review, namely the necessity of having strong leadership which champions inclusivity and flexibility in service delivery (see section 3.5.2.5). Without enabling

inclusivity and flexibility in care delivery, practitioners have little scope to go beyond narrowly defined goals to solve the specific (often bio-medical) problem a patient is presenting with at that moment. They should be able to look more holistically at their needs and have the ability to build relationships to work to meet them over time. Additionally, working within the confines of a fragmented, duplicative system focused on following rules and limiting costs, makes it difficult for practitioners to use their expertise and provide care that is organised around their clients.

Interviewee 4 spoke about the importance of flexibility and being able to build a relationship with a client without reaching a particular end at any given interaction:

> The focus isn't always going to be on the one thing that is, is the 'bad thing' that you're doing . . . Healthcare providers need to be flexible, opportunistic. It takes like 5000 more tries to do one thing. And it's those little wins that are the success stories. People always ask me isn't it sad that people never stop or that they never get better, and you know it's little things like oh my gosh they actually went to that appointment today. That took me nine, that's nine months of not nagging them but gently, you know, you could have six failed attempts to get somebody to this one place and then they finally go, and it's just about the fact that you need to be creative, that the usual pathway that you follow or how things are supposed to happen. You need to understand that that's not going to happen that way. You need to be really creative in how you bring that support to the person or how you get that person to the support and it takes a long time. – Interviewee 4

Several of the interviews used in the realist evaluation showed the toll on healthcare practitioners and staff in Dublin of operating in a fragmented system with many co-occurring processes to constantly manage. Comparing the realist studies and the policy analysis, a lack of connection, direction, and communication between the policy domain and the realities of practice at the front line is clear.

Healthcare practitioners who work in mainstream systems and have an interest in socially excluded populations are to a large extent on their own, leading from the ground up. They operate using work-arounds, and must manage and follow multiple ad-hoc pathways. Mainstream practitioners rely on networks and professional favours while NGOs have more space to take on the role of meeting emerging needs as they identify them. But taken together, these necessary practices lead to a system which is more fragmented not less. Interviewee 3 said the following on this topic:

> And I think the more we set up this, this idea that, and support and resource, a safety net, rather than primary care and non-fragmented general practice, I think the more fragmented healthcare, you get. And I would be of an opinion that we need to do more to fix the fundamental issues and gaps, as we've been articulating, with the first port of call, rather than buttressing up a safety net, that can just fragment care further, and cause more division. And I think for a variety of reasons therefore, it is imperative to support primary care and general practice first, to absolutely call it stigma amongst healthcare professionals and say it's unprofessional and have sanctions. And then, after and in parallel with that obviously support a safety net. And then in the safety net to actively support someone getting back into general practice, which I don't believe is really happening. – Interviewee 3

The fact that health systems are not designed with vulnerable service users in mind is a basic assumption underlying much of the international literature on the topic. Studies examine approaches to making health systems and services not suited for these populations suit better through a variety of different strategies such as providing health services using an inclusion health approach which builds on an understanding of and expertise meeting the particular needs of homeless populations (Cabinet Office Social Exclusion Task Force, 2010b), utilising key workers or peer advocates to help with accessing services (Wallace et al., 2018), and/or using a harm reduction approach that allows clients to access services without first meeting requirements related to substance use or behaviour (Carver et al., 2020).

Similar to the studies in this thesis, Klop et al (2018) found that populations experiencing homelessness have difficulty accessing healthcare because of the complexity of healthcare systems. They argue that healthcare is 'complex, multifaceted and scattered in its organisation' and that this makes access especially difficult for populations experiencing homelessness. Additionally, they contend that having to meet pre-conditions for accessing services, such as not using substances, answering specific questions and naming care needs, and going through processes quickly, do not sufficiently consider 'the needs or capabilities of homeless people'. They also found that even when people experiencing homelessness access healthcare, the care they receive is often not appropriate because of their complex and multifaceted needs (Klop, Evenblij, et al., 2018).

Using a realist review approach with an interest in healthcare access for low-income rural older adults, Ford et al (2016), had a number of similar findings to those in the realist review in chapter 3. They uncovered health access barriers for those populations related to health service navigability, social status, patient empowerment, practitioner responsiveness, trust, and clinician empathy and capacity.

6.3.3.5 Adaptability

While there is a disconnect between policy and practice in Ireland, there is also a practice of adaptability, and staff and practitioners figuring things out along the way. This is reflected in this quote from Interviewee 1 where they talk about the Irish way of doing favours for people in your professional network who you can then call on when you need a favour to be able to access a test or provide a given service for your patient:

> [It's] you know, a bit of ah will you do me a favour. And I suppose in some ways, that's a very Irish way of dealing with things that anyway erm so I would be really interested to see how that system would work somewhere [that is more intentional] . . . where it's not about pushing people around the edges

Interviewee 8 spoke about the importance of being adaptable in their clinical practice:

> . . . flexibility is probably the most [important] one because you have to be so flexible in the sense that, you know, these people are extremely unwell, they're navigating the homeless system. They're navigating all this kind of, you know, socio-economic stuff . . . [and] they're all quite unwell. So they're trying to move on so we have to be really flexible in how we how we work with people, because like I said generally they don't come to us, we go to them. – Interviewee 8

Meanwhile, Interviewee 4 spoke about clinical guidelines at times acting as barrier to being adaptable and flexible in their work:

> . . . clinical guidelines are exactly what they are, they're guidelines, they're not [everything]. They're . . . the best available evidence possible but they don't fit every population, they don't fit every person and they don't fit every situation. And I think as a practitioner . . . slightly down the hierarchy in terms of the medical field . . . I think there's a lot of anxiety there about 'oh my license' or 'I be a can't be innovative, or I can't flex from the guidelines or I can't do this'. – Interviewee 4

At a structural level, health system adaptability is a key feature of health system resilience according to the European Observatory on Health Systems and Policies (European Observatory on Health Systems and Policies et al., 2020). The Irish health system proved resilient both during the initial period of the financial crisis (2008-2012) (Burke et al., 2014) and recently during the COVID-19 pandemic.

At a day-to-day, practice level Gilson (2017) describes the importance of 'everyday resilience' as a health system feature which enables frontline health practitioners and staff to meet the challenge of working in an ever changing and challenging environment. She argues that 'everyday resilience' depends on adequate resources and stable governance structures but that those alone are not enough. Social networks and relationships within a health system underpin 'everyday resilience'. Similarly, leadership which empowers front-line staff and embodies respect is needed too as resilience 'is not a function of what a system has but of what it does and how it does it' (Gilson et al., 2017).

Healthcare staff and practitioners working with populations experiencing social exclusion, homelessness and complex needs in Ireland, utilised their adaptability during the first phase of the COVID-19 pandemic in particular. In the spring of 2020, coordinated efforts across mainstream and specialised housing and health services resulted in the rapid housing of the vast majority of people experiencing homelessness in Dublin, with those with particular vulnerabilities being offered housing in cocooning units which also resulted in overcrowding in hostels being eliminated. Health services such as opium replacement therapies were offered to people in the place they were living (O'Carroll, 2020).

The COVID-19 response shows how important political will is and that when it is present, improvements for populations experiencing homelessness can be made rapidly (O'Carroll, 2020). Similarly, Currie and Clancy (2011) found that when Ireland, as the first country in the world, implemented a national smoking ban in 2004, that policy was successful due to political will in the form of the presence of a strong political champion, the Minister for Health and Children.

6.3.3.6 Capacity

While healthcare practitioners and staff working with populations experiencing homelessness and complex needs show incredible adaptability, flexibility, and ingenuity, their work also take a personal and professional toll. When health systems do not provide resources such as training to develop expertise and opportunities to have exposure to different populations groups, and when staff and practitioners commonly encounter traumatic events or are exposed to secondary trauma, it has a cost.

Interviewee 8 spoke about the effects on staff and practitioners of working incredibly hard without proper supports:

> . . . across the board for all professionals within something that's so traumatic as acute hospitals because we see people dying every day. . . [It is] like we're on a sinking ship, erm unless we have [supports] for all professionals, the quality of the of the interventions won't be as strong as they could be. They might be good enough and some areas might be fantastic because they have a team that works in that collaborative way. Other areas might be less. It's not a system until it's a systemic approach. . . it's been stated numerous years that the nursing profession should be clinically supervised because they're dealing with the quickness of everything in the hospital setting. They're dealing with people living and dying on their watch. . . But you come to come to a stage where you're you allow yourself to be desensitized to the level of ignoring. And for me . . . there's a link between the culture of an organization, the supports that the healthcare staff gets. – Interviewee 8

And Interviewee 5 reflected on what it would be like to have bigger inclusion health teams in clinical settings:

> Like one day when we have a team . . . [of] at least had two nurses, then you can at least, my thought would be that you could do three days each, or do a four-day week, [with] a longer day? Because getting in that bit earlier in the morning . . . or ending the shift in the evening, or something like that, you have a little quiet time at the end of the day where you can think of okay, what's my to do list that I need to do? Because if you're reacting all the time, you're missing things, and that I find very, very frustrating in this position that I know I am missing things. Erm and it's hard to keep yourself going with that. You can rationalize it later and say, you know, I did what I did, but it still is always a feeling that you're coming in with stuff undone. – Interviewee 6

The toll of a fragmented, disorganised, reactive health system is not just on the patients which have largely been the focus of the research in this thesis. There is also a huge toll on staff which needs to be further researched.

These findings are similar to those of several of the articles in the realist review in chapter 3. Hudson et al (2016b), in a study of access to and provision of palliative care for people experiencing homelessness, found that working with dying clients in homeless accommodation places a large strain on staff members and that they have to be personally very resilient to manage the secondary trauma they experience. They also found that when staff members do not have specialist training and are inexperienced, they can feel like a failure when not meeting the needs of clients successfully (Hudson et al., 2016b).

Similarly, Mahon (2016) found, via interviews with staff members in Irish homeless organisations, that they often feel that they are expected to do more with less and should be motivated by their caring personalities rather than adequate pay and conditions. She also found that working conditions were often challenging because of the unpredictable and at times chaotic nature of the work. Burn-out is a significant concern which staff members try to prevent through promoting team work and relying on strong connections to their colleagues. Trusting one's co-workers is key to feeling secure in the work environment. Having clinical supervision, as is typically provided for social workers and other allied health professionals, with dedicated time to think through difficult situations is another important outlet for staff and practitioners where they can reflect on their development and performance and receive support (Mahon, 2016).

Meanwhile, West and Dawson (2012) found that staff engagement is crucial for patient outcomes. Staff engagement refers to a combination of the psychological engagement with work including proactivity, enthusiasm and initiative, organisational commitment, involvement in decision-making, and positive representation of the organisation to outsiders. Poor engagement can lead to burn-out and stress.

West and Dawson undertook an analysis of the connection between staff engagement and patient outcomes within the UK's National Health Service. They found that patient satisfaction was significantly higher and mortality lower in health trusts with higher levels of staff engagement. Higher engagement was also a predictor of lower staff absenteeism and turnover (West & Dawson, 2012).

6.3.3.7 Funding

The mainstream health system in Ireland is typically funded on an annual basis through the Health Service Executive's budgeting process where individual departments within hospitals apply for funding each year. Specialised services provided by NGOs are funded through annual service level agreements with the Health Service Executive, primarily through the Social Inclusion Division (Health Service Executive, 2021a) and through their own fundraising. This procedure for allocating funds

mirrors other ways in which health services looking after populations experiencing homelessness face precarious conditions in Ireland with a lack of a unified political strategy setting a multi-year course for their sector. To produce successful funding bids, services must focus on short term goals that can be met in one year to be able to produce outcomes that will allow departments and services to get renewed funding the next year.

Precarious funding arrangements echo the historical charity model of healthcare where people without means were given free care in a paradigm of charity and not entitlement, and were expected to show gratitude and deference to their benefactors (Dukelow & Considine, 2017; Geary et al., 2018). This is contrary to a rights approach to healthcare which is a paradigm used in most European countries where residents are entitled to a package of services regardless of their income and based on need.

Malone and Millar (2020) characterise the model of access to healthcare in Ireland as being based on a paternalistic vision of equality where those in most need are taken care of instead of providing universal entitlement to healthcare. They quote a former Minister for Health as saying that in Ireland there is equality within groups, such medical card holders and those who have private health insurance, but not between those groups. The system as a whole, they say, has no 'built-in form of equality'. Between groups then, Irish health policy endorses the idea that access to healthcare should not be denied based on an ability to pay but allows for the fact that those who cannot pay out of pocket or through private insurance will have to wait longer for treatment (Malone & Millar, 2020).

In the absence of secure funding to support the implementation of high-level policy goals, the health system remains fragmented. The stated policy intents are not being enabled and supported through funding practices which in fact target the wrong kinds of approaches and practices – short term vs long term, fragmented vs integrated and collaborative.

Malone and Millar argue that the lack of financial protections and the presence of co-payments in the Irish health services can 'undermine health status, deepen poverty, and exacerbate socio-economic inequalities' (Malone & Millar, 2020). They quote an 'administrative actor' from the Department of Health explaining that policy makers in Ireland seek to make healthcare access fair but not equal or universal:

> [O]ur concern has always been what is fair and what is reasonable. The tenet of Irish health policy has been: whatever else the rest of the population, the higher-income groups have, try and make sure that the lowest income groups have some minimum standard [...] there has been far less attention to equality as I have defined it; i.e. equal access between groups and equal availability of services between groups or between individuals (Malone & Millar, 2020).

6.3.4 Integrated findings

The full set of findings of the PhD have been put together in the model below (Figure 29).

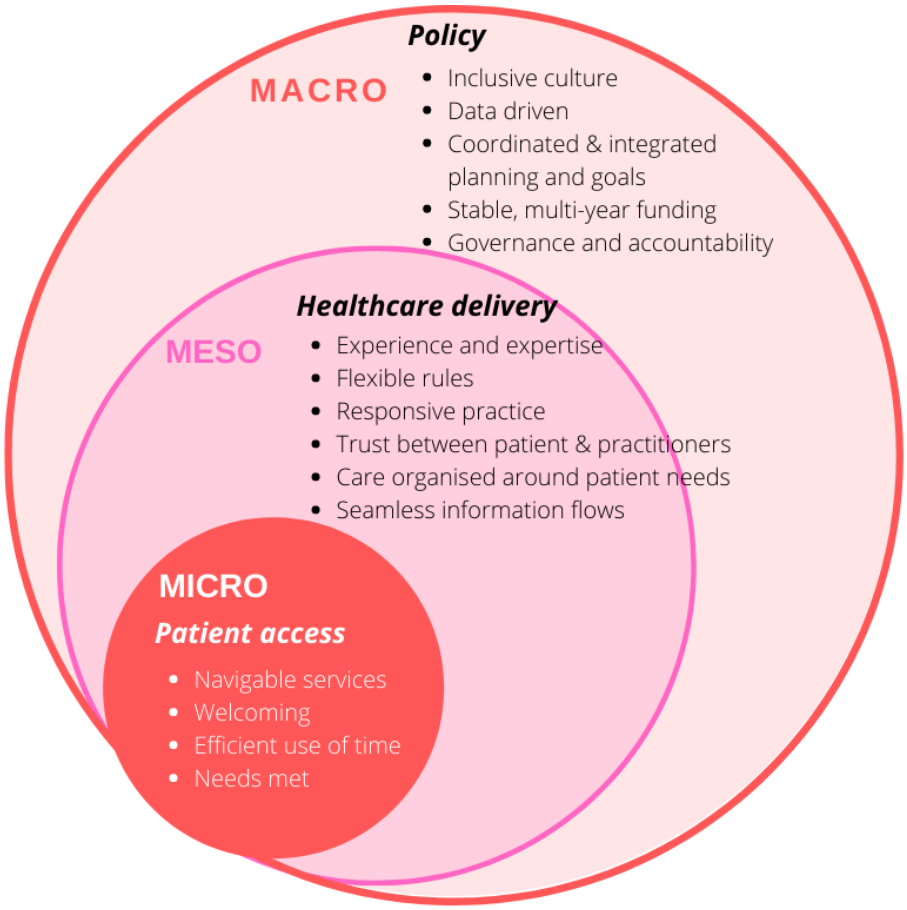

Figure 29: Integrated realist and policy analysis

This model incorporates the findings of the three studies in this thesis into one overarching schematic, showing how health services should be delivered at macro, meso and micro levels to be accessible for populations experiencing homelessness.

At the macro level, the policy analysis has uncovered important factors in policy settings that impact healthcare delivery. Specifically, health policies must enable heath systems to provide care in a culture that is inclusive and accountable, where services are coordinated, integrated and data driven, and which rely on stable funding. The policy intent in Irish health policies is to provide these enabling contexts but as yet it is not fully realised and has not been translated adequately into actual organisational, service, and practice designs.

At the meso level where practice decisions are made by health systems, the realist analyses have uncovered important factors which impact on healthcare accessibility. Access depends on services being delivered by practitioners with experience and expertise in meeting complex needs, and the

application of rules and guidelines in a flexible manner. Care must be focused on the individual patient's needs at the moment of the clinical encounter and should seek to build trusting relationships. Additionally, information flows are key to supporting flexible care and integration of services.

Currently mainstream health services in Ireland are not designed to allow for flexibility. Many practitioners need more training to be able to provide expert inclusion health care and to be able to apply rules and guidelines with some flexibility with the needs of the patient being paramount.

By contrast, specialised services step in to meet the needs that are not provided for. These are innovative and responsive but also do not have the security of predictable funding and resources that services which are considered core to the mainstream system do.

Individual healthcare encounters with people experiencing homelessness are situated at the micro level. For services to be accessible at this level they need to be welcoming and non-judgemental. Patient pathways should be easy to navigate with extra supports provided as needed via peer-navigators or key-workers. Waiting times should be limited and as many services should be provided in a single visit as possible in an opportunistic and anticipatory manner. In the Irish health service currently, healthcare access is often precarious and fragmented for populations experiencing homelessness. Needs are not met or only partially met across a patient pathway where some services and practitioners are excellent while others are lacking. Mainstream settings are often experienced as unwelcoming and confusing.

6.4 Strengths and Limitations

There are a number of strengths and limitations in the research presented in this thesis. Many of these are specific to the study in which they were encountered and have accordingly been discussed in the context of studies 1-3. There are three overarching strengths in addition, which are listed next.

Of the three overarching strengths identified, the first one is that this is the first realist study of health systems perspectives on healthcare access that I am aware of. It is also the first realist study to examine healthcare access for populations experiencing homelessness from any angle, as far as I am aware. It adds to other studies that have explored healthcare accessibility using a realist approach such as Ford et al (2016) and realist studies which have sought to use a health systems lens (Prashanth et al., 2014).

Second, both of the realist studies presented above were done with the consultation of experts not involved in the studies. In the case of the realist review, the expert panel met in-person to review the findings and make recommendations. In the case of the realist evaluation, the expert panel was

smaller and more informal due to COVID-19 restrictions. I undertook three individual meetings between myself and two people with lived experience of homelessness who now work in homeless services and so have a dual perspective, and with a health professional who was also interviewed for the study. In both cases, the expert input confirmed, challenged and refined findings and it was a useful process to progress and enhance the work.

Third, an additional strength of this study is that it is one of relatively few Irish studies to use realist methodology. As such, it adds both to an emerging Irish realist scholarship and it also adds to what is already known about healthcare access among populations experiencing homelessness in the Irish context by adding causal explanations around what works and why.

6.4.1 Reflections on the use of realist approaches

Previous to starting my PhD I had been working for a year as a research assistant in the same department where I have now undertaken my own research (the Centre for Health Policy and Management in Trinity College Dublin). Amongst other projects, I was assigned to a research team in the beginning stages of a systematic review and so got some experience with that method, including the process of writing and registering a protocol from which the research is not supposed to stray. As that review got under way, I experienced the many junctures at which interpretation and choices guide a systematic review process which reflect the particular expertise, values, and interests of the researchers involved. The process did not seem as unbiased and regimented to me as it was intended, especially in the case of complex and messy areas of research which are concerned with social or policy intersections with health. Systematic review did not seem particularly well suited to those kinds of questions.

I had never heard of realist approaches when I entered my PhD programme but a few colleagues in my cohort were considering using them to investigate complex questions which were similar to mine and for that reason I became interested in finding out more. As I learned about realist review and realist evaluation, I was attracted to the fact that it was suited for making sense of areas of complex study in open social systems, and the iterative nature which seemed to me to better reflect the needs of research processes where discoveries are made along the way that could, and sometimes should, change the direction of the research.

I also appreciate the intellectual honesty in undertaking a realist review as opposed to a systematic review in which the researcher draws on their own experience, knowledge and creativity in the analysis rather than attempting to be a neutral synthesiser of information. I am not sure that it is possible to be neutral and I was drawn to an approach which did not claim that it was. Most research has an art to it and creativity enters into the act of synthesising information and creating

new findings. I was excited to discover a method which not only allows for but actively asks the researcher to be creative.

However, I found using realist approaches to be a very challenging undertaking and one that needs a lot of training and support. Over the course of the PhD I undertook a number of formal trainings ranging from one-day to one-week courses. Additionally, with the aid of my supervisory team at the time, we also got a realist expert involved as a co-supervisor (Dr John Ford) about six months in to my realist work. John lives in the UK and it became clear to us early on that the expertise we needed could not be found in Ireland as the community of researchers doing realist research is still small.

Over the course of my study, I have also engaged extensively with peer groups of people using realist approaches. Due to the COVID-19 pandemic and many things taking place remotely, I have been involved regularly with other early career researchers using realist methods primarily in the UK, and have built a small international network through those activities. To contribute to the development of realist expertise in my own department, I started a realist journal club where we discuss good examples of realist work.

Beyond training and peer support, having a realist co-supervisor made all the difference and I think, reflecting on my experience, that there is a huge need for mentorship and apprenticeship for new realist researchers. It is a tricky approach to get one's head around, especially if one is coming from a more positivist approach in conducting literature reviews using methods such as systematic review. Having ongoing feedback and engagement with someone who really understands the approach and what you are trying to do, even as you learn as you go, is key.

6.4.2 Reflections on the use of policy analysis

The year before undertaking my PhD study, I primarily worked on a research project which was investigating how to best introduce universal healthcare in Ireland. It was by nature a policy focused project and I learned a lot about the politics and history of the Irish health service in a short time, having just moved to Ireland prior to taking that job. I found policy analysis to be an interesting approach which reflects an interest I have always had in understanding how political choices are made and how those choices have ripple effects that create many intended and unintended outcomes in societies.

For this reason, I had the desire to include a policy analysis as part of my thesis from the start. As a method, it allowed me to analyse aspirational documents which do not necessarily provide details about how the interventions they prescribe will work, as needed for a realist analysis. Rather they bring to the fore the values and goals their authors, in this case the Irish government, seek to

officially project and represent. In bringing that analysis together with the realist evaluation, in this the final chapter of the thesis, I could then highlight the discrepancies between policy intent and the realities of healthcare practice.

Additionally, examining the historical roots of healthcare provision for the poor in Ireland added another layer of understanding, placing the realist studies in a national and historical context by showing how and why health systems, which officially have altruistic missions, arrive at demonstrably unequal modes of practice. In doing so, the analysis adds a layer of explanation which suggests that health policy making and implementation is not driven solely by a desire to keep a population healthy. Many other cultural, political and financial priorities and values influence policy decisions and implementation. If policy makers seek to make fundamental health systems changes to promote healthcare access for vulnerable populations, or to undertake other improvements, they have to take into account its history and proceed accordingly to not repeat previous mistakes.

6.5 Implications of thesis

The findings in this thesis have relevance to policy, practice and research. The research presented in this thesis is consistent with much of the published research and with what both policy makers and practitioners know, namely that policies must create the conditions for services to be adequately resourced, integrated and connected, and that practice should take place within inclusive, flexible cultures in organisations which focus on the needs of the patient. These are the basic building blocks for health systems making healthcare accessible for populations experiencing homelessness. Specific policy and research implications are discussed in further detail below.

6.5.1 Policy and practice implications

Irish national health and housing policies should retain their focus on deprived populations, however fundamental reforms such as introducing universal healthcare and eliminating two-tier healthcare must accompany the more focused policy initiatives in order to reorientate the culture and practice of healthcare in Ireland. Sláintecare reforms should be implemented fully and be adequately resourced. As a result of that, health services should be integrated and based on the needs of the individual person. The role of stigma and trauma in the experience of healthcare access for populations experiencing homelessness must be widely taught throughout the health services.

The Irish government and high-level health system leadership should take the following measures to enable healthcare services to become more accessible for populations experiencing homelessness:

- Develop a national strategy to guide the integrated, coordinated health services to make the health system responsible for recognising and responding to social determinants of health with adequate funding and specific goals attached
- Provide all practitioners and staff with adequate training and exposure to socially excluded populations to develop a baseline of knowledge and expertise in providing appropriate services to them, and provide expert training to specialist practitioners
- Develop and support trauma awareness and understand the role of trauma in homelessness, social exclusion and health
- Provide training to staff and practitioners to help them understand the effects of trauma, and to understand the complex reasoning that some patients have for seeing their needs differently to the way practitioners may
- Embrace definitions of health that are not narrowly focused on bio-medical outcomes but holistically embraces all aspects of health depending on patient wishes at the time of a clinical encounter
- Adopt a flexible and inclusive culture championed by leadership at every level of the system
- Provide multi-year funding for health services
- Enable practitioners to organise services around the needs of patients by creating service structures and pathways with patient input, and though empowering practitioners to respond flexibly to the situations in which they provide care and need to act outside of the typical set of procedures.
- Take responsibility for meeting the needs of all populations and put into place tools for gathering pertinent information for continual planning to adequately meeting changing needs on an ongoing basis

These recommendations likely are applicable in other high-income countries where the majority of healthcare is provided by the state. They will likely benefit most patients, housed or not, and as such investing in them would pay dividends for populations beyond those experiencing homelessness. However, for homeless populations these are crucial to ensuring that an already vulnerable group does not face further social exclusion when accessing healthcare.

6.5.2 Directions for future research

A next step from the policy analysis in this thesis (study 3/chapter 5) could be to conduct a realist evaluation of policy implementation of one or several policies related to homeless healthcare in Ireland. This would provide an opportunity to understand how and why policies are and are not implemented and provide a realist, causal explanation for the outcomes which have been observed

in this thesis by comparing the realist evaluation and policy analyses. Questions to potentially answer include: why are policy intentions not carried out? Why is funding allocated how it is? How is a high-level policy agenda set and why? Who does the policy agenda serve and not serve? Primary data should be collected to illuminate these questions.

Another direction for future research would be to go back to the realist review in chapter 3 and to further investigate the set of findings which were abandoned early in the process for time and resource reasons. The realist review had two broad sets of findings – one around how health services are organised and delivered, and one around how healthcare professionals are trained and how expertise with populations experiencing homelessness develops. The review focused on the first set of findings and a subsequent study could focus on the second set of findings to explore contexts and mechanisms that allow for healthcare practitioners to develop experience and expertise.

Additionally, in general this thesis points to the need for further research of how health systems and health services impact healthcare access and health outcomes for socially excluded populations. There is a need to understand this side of the healthcare 'supply-demand' equation in more depth and in different contexts.

6.5.3 Contribution to original knowledge

As noted early in the thesis, a majority of the research regarding healthcare accessibility for populations experiencing homelessness has focused on the individual patient journey and the particular factors that impede or encourage their ability to access needed services. However, research examining the health system side of the healthcare access equation has been lacking. This research adds findings in relation to how health systems can be better funded, planned and organised in order to meet the needs of excluded populations in this instance people who experience homelessness and complex needs. Such research is critical to finding macro system level responses so that all services are accessible, especially to populations who may otherwise face extensive barriers. Improvements at a system level to meet these populations' needs are likely to positively impact on access for the whole population.

The research undertaken in this thesis has confirmed a number of previous findings from individual level research but has contributed an understanding of how, why and in what circumstances health systems create the conditions in which the individual level research has taken place. Individual level research tends to focus on individuals as being both the problem and the potential solution. This research refocuses the frame to how health systems and societal responses can work differently to meet the needs of populations who experience homelessness.

Prior research focused on the individual found that health systems impact on healthcare accessibility for populations experiencing homelessness and complex needs through both action and inaction. This research reinforces this finding but from a system level, raising important challenges for planners, leaders and health system managers on how to make services more accessible to populations' experiencing homelessness.

A key finding emerging from this research is that healthcare accessibility for socially excluded populations such as those experiencing homelessness and complex needs has to be enabled at a systems level to craft systematic solutions to systematic problems. In particular, this research has found appropriate funding and performance management arrangements could greatly enhance accessibility for people experiencing homelessness by ensuring services are funded, planned, and delivered to enable long-term engagement between flexible practitioners with adequate expertise and resources, and patients who are empowered to express their needs and expect to have them met.

Another key finding of this research is the striking dissonance between the stated policy intention for health services in Ireland to be integrated and patient-centred and yet practitioners find that the realities at the front line is of a fragmented landscape where they are left to take responsibility for creating the best possible patient outcomes with limited resources, as discussed in the realist evaluation in study 2. While it was beyond the remit of this research to understand why this is, it is hard not to speculate that this must be related to agency and the voicelessness of such powerless groups of people.

The historical analysis has shown that the reality of fragmentation in service provision has developed over time through policy decisions and inactions of a society focused on promoting values and goals held by powerful stakeholders such as the Catholic Church and the medical profession above the needs of the individual patient. The current fragmented health system has not emerged by accident and the cultural meaning, per Gilson as discussed above in section 6.3.3.1, of the Irish health system is essentially that not everyone in society is equal and those who can pay more get more, faster.

Finally, another key finding of this research is that a fragmented health service serves none of its actors well. Certainly, patients have difficulty accessing and navigating care but equally practitioners and staff experience staff burn-out and low job satisfaction. When all parties in a clinical encounter are stressed and overwhelmed, conflicts arise and the power differential between staff and practitioners, and patients, come to the fore. This research has shown that in these conflicts, when experiencing uncertainty and stress, clinicians want to meet their own needs for looking after the health needs of their patient as they observe them. But the patient may have a different view of

what their needs are, in that moment. For healthcare to be truly focused on the patient, the practitioner must be empowered to treat the full person rather than focusing on bio-medical guidelines and check lists and first build relationship that serves to meet that person's needs in that moment and over time.

6.6 Reflexivity

In the process of conducting this research, I have gained a lot of knowledge about the complexity of homelessness, and in the process have learned a lot about myself as well. I have encountered and challenged my own stigma against socially excluded people, have sat with my own discomfort in the face of other people's misfortune and suffering, have begun to unpick my own ignorance of how socially excluded populations should be helped, and have probably gained more questions than answers in the process.

I did not know very much about homelessness when I came to this work. Through the work presented here, I have come to understand that homelessness is complex and often has roots in painful childhood trauma and neglect. It has shifted my understanding from a previous vague intellectual understanding that homelessness is not the fault of homeless people to a deeper, heartfelt view of homeless people as every bit as human and important as anyone else.

This shift has also necessitated a change in my view of homeless people as poor, unfortunate victims of circumstance to seeing them as full humans with agency and rights and choices. I have undertaken introspection and reflection when learning about the experiences that homeless people go through and when realising that I do not have a right to assume that I know what they need or want even though I have a privileged position as a middle-class comfortable person undertaking PhD researcher training. These realisations have driven me to work toward producing research findings which are based on the data I have collected and not on my own values and biases. I hope that this thesis lives up to this desire.

I wanted the research in this thesis to be policy relevant because of my own experience working on the team from Trinity College Dublin which provided technical assistance, over a period of six months, to the Committee on the Future of Healthcare which produced the Sláintecare Report to reform the Irish health service in 2017 (Houses of the Oireachtas, 2017). Through this process, I experienced first-hand the importance of health services researchers understanding policy processes and for their work to be comprehensible and useful to policy makers, if they and their work are to have an impact.

Additionally, work produced by SPHeRE scholars is required by that programme to have policy relevance. For that reason, it was my intention from the early stages of this PhD research that I would actively think about how to make my work relevant to important issues in the real world and supporting solutions for them.

With regards to specific research reflexivity, I have done several things during the process of conducing the three studies presented above to reflect on the research process itself and to minimise any risk of bias. I have undertaken expert training in the methods used (realist approaches and policy analysis), and have sought expert supervision through each step of the research process. I have also involved external experts in both of my realist studies as the approach allows for as an integrated part of a study.

With regards to data collection, I took several trainings on realist interview technique to enable myself to conduct the best interviews possible. When conducting my interviews, I first did two pilot interviews to test out my questions and get feedback on my technique. I also took notes on the interview process after each interview and reflected on how I had presented myself and my theories for further development.

6.7 Chapter conclusion

For all populations, the Irish health system is difficult to navigate. Universal entitlement to care is lacking and there is a confusing patchwork of eligibility categories and many services have a fee. Care is provided by a mixture of state-employed staff and contractors (whether charities, small businesses or self-employed individuals) who are reimbursed by the state and/or private insurance schemes. People who can pay privately for services or who are among the approx. 46% (The Health Insurance Authority, 2020) who have private health insurance gain access to diagnostic test and hospital care quicker than those relying on the public system alone. The reliance on optional private health insurance in Ireland indicates the sentiment and expectation among Irish residents that private care is better and that insurance equates to better access. And for populations experiencing homelessness, the current system is particularly unsuited.

This thesis has examined how health systems impact healthcare accessibility for populations experiencing homelessness and complex needs. The findings show that the answer is multifaceted and with many interconnected factors related to workforce, funding, planning, goal setting, governance and much more. But in my view, it really boils down to the perspective that is taken and whose needs are sought to be met. A health system has the choice to seek to meet the needs of patients and clients for flexibility, being heard, time to build trust, and being understood, or to meet its own needs to attempt to contain costs, limit bed days, and follow internal rules.

The people who are best placed to see the needs and perspectives of both patients and the system as a whole are the people who work at the frontline of healthcare: the nurses, doctors, allied health professionals, mental health professionals, social workers and more. These people made this study what it is and these people, by trusting me and sharing their invaluable knowledge and expertise with me, allowed me to produce many key findings in this thesis. And with that in mind, I leave the last word to one of them, Interviewee 4, who sums up what healthcare accessibility for populations experiencing homelessness is all about:

> Accessibility to me, isn't just about putting a clinic in the hostel. It's not just about giving you a taxi to go there. It's about empowering people to understand, giving them the space, giving them the attention so that they can take in the information, and also making sure it's not about your own shit. – Interviewee 4

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Appendices

Appendix 1: Study 1 (realist review) study protocol

Access to healthcare for adults experiencing long-term homelessness
A realist review study protocol

Final version 11 March 2019

Background

The link between social status and health is well established: populations who experience deprivation and lower socioeconomic status have poorer health outcomes. Disadvantages such as low income, poor education, inadequate housing, and insecure employment all influence health negatively. Multiple hardships cumulate and amplify each other resulting in a 'social gradient' in health with multiple co-occurring and worsening outcomes (Marmot and Bell 2012; Aldridge et al. 2017). It is also well established that those most in need of healthcare find it hardest to access it (Tudor Hart 1971).

Homelessness is a state of severe deprivation, experienced by people lacking a stable and secure place to live. Homelessness occurs on a spectrum from sleeping rough, to living in emergency accommodation (eg hostel, night shelter or B&B accommodation), to staying with family or friends (Ní Cheallaigh et al. 2017). Long-term homelessness is associated with 'tri-morbidity' - the combination of physical ill-health, mental ill-health, and substance misuse (Cornes et al. 2017).

People who experience long-term homelessness along with other socially excluded populations such as people with problematic drug use, Travellers, prisoners, asylum seekers, undocumented migrants and sex-workers have more frequent, complex and significant need for healthcare services at both primary and secondary level than other populations (Luchenski et al. 2017). However, these groups often find accessing appropriate care at the right time difficult (Keogh *et al.*, 2015; Ní Cheallaigh *et al.*, 2017). In Ireland, homeless people use relatively less primary care and relatively more secondary care compared with housed populations and often make their first contact with the health service through the ED (O'Carroll and O'Reilly 2008; Ní Cheallaigh et al. 2017).

In recent years, homelessness has been on the rise in Ireland. The number of homeless people in the state has grown from 3,845 individuals in January 2015 to 9,987 in January 2019, an increase of 160%. The number of Irish families experiencing homelessness has grown by 302% during the same period with a total of 1,614 families reported as homeless in January 2019. The majority of these individuals and families live in Dublin (Focus Ireland, 2019). Across Europe, all countries, excepting Finland and Norway, have also experienced a rise in homelessness in recent years (FEANTSA and Foundation Abbé Pierre 2018). There is a difference in the needs of individuals experiencing long-term homelessness and those of families experiencing homelessness – this review focuses on the first group.

Realist review methodology seeks to understand questions such as 'how?', 'why?', 'for whom?', 'in what circumstances?' and 'to what extent?' services or interventions 'work'. It is well suited to understanding the complex, non-linear ways people who experience long-term homelessness access healthcare because it seeks to uncover the contextual factors and specific mechanisms, under the control of the health system, that influence the healthcare accessing continuum (as described in the

conceptual framework by Levesque et al below). This review will seek uncover these system-level contexts that impact healthcare accessibility and the causal mechanism that are triggered by particular contexts to create the outcome of interest: increased access to healthcare.

In particular, we are interested in understanding mechanisms related to how system-level health services respond to individual-level factors such as stigma, discrimination, poor mental health, unequal power dynamic between patient and provider, feelings of shame, and more. These individual-level phenomena are described in the peer-review literature. We are interested in understanding how specific healthcare system contexts could be modified to trigger mechanisms and lead to improved outcomes that enable individual patients to seek the care they need when they need it despite the individual-level challenges listed above.

Aim

The overall aim of this reviews is to understand how healthcare systems can provide optimal access to healthcare for long-term homeless populations.

Realist review methodology will be used because it is designed for reviewing complex interventions such as the one in this study and because it seeks to explain how complex programmes work in particular contexts and settings, or why they fail (Pawson et al. 2005). The review will include the following sources: health data, commentaries, grey literature, and peer reviewed studies. The review will follow an iterative process and will benefit from expert panel input from Dublin NGO sector, healthcare professionals serving socially excluded populations and academics.

Review question

The research question for the review has been amended from the initial thesis proposal submitted to the SPHeRE programme academic panel in July 2018 to create a manageable focus and to make it in line with realist methodology. The original research question read:

- How are healthcare services best conceptualised, organised, resourced and delivered to provide equitable access for socially excluded populations?

The revised question:

- How, why, for whom, in what circumstances and to what extent can healthcare systems improve access to healthcare for populations experiencing long-term homelessness?

Methods

Based on Wong et al (2015), the review will go through the following stages

1. Project set up
2. Informal searching and developing initial programme theory
3. Iterative cycles of searching for evidence, selecting articles, extraction and data organising, synthesising the data and refining the programme theory. (The programme theory will be built from the ground up through the tagging evidence of aspects of contexts, mechanisms and outcomes in NVivo.)
4. Iterative consulting with expert panel

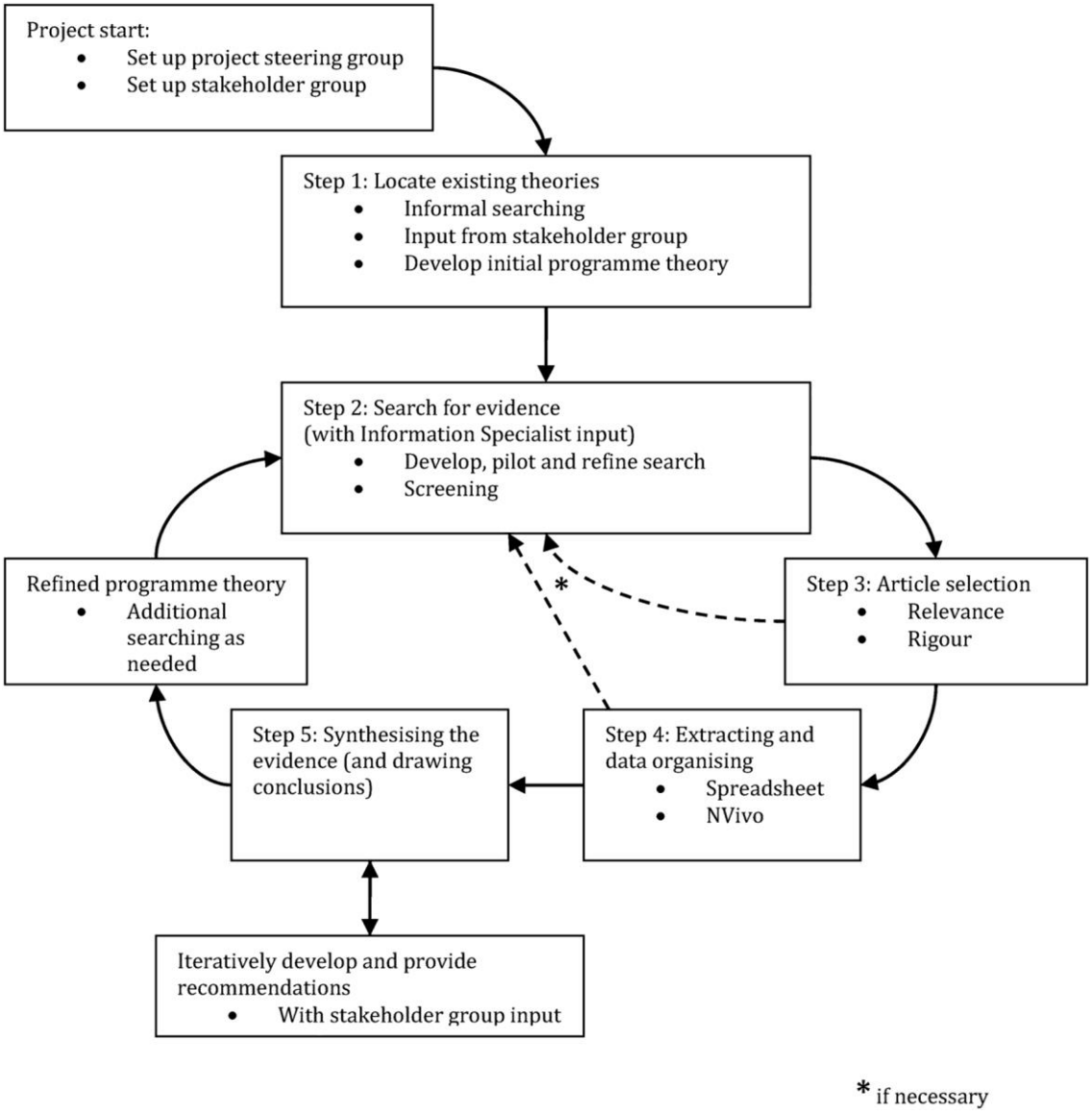


Figure 30: Stages of a realist review per Wong et al, 2015.

Healthcare access will be defined on a continuum using the contextual framework by Levesque et al (2013) which takes into consideration the various stages at which a person perceives a health need and acts accordingly and the response by providers and health services.

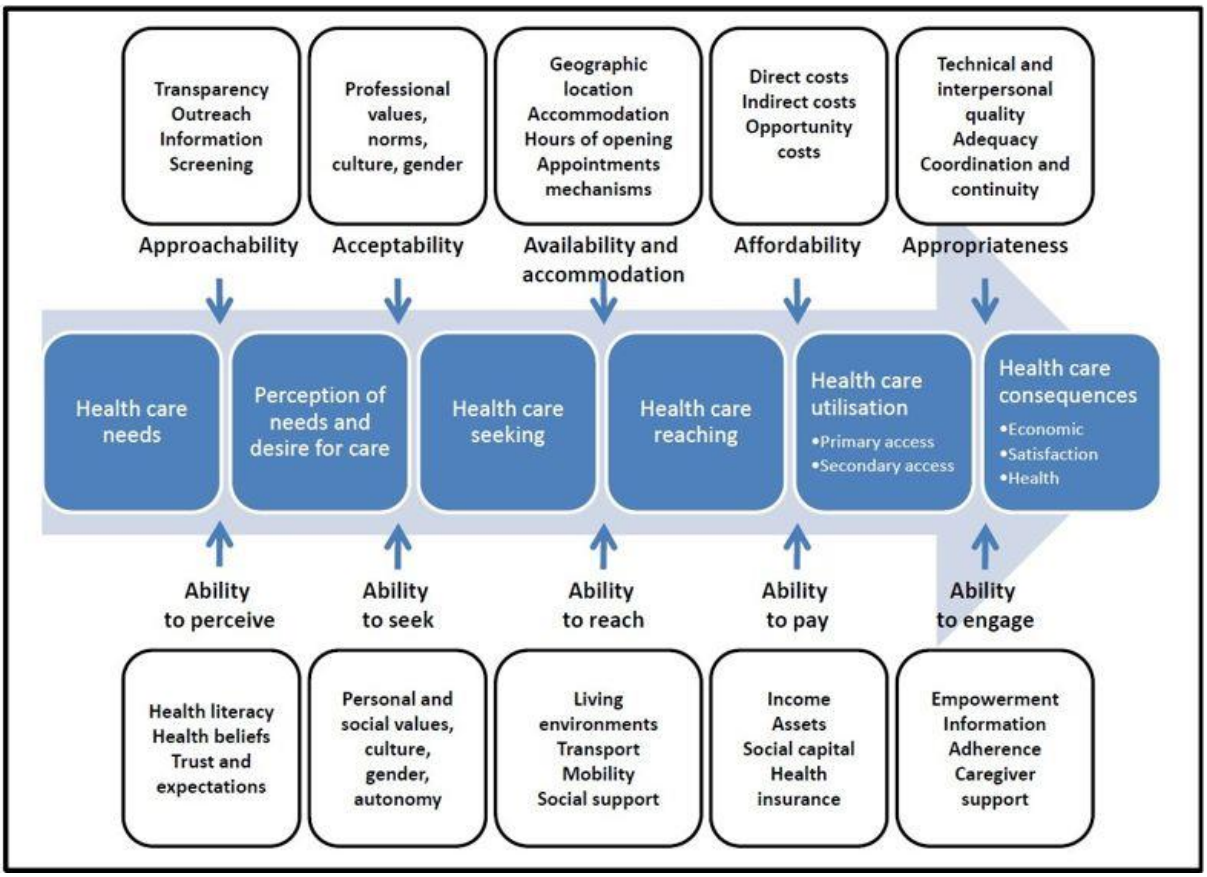


Figure 31: A conceptual framework of access to health care per Levesque et al, 2013

Searching process

A systematic literature search of peer reviewed literature will be undertaken in MEDLINE, EMBASE, CINAHL, PsycINFO, Web of Science and selected social science databases from inception to present. Search terms and a refined list of databases to be used will be decided with the help of a librarian. There will be no restriction on study design. After the initial search, an auto-alert will be created to capture new articles matching the keywords.

Grey literature will be searched using an internet browser (eg google) and via specific websites (eg The Department of Health, Health Service Executive, homelessness NGOs, Pathway, The King's Fund, Nuffield Trust). As the analysis goes on, further searching may be required to understand specific aspects of the programme theory as it emerges.

Selection and appraisal of documents

All titles and abstracts will be downloaded to EndNote, screened and assessed with inclusion/exclusion criteria. Included articles will describe how health systems respond to the healthcare needs of individuals and populations experiencing homelessness and the barriers faced. Studies in English describing high income countries will be included.

A second reviewer will independently screen a random sample of 10% of titles and abstracts and differences will be discussed between the two reviewers. Articles will be sorted into excluded or possibly included and the full text of possibly included articles will be downloaded. The full text of these will then be reviewed to elucidate aspects contributing to CMOs and again a second reviewer will read a random sample of 10% of the articles.

Data extraction

Data will be extracted using a data extraction *pro forma* listing article details, participant details, study method, research question, contexts, barriers/facilitators to access, and definition of access. Direct quotations will be included. A random 10% sample will be checked by a second reviewer for consistency and accuracy of data extraction. The data extraction process may evolve if evidence is gathered which identifies gaps. The focus of the review will be re-considered at this stage and decisions made as to which specific avenues to pursue to maximise understanding and usefulness.

Analysis

The data analysis will seek to identify factors assuming a starting point of not having enough knowledge and expertise to rely on the initial programme theory as the basis for the analysis. Using NVivo, findings, data and sections of text marked as relating to context, mechanism or outcome. For each, inferences will be made as to what the context-mechanism-outcome configuration (CMOC) might be. In other words, if data is interpreted as relating to context, then the next analytic task is to infer which outcome the context is related to and what the mechanism might be. During analysis the expectation is that no one article is likely to contain relevant data for an entire CMOC, but that instead relevant data to build a CMOC will ideally come from multiple articles. Any substantive or formal theory identified during the search will also be added if relevant.

In summary, the analytic process may be understood as a series of questions:

1) Is the section of text referring to context, mechanism or outcome?
2) What is the CMO configuration (partial or complete) for it?
3) a) How does this (full or partial) CMO configuration relate to the programme theory?
   b) Is there data which supports how the CMO configuration relates to the programme theory? In light of this CMO configuration and any supporting data, does the programme theory need changed?
4) a) Is the evidence sufficiently trustworthy and rigorous to change the CMO configuration?
   b) Is the evidence sufficiently trustworthy and rigorous to justify changing the programme theory?

Rigour will be defined according to Pawson (Pawson et al., 2005).

The analysis may prompt the need for more literature searching around a particular CMO configuration. The review team will decide which types of sources are most useful to search to identify further literature, taking into consideration the time and resource constraints.

Dissemination

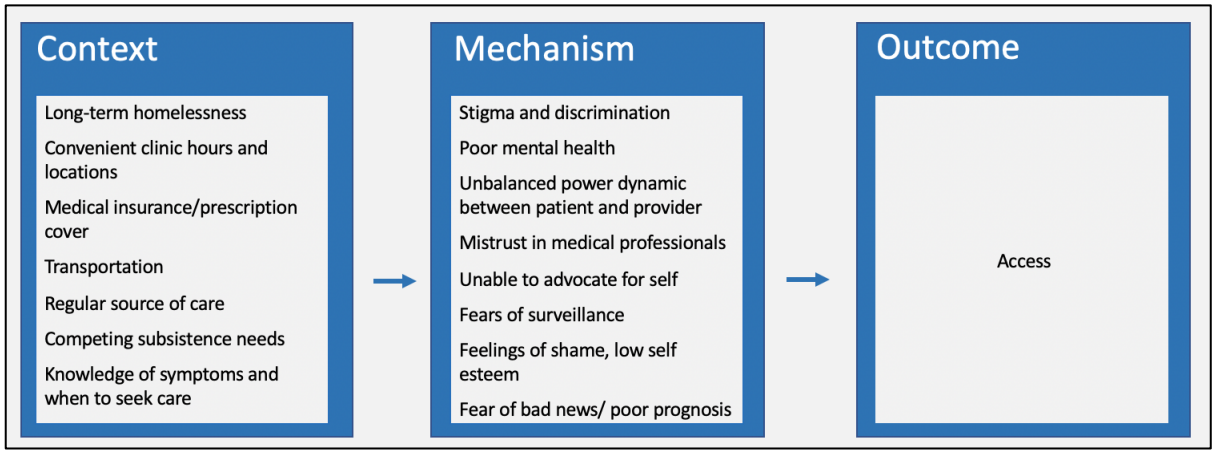
The realist review will be written for publication in a peer review journal using the RAMESES publication standards.

Team

Rikke Siersbaek – SPHeRE Scholar

Sara Burke – Supervisor with expertise in health policy analysis and qualitative methods
Clíona Ní Cheallaigh – supervisor and clinician with expertise in homeless healthcare
John Ford – supervisor with expertise in healthcare access and realist research methods
Steve Thomas – Supervisor with expertise in health systems

Rough initial programme theory



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Appendix 2: Study 1 (realist review) systematic literature search

Ovid MEDLINE (25 April 2019)

Number	Search details	Hits
1	exp Homeless Persons/	8,246
2	(homeless* OR "homeless person" OR "homeless population*" OR "no fixed address" OR "no fixed abode" OR "emergency accommodation" OR "supported accommodation" OR "supported housing" OR hostel* OR "night shelter" OR "bed and breakfast" OR "hard to reach" OR vagrancy OR vagrant* OR "rough sleep*" OR "sleep* rough" OR "street people" OR "street person*" OR squatter* OR vagabond* OR "indigenous people" OR "indigenous population*").ab,ti.	16,947
3	exp Health Services Accessibility/	104,062
4	("health service* barrier*" OR "health service* access*" OR "health care access*" OR access adj2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet) OR barrier adj2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet)).ab,ti.	22,007
5	1 OR 2	19,141
6	3 OR 4	118,956
7	5 AND 6	1507
11	limit 10 to (english language AND “review articles”)	154

Embase.com (26 April 2019)

Number	Search details	Hits
1	‘homelessness’/exp	10,242
2	'homeless person'/exp	1,371
3	‘vagrancy’/exp	11

4	(homeless*:ab,ti OR 'homeless person':ab,ti OR 'homeless population*':ab,ti OR 'no fixed address':ab,ti OR 'no fixed abode':ab,ti OR 'emergency accommodation':ab,ti OR 'supported accommodation':ab,ti OR 'supported housing':ab,ti OR hostel*:ab,ti OR 'night shelter':ab,ti OR 'bed and breakfast':ab,ti OR 'hard to reach':ab,ti OR vagrancy:ab,ti OR vagrant*:ab,ti OR 'rough sleep*':ab,ti OR 'sleep* rough':ab,ti OR 'street people':ab,ti OR 'street person*':ab,ti OR squatter*:ab,ti OR vagabond*:ab,ti OR 'inadaquate housing':ab,ti OR 'hidden homeless*' :ab,ti OR 'indigenous people':ab,ti OR 'indigenous population*':ab,ti	20,523
5	'health care access'/exp	55,849
6	("health service* barrier*" OR "health service* access*" OR "health care access*" OR access NEAR/2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet) OR barrier NEAR/2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet)).ab,ti.	28,437
7	#1 OR #2 OR #3 OR #4	23,407
8	#5 OR #6	78,165
9	#7 AND #8	1,286
10	#7 AND #7 AND [review]/lim AND [English]/lim	173

CINAHL (26 April 2019)

Number	Search details	Hits
1	(MH "Homeless Persons")	4,724
2	(MH "Homelessness")	3,378
3	TI homeless* OR "homeless person" OR "homeless population*" OR "no fixed address" OR "no fixed abode" OR "emergency accommodation" OR "supported accommodation" OR "supported housing" OR hostel* OR "night shelter" OR "bed and breakfast" OR "hard to reach" OR vagrancy OR vagrant* OR "rough sleep*" OR "sleep* rough" OR "street people" OR "street person*" OR squatter* OR vagabond* OR "inadequate housing" OR "hidden homeless*" "indigenous people" OR "indigenous population*"	7,879

4	AB homeless* OR "homeless person" OR "homeless population*" OR "no fixed address" OR "no fixed abode" OR "emergency accommodation" OR "supported accommodation" OR "supported housing" OR hostel* OR "night shelter" OR "bed and breakfast" OR "hard to reach" OR vagrancy OR vagrant* OR "rough sleep*" OR "sleep* rough" OR "street people" OR "street person*" OR squatter* OR vagabond** OR “inadequate housing” OR “hidden homeless*” OR "indigenous people" OR "indigenous population*"	8,236
5	(MH "Health Services Accessibility+”)	72,405
6	TI 'health service* barrier*' OR 'health service* access*' OR 'health care access*' OR access ADJ2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR 'culturally competent' OR 'safety-net' OR 'safety net' OR safetynet) OR barrier ADJ2 (health or service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR 'culturally competent' OR 'safety-net' OR 'safety net' OR safetynet)	80,358
7	AB 'health service* barrier*' OR 'health service* access*' OR 'health care access*' OR access ADJ2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR 'culturally competent' OR 'safety-net' OR 'safety net' OR safetynet) OR barrier ADJ2 (health or service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR 'culturally competent' OR 'safety-net' OR 'safety net' OR safetynet	80,625
8	#1 OR #2 OR #3 OR #4	12,280
9	#5 OR #6 OR #7	81,401
10	#8 AND #9	1,537
11	#8 AND #9 (limited to English and publication type: Meta Analysis, Review, Systematic Review)	101

ASSIA (26 April 2019)

Number	Search details	Hits
1	MAINSUBJECT.EXACT("Homelessness") OR MAINSUBJECT.EXACT("Homeless elderly people") OR MAINSUBJECT.EXACT("Homeless men") OR MAINSUBJECT.EXACT("Homeless families") OR MAINSUBJECT.EXACT("Homeless women") OR MAINSUBJECT.EXACT("Homeless people") OR MAINSUBJECT.EXACT("Homeless pregnant women") OR MAINSUBJECT.EXACT("Homeless older people")	4,008

2	ab(homeless* OR "homeless person" OR "homeless population*" OR "no fixed address" OR "no fixed abode" OR "emergency accommodation" OR "supported accommodation" OR "supported housing" OR hostel* OR "night shelter" OR "bed and breakfast" OR "hard to reach" OR vagrancy OR vagrant* OR "rough sleep*" OR "sleep* rough" OR "street people" OR "street person*" OR squatter* OR vagabond* OR "inadequate housing" OR "hidden homeless*" OR "indigenous people" OR "indigenous population*")	7,083
3	ti(homeless* OR "homeless person" OR "homeless population*" OR "no fixed address" OR "no fixed abode" OR "emergency accommodation" OR "supported accommodation" OR "supported housing" OR hostel* OR "night shelter" OR "bed and breakfast" OR "hard to reach" OR vagrancy OR vagrant* OR "rough sleep*" OR "sleep* rough" OR "street people" OR "street person*" OR squatter* OR vagabond* OR "inadequate housing" OR "hidden homeless*" OR "indigenous people" OR "indigenous population*")	3,796
4	ab("health service* barrier*" OR "health service* access*" OR "health care access*" OR access NEAR/2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet) OR barrier NEAR/2 (health or service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet))	10,687
5	ti("health service* barrier*" OR "health service* access*" OR "health care access*" OR access NEAR/2 (health OR service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet) OR barrier NEAR/2 (health or service OR medical OR prescription OR prescribe OR therapy OR therapies OR treatment OR treatments OR "culturally competent" OR "safety-net" OR "safety net" OR safetynet))	1,708
6	S1 OR S2 OR S3	7,884
7	S4 OR S5	11,386
8	S6 AND S7	335
9	S6 AND S7 (limited to English language and "literature reviews" and "reviews")	1

Appendix 3: Study 1 (realist review) conceptual codes

Codes

Name	Files	References
Access	0	0
Individual	0	0
Confidentiality	4	5
Context	0	0
Experiencing homelessness and deprivatio	1	1
Family support	1	1
Health insurance	1	1
Incentives	3	9
Link worker support	1	1
Mechanism	0	0
Ability to choose level of disclosure	2	2
Availability of provider at time of need	1	2
Luck	1	2
Perceived need and problem awareness	1	1
Previous positive experience	1	1
Religious belief	1	1
Positive self-perception	2	3
Respect, empathy, acceptance	6	8

Codes

Name	Files	References
Shorter length of homelessness	1	1
Usual source of care	1	1
Provider	0	0
Building relationships	3	4
Going outside traditional role - above the call	1	1
Good communication skills	3	6
History taking	1	2
Identifying homeless patients	3	8
Non-judgemental	9	25
Providing anticipatory care_harm reduction	3	8
Seeing through patient's eyes	4	4
Settings_Secondary care	3	3
System	0	0
Co-located care	1	2

Codes

Name	Files	References
Context	0	0
Adequate funding for services	2	2
Community based, familiar setting	1	1
Non-hospital setting	1	1
Non-specialised care	1	1
Regular source of care	3	5
Rights and standards	0	0
UHC and free care	2	2
Coordinated care	12	19
Flexible opening hours and appointment times	5	5
GP as gatekeeper	1	1
Inclusive facilities	4	6
Inclusive language	2	3
Integrated multidisciplinary care	4	7
Low threshold and flexibility	10	17

Codes

Name	Files	References
Mechanism	0	0
Adherence to protocols	1	1
Advocacy and poverty reduction	6	11
assertive follow up	4	4
Case management	6	7
Co-design	1	1
Continuity of provider-patient relationshop	2	2
Cultural competency	7	8
Governance	1	1
Informed by people with lived experience	1	4
Intermediate care	1	1
Outreach	7	10
Peer advocacy	9	22
Personal methods of contact	1	1
Proportionate universalism	1	1
Reducing duplication	1	1
Simplifying referral	1	1
Specialisted and street services	13	32
Trust	9	14

Codes

Name	Files	References
Multifactoral interventions	3	6
Patient health records accessible from various l	2	2
Professional networks	7	8
Provider training to reduce stigma	9	16
Referral pathways	7	14
Respectful person-centered care	8	19
Social care and healthcare integration	10	16
Systemic changes	1	1
Barriers	0	0
Individual	0	0
Aggression	1	1
Authority figures	3	3
Competing priorities	13	20
Confidentiality	5	8
Context	0	0
Complexity of needs	0	0
Housing status	6	29
Mental illness	3	4

Codes

Name	Files	References
Mobile chaotic lifestyle	2	10
Multimorbidity	1	1
Woman	1	1
Cost	5	6
Delaying seeking treatment	2	2
Fear of medical investigations	4	4
Feelings of unentitlement	3	4
Health attitude and knowledge	11	17
Isolation	4	7
Knowledge where to access healthcare	7	14
Label of mentally ill	1	1
Lack of entitlement to care	6	7
Lack of health insurance	7	8
Mechanism	0	0
Embarrassed to ask for help	2	3
Peer influence	1	2
Reliance on family and friends	1	1
Migrants	1	1

Codes

Name	Files	References
Money	5	7
Multiple deprivation compounds	2	2
Navigating healthcare systems	5	5
Not seen, not undersood	5	9
Place in ones community	1	1
Poor hygiene	2	2
Previous negative experiences	3	3
Problematic substance use	4	5
Retelling story	2	2
Shame	4	4
Transportation	7	9
Trust	8	20
Valuing self sufficiency	3	3
Wanting to stay in known locality	3	6
Provider	0	0
Communication skills	5	7
Judgemental attitude	2	2

Codes

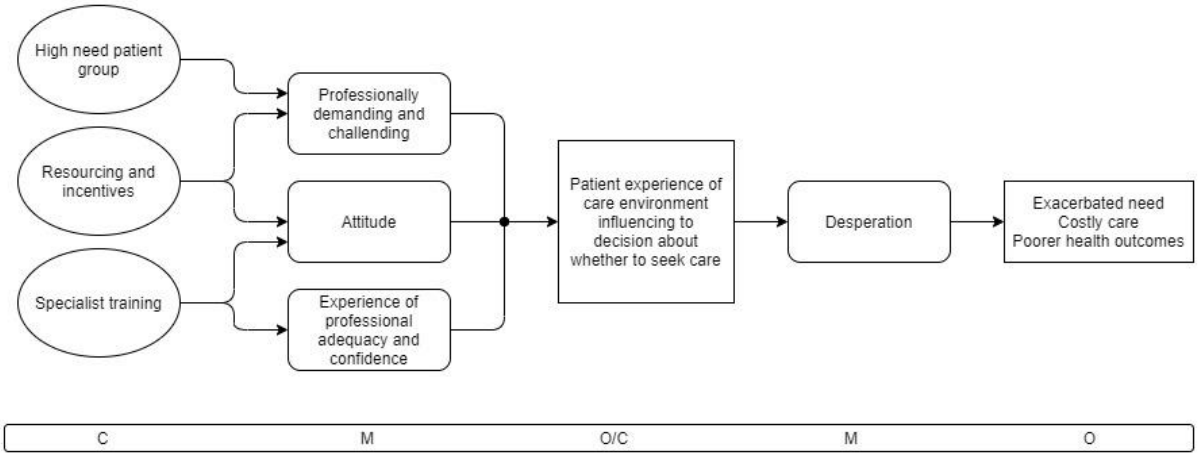
Name	Files	References
Mechanism	0	0
Reticence about treating homeless	3	6
System	0	0
Abstinence requirement	4	6
Care provided by non-medical professionals	1	1
Clinic locations	3	4
Complex interplay between individual and syst	3	5
Context	0	0
Address requirement to access GP	1	1
Commissioning	0	0
Geographic variation in funding	1	1
Variation between areas	0	0
Fear of change	1	1
Fees for healthcare	2	3
Hierachies	3	4
Identification as homeless	1	1
Inadequate workforce training to work with soc	4	6
Inflexible policies	8	8

Codes

Name	Files	References
Lack of training	3	5
Lack of women only services	2	2
LGBTQ lack of understanding	1	1
Limited psychosocial supports	3	3
Mechanism	0	0
Bureaucracy	3	3
Repetitive paperwork	1	1
Need for adult consent for youth seeking treat	4	5
Placing responsibility for access on patients	1	2
Requiring identification	2	3
Rural communities	1	2
Staff burnout and secondary trauma	2	3
Stigma	14	36
Treatment not available right when needed	1	1
Uncoordinated care	7	14
Waiting times	3	3

Appendix 4: Data used to construct study 1 (realist review) consolidated CMOCs

Consolidated CMOC 1: Resourcing



Supporting data:

"Why is it important? Evidence shows that when there is a lack of cultural responsiveness, health outcomes are much poorer. Improving cultural responsiveness can not only remove barriers to accessing healthcare, but may also reduce inequitable health outcomes for marginalised and vulnerable groups" (Agency for Clinical Innovation, n.d.)

There is a limited evidence base on what works for these clients and, particularly in small specialist services, a lack of capacity and/or capability to evaluate effectiveness and impact
• Services often lack the flexibility to respond to complex needs and chaotic lifestyles • There are few incentives to promote partnership working around clients with complex needs • It is easy for clients to fall between the gaps of different services leading to expensive unplanned care and clients 'revolving' through the system (Cabinet Office Social Exclusion Task Force, 2010b)

The other issue is resources. Nine out of ten GPs in the Crisis survey felt that GPs need extra resources in order to provide homeless people with the same levels of access to GP services as the average person. Homeless people do present with multiple and complex needs which require extra resources and sometimes specialist knowledge. GPs and practice staff are not, in general, given any specialist training in understanding the specific needs of homeless people (Crisis, 2002)

GPs do feel that the transitory nature of homeless people's lifestyle prevents them from providing long term and preventative care to the standard that they are accustomed to. **Some GPs do hold stereotyped images of homeless people and expect them to present with problematic and disruptive behaviour, fear that they will abuse prescriptions or cause difficulties in the waiting room** (Crisis, 2002)

Homeless people can come to mistrust institutions and authority: if someone has had a bad experience trying to register with a GP it can put them off trying again. Expectation of rejection and anger can be quite near the surface and if a person does not get a good response from primary care practitioners it can spark off aggressive behaviour. Homeless people often experience feelings of low self-esteem and depression which make it hard for them to use mainstream services.

The lifestyles of some homeless people also makes it difficult for them to keep appointments and fit into the inflexible working practices of a surgery (Crisis, 2002)

A Queen's Nursing Institute Homeless Health Initiative survey of homeless and non-homeless health specialists found that:
• Only 36% of all specialists and 8% of nonspecialist nurses had ever received any training on homelessness and health
• 71% of non-Homeless Health Specialists were not confident in their ability to care for homeless people
• 74% of all respondents (mainstream and specialist) are lone workers always, often or sometimes (Cabinet Office Social Exclusion Task Force, 2010b)

Access to services:

- GP surgeries are often reluctant to register patients from travelling communities.
- All those from vulnerable groups have the right to be fully registered with an NHS general practice, unless the list is full or the person resides outside the practice boundary81.
- Access to primary NHS health care in the UK is based on residency and not on a permanent postal address82.
- **Financial disincentives for GPs to register rough sleepers**38.
- **No or inaccurate postal address results in lost appointment letters**83.
- Transport costs to hospitals and health centres38.
- Lack of integration between services that support vulnerable groups, e.g. between primary care and secondary care; between healthcare and other local non-health services38 (Davis & Lovegrove, 2016)

An overall theme from the literature is that healthcare professionals can lack knowledge, confidence and expertise about the beliefs and culture of vulnerable groups 15,60,61,62,63,64,65. **One approach to address cultural differences is the development of cultural competence among healthcare professionals. Ideally, this development should start in undergraduate education and be part of the inservice training of healthcare practitioners65. It has also been suggested that the concept of cultural competence should go beyond individual health workers and encompass whole organisations, which need to commit to dealing with diversity65**.
It has been reported that there is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive services66. The understanding of distinct cultures is essential to improving access to services and to the effectiveness of these services. The Royal College of Nursing67 recommends cultural awareness training for all frontline staff to feel confident in working with these communities (Davis & Lovegrove, 2016)

The negative attitude of other healthcare professionals can be a big hurdle for specialist clinicians working with these clients. Some staff are very judgemental and can be very discriminating against people who are homeless. **This may be because of a lack of knowledge, understanding and skills needed to care for them. It is very important that all staff, including commissioners and managers, try to be accepting, nonjudgemental and appreciate the additional basic requirements** (Davis & Lovegrove, 2016)

Sometimes the reluctance to help patients from vulnerable groups can be attributed **to a lack of confidence by healthcare professionals as illustrated below.**
"If there are 10 people asking you questions in that community because they are so desperate to have answers you are not going to want to go back. It can be overwhelming for professionals who do not have experience of working with this community." Health visitor working with Gypsies and Travellers (Davis & Lovegrove, 2016)

However, shelter-based youth said that health care was not usually a priority until they became ill or injured and they did not have a regular PHC service provider (Dawson & Jackson, 2013)

"Whilst access to secondary care is often seen as an area of less concern than primary care, and the main issues identified mainly relate to cultural sensitivity, the admission and length of stay patterns for members of socially excluded groups are showing an underlying problem. These patients are admitted more often, stay longer and are re-admitted more frequently. **This highlights a number of issues further upstream: that these patients struggle to access other services, and therefore they turn to secondary care, and that they are sicker and do not receive the same quality of care as other patients, particularly when looking at discharge arrangements**" (Gill et al., 2013)

Communication difficulties between patients and specialists are a common finding in the HCV treatment literature. Research participants have reported feeling unprepared for HCV treatment and experiencing more severe and varied side-effects than they had been led to expect by medical providers [33,34,46]. **Reasons for poor communication include: physician's inadequate explanation of treatment side-effects; use of medical jargon; insufficient duration of consultation; and lack of time and minimal attention to patient concerns** [31,33,34,40,44, 46,74]. **Training in providing care for, and addressing issues relevant to, PWID is often lacking or only superficially provided to HCV treatment providers which may exacerbate unrealistic expectations and communication difficulties** [72]. Pre- and post-HCV test counselling has been identified as an area requiring skills development [42,105], **and there is a need for physicians to be responsive to patients' reports of adverse treatment effects** [72]. An obstacle to communication that has received little attention to date is language barriers between some immigrants and minority ethnic groups and their HCV treatment providers [61,106] (Harris & Rhodes, 2013)

"The unwelcomeness from the medical staff is a big issue. That's the major one that really needs to be addressed and I feel…there needs to be a lot of education… to overcome this barrier. I understand there are issues of hygiene and behavioural problems but I think … we could tear down a lot of these barriers" - Social worker [37] (Hudson et al., 2016b)

Many studies called for more training for health and social care professions and exposure to the realities of homelessness to promote insight and understanding into the lives and experiences of homeless people [9, 36, 37, 39–41, 44].
"Have a doctor, an intern, or…a medical student come and work at a shelter for a week, just to see how it is. To get woke up at 6:00 in the morning and booted out… getting a cold bowl of cereal… for breakfast, and just shadowing somebody that… is homeless… if just to say 'I know this guy; he's homeless and this needs to be taken care of right away… not making him wait. Then they will have an ideal of what it's like being homeless" - Homeless person [40] (Hudson et al., 2016b)

"**People who are living on the street...it's much harder to access them. They don't come to us and they don't go anywhere for help until they're so sick that they're picked up by an ambulance**"– Health care professional (Hudson et al., 2016b)

Health professionals described experiencing **"feelings of failure or lack of achievement"** [35] when working with homeless people. Treating an individual with needs that are very different to those of their usual patient group, with little training could limit the provision of quality palliative care for this population [36, 37**]. Inexperience in caring for people who are homeless may contribute to some of the attitudes health care professionals may hold towards homeless and may also contribute to their perceptions of stress and burden** (Hudson et al., 2016b)

In what is essentially a transactional, or contingent relationship such as the GP consultation, where there is a significant difference in status and power, elements of these 'fluid roles' are often

used in an attempt to put both parties at ease. This masking of differential status and power appears helpful, or unproblematic in consultations about problems with a clear physical origin. However, in mental health consultations the uncertainties inherent in this fluidity of roles can act as a further barrier to service entry**. The successful negotiation of patient and practitioner roles and the establishment of a mutually acceptable understanding of the problem requires more time than is often available in orthodox settings such as the general practice consultation** (Lamb et al., 2012)

People with multiple needs want to be placed at the centre of their own support. However, people felt that their needs and aspirations were not always seen as a priority, and that services' ability to provide support can be limited by the way they are designed and commissioned.
People also felt that targets or conditions attached to funding meant that practitioners weren't able to focus on the individual and decide what was best for them (Making Every Adult Matter Coalition, 2015)

High (often described as inappropriate) usage of Emergency Departments (ED). Again, as described in the literature**, participants described situations where they used the ED in a manner that would be described by Health Planners as inappropriate**. Firstly, they described using it for complaints that planners describe as being more suitable for primary care services (9 sources/14 references). Participant-47 had not been able to access health care except for the ED … as he had no medical-card and did not know how to get one (O'Carroll & Wainwright, 2019)

A number (9 sources) **referred to the 'disdain' they experienced from health professionals.** Participant-16: "He just looked at me as if I was bleedin dirt like." Participant-14 was always buying new clothes to avoid looking homeless as she felt people's discriminated against her when she 'looked homeless' (O'Carroll & Wainwright, 2019)

Some mainstream health providers believe that the health service is not for patients who 'deliberately' harm their own health in particular by using drugs. The blaming interaction is where the health professional blames the patient for causing their own health problems. Participant-46: "They told me in the A&E that they couldn't take me in because I was a drug addict and I made my own choices" (O'Carroll & Wainwright, 2019)

Without a true understanding of the 'lived experience' of these patients, it can be difficult for professionals to improve their access to primary care, and ultimately their health. The view that those working in primary care needed to try extremely hard to understand the difficult lives of these patients was a priority for all participant groups. Another participant explained the huge social distance between the providers and marginalised patients can make engagement and collaboration around health very hard:
'Girls that are on the street [sex] working, they'd rather talk to another girl that is working than go and talk to a complete stranger, or a doctor about something that they might have wrong with them … Yeah it's like, you [the doctor] haven't clue what I've been through.' Sex working participant 2 (T) Participants (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

A higher propensity of GP burnout was found among GPs with a high share of deprived patients on their lists compared with GPs with a low share of deprived patients. Very often deprivation in rural areas is less visible to the general public but highly apparent to GPs. The specifics are often different from those seen in urban areas but equally as detrimental and under resourced. Geographic, financial and social isolation and the closure of once vital rural life including post offices, Garda stations, pubs, schools and GP surgeries has led to ever increasing difficulties in rural Ireland. In the current system, it is difficult to recruit GPs to work in areas of deprivation. **There is no**

incentivisation financially, professionally or personally for GPs to work in these areas (Osborne, 2015)

They have ineffective contact with services**. People facing multiple needs usually look for help, but most public services are designed to deal with one problem at a time and to support people with single, severe conditions. As a result, professionals often see people with multiple needs (some of which may fall below service thresholds) as 'hard to reach' or 'not my problem'. For the person seeking help this can make services seem unhelpful and uncaring**. In contrast to when children are involved, no one takes overall responsibility (Page & Hilbery, 2011)

Improving capacity and capability
There is a wide range of health services nationally, but a far smaller pool of experienced nurses focused on holistic and integrated healthcare for people experiencing homelessness. This type of healthcare is time and labour intensive**. It is vital that commissioners understand the complexities around engaging and building relationships and trust with people who are homeless as one of the crucial elements of delivering healthcare** (The Queen's Nursing Institute, 2018)

Funding
'This can definitely be improved. Funding is a big issue and I have not had contact with a commissioner for a long time as they keep changing.'
'As I am employed by an NHS Trust I have difficulties improving and developing services due to financial constraints' (The Queen's Nursing Institute, 2018)

The services consulted work with homeless people who have often been living with multiple and chronic health conditions, **which may have been exacerbated by years of sleeping rough**. The case studies illustrate the extremely broad range of health conditions presented, and how homeless health services work to address these conditions.
Common themes in providing appropriate primary care to homeless people include a flexible approach, longer appointments to enable assessment and investigation of complex healthcare needs, assertive outreach offering support in a range settings including street-based support, and a triage approach where different health needs are prioritised and addressed through a structured health programme (St Mungo's, 2013)

A consistent message from services consulted was that some mainstream GP surgeries and some hospitals struggle to serve the needs of homeless people. Staff attributed this to both organisational and attitudinal factors. Operational factors included a strict, and at times inappropriate, application of rules requiring identification documents or an address when joining a surgery and highly structured appointment pre-booking systems which do not operate well for individuals who live chaotic lives. There was also a perceived lack of understanding of multiple health problems and the impact on homelessness, and reports of unwelcoming attitudes from staff or other members of the public. Although the latter may in part be explained by the challenging behaviour which homeless people may present, there is a clear need to improve perceptions and understanding of homelessness and its relationship to health problems (St Mungo's, 2013)

Overcoming cultural and attitudinal barriers, which shape staff and the wider public's beliefs about what people who sleep rough deserve, continued to be a challenge for local areas. It also emerged as a strong theme in the focus groups. **Focus group participants reported being made to feel unwelcome and being denied access to health and care, for example being unable to register with a GP or a dentist, despite clear guidance that states that you do not need to have proof of address to register** (The King's Fund, 2020)

Therefore, to provide quality care, providers must understand the unique needs of the homeless. Their needs are more complex than the general population and health provider characteristics influence whether homeless persons will use health services.21,37 **If providers are not familiar with this population's needs, or are not willing to meet their needs, this may impede health care use.** Improving interpersonal communication can facilitate primary care access and advance the quality of care in this population. Using "I" and "you" statements are one strategy to improve patient–provider communication with the homeless population by creating a welcoming and receptive environment without judgment.**37 Formal training for health care professionals that improve cultural understanding and awareness is another strategy to improve provider communication**.38 There are several existing curricula to improve provider knowledge of diverse groups such as the homeless, as well as attitudes and beliefs (White & Newman, 2015)

As already described, Primary Care is a key touchpoint for those in need of services. However, barriers go beyond simple gate keeping and understanding other ways in which this group can become excluded is important as it identifies training needs for potential gate keeping staff and others. A study by Wood et al 15 (1997) **found there to be a variety of disincentives described by practices when considering registering a homeless patient. These included (from a survey of 155 GP practices); · Associated social problems (90% of respondents agreed); · Lack of medical records (88% agreed); · Complex health problems (79% agreed); · Associated drug or alcohol abuse (78% agreed)** (Wilson & Astley, 2016)

Consolidated CMOC 2: Funding stability and source

Supporting data:

Others felt that longer term funding contracts would offer staff more security of employment. The underlying fact is that we are government funded for cycle periods where funding contracts and notifications of outcomes continues to be delayed or left to the last minute where we may lose staffs due to uncertainty in ongoing funding or new contracts. (Medium non-metropolitan SHS provider) **Job security - not having to tie employment to funding contracts.** (Large nonmetropolitan SHS provider) (Cortis & Blaxland, 2017)

While funding of homeless service through Department of Housing Section 10 funding was largely frozen during the period of austerity budgets, funding from the Department of Health/HSE experienced massive cuts, in some cases of over 40%. Severe reductions in HSE funding during the course of the recession placed a significant strain on the range of social care, mental health and physical health services which are essential in supporting people who are experiencing homelessness to exit to independent living. **These cuts happened in parallel with a massive increase in the numbers of people who were homeless and an increase in the support needs of many**

groups. To a large extent, these cuts were absorbed through wage cuts and wage freezes for the staff in the voluntary sector. While the public sector is going through a process of pay restoration, staff in voluntary sector services, particularly those funded by the HSE, have seen little pay restoration and, frequently, no increments for several years. This is leading to recruitment problems in front-line services, just when need is greatest (Focus Ireland, 2019)

The main problems encountered in this sector are excessive service fragmentation and duplication, missing economies of scale, sometimes lack of skills and capacity, **short funding cycles** and the need for better mechanisms to share good practice (Gill et al., 2013)

For these reasons, medical treatment of homeless persons is provided mainly within alternative healthcare systems that are **funded by government institutions and non-governmental organizations (NGOs), and on a project-related basis also by health insurers and associations of statutory health insurance physicians** (Kaduszkiewicz et al., 2017)

Non-profit staff is seen as motivated in distinctive ways when compared to workers in other sectors through greater commitment, stronger non-monetary orientation and greater degrees of altruism to serve others (Jäger et al. (2012) and Bassous (2014)). **The strong mission attachment among staff has led conventional wisdom to assume that they are seen as willing to work for lower salaries and fewer benefits** because they associate so strongly with the organisational goals (Bassous, 2014; Benz, 2005**). However, in a time of recession, non-profit organisations are faced with the dilemma of cutting back on terms and conditions, while at the same time relying more than ever on dedicated staff to deal with increasing demand.**
"A lot of voluntary employers seem to think that because the social purpose of the organisation is so laudable, that people ought not to fuss about their salaries, their working conditions and other issues" (Cunningham, 2001:236) (Mahon, 2016)

The current economic climate in the country was something which was very prevalent in the minds of those interviewed**, in terms of increasing needs of clients, further demands on services and negative impacts on employment terms and conditions. Staff interviewed felt in some cases that there was an expectation that staff could do more with less, and it was assumed that pay and conditions were not as important to them.**
"Sometimes it's seen as, 'well you've a caring personality so just get on with it'. Well it takes a bit more than a caring personality." (Interview D)
Staff perceived a shift in approach by organisations, to what one interviewee described as becoming more business-like (Interview F). This influenced opinions about senior management, especially when implementing cuts, taking decisions about the direction of the service and whether staff trusted them to act in line with the organisational ethos (Interview A). Interviewees also reported more administrative tasks within their day- to-day role. **Relying on mission attachment alone to motivate staff – at the expense of terms and conditions and work tasks – may be ill-advised when "the link between their work and the mission has become weaker because of the loss of time to provide services as a result of excessive workload"** (Kim and Lee, 2007:241) (Mahon, 2016)

Multiple budgets: People facing multiple needs require help from a wide range of services, each funded from different budgets, held at different levels. Many agencies and commissioners view their role as being for a particular group of individuals (usually with one severe problem rather than multiple problems) and **allocate their resources accordingly** (Page & Hilbery, 2011)

Since 2012 the lead responsibility for commissioning drug and alcohol services has rested with local authorities. **Drug and alcohol services are increasingly being put out to tender at 2- to 7-year intervals.** There is a danger that the drive to reduce costs results in less flexible services, with service

users increasingly being asked to fit in with strict appointment schedules, and less access to consultant psychiatrists. Homeless people, for whom flexibility is especially important, may be disproportionately affected by these changes and less able to access services. Homeless people may also find a lack of continuity in services particularly difficult to navigate, partly because they may have more complex substance misuse problems, necessitating a longer treatment journey, **and also because it may take longer to build up a trusting relationship between client and key worker**. As a Faculty we would urge that consideration be given to longer commissioning cycles for substance misuse services (The Faculty of Homeless and Inclusion Health & Pathway, 2018)

All the case studies reported difficulties in recruiting staff, particularly nurses, who were willing to work on the streets with people sleeping rough. Depressed wages and short-term contracts related to the short-term nature of funding through the Rough Sleeping Initiative made it hard to attract workers with the right level and type of expertise to make a real difference. This impact was felt across sectors – the NHS, the voluntary, community and social enterprise (VCSE) sector and local authorities (The King's Fund, 2020)

However, short-term contracting and funding – sometimes a result of national project funding rather than local commissioning – makes it difficult to retain staff and the process of retendering contracts can cause significant barriers to progress. Commissioners need to actively manage and minimise these risks (The King's Fund, 2020)

Commissioning for sustainability
Interviewees highlighted the potential of funding from the government's Rough Sleeping Initiative for piloting new services such as integrated hubs or new specialist roles. **However, they were sometimes struggling to use this funding in a way that did not destabilise existing successful services. We heard of areas being offered money for a new pilot project at the same time as money for an existing scheme was being cut. Both providers and commissioners were finding it difficult to retain skilled staff and high-quality services. Secondments were being used as one solution to this, but there was a danger that this was a short-term response to a broader workforce crisis** (The King's Fund, 2020)

We also heard concerns about the sustainability of local funding, and the instability caused by continual contract renewal, as well as clashing commissioning cycles of the clinical commissioning group and local authorities. **Others reflected that the lack of stability from commissioning created particular challenges: when services were 'forever in a state of flux' it was hard to achieve good outcomes for people who need the space and time to recover from being homeless** (The King's Fund, 2020)

Consolidated CMOC 3: Health System fragmentation and goals

Supporting data:

There is a limited evidence base on what works for these clients and, particularly in small specialist services, a lack of capacity and/or capability to evaluate effectiveness and impact
• Services often lack the flexibility to respond to complex needs and chaotic lifestyles • **There are few incentives to promote partnership working around clients with complex needs • It is easy for clients to fall between the gaps of different services leading to expensive unplanned care and clients 'revolving' through the system**
• There are gaps in and barriers to provision e.g. access to mental health services for those with dual diagnosis
• There is an artificial divide between clinical and social models of care (Cabinet Office Social Exclusion Task Force, 2010a)

Many of the practitioners noted the lack of joined up working between the numerous services that are involved in this client's care as a result the care is often fragmented, reactive and can be disordered. For example the voluntary and non-statutory services, that support people who are homeless, have different agendas to the public health services in the way they care for the clients (Davis & Lovegrove, 2016)

The main problems encountered in this sector are **excessive service fragmentation and duplication,** missing economies of scale, sometimes lack of skills and capacity, short funding cycles and the need for better mechanisms to share good practice (Gill et al., 2013)

b) Information sharing
"[We] need to check local connection as soon as possible. The referral comes via email or fax to us with as much information about the patient as possible, including their immediate medical history." Local Authority staff in particular talked about how critical it was to have sufficient information about the patient's housing status, local connection, and medical history, in order to put an appropriate response in place. Where this is outlined in the protocol, it was far more likely that this information would be received because medical staff were more aware of the local authority's needs and requirements (Homeless Link and St Mungo's, 2012)

However for others, this was an area which lay beyond the hospitals' remit. While some of this variation is likely to be affected by the individual nature of the staff role, it is also indicative of the lack of clear understanding about where the involvement of each sector or agency should start and end.
There was a clear lack of consensus about who is responsible for ensuring homeless people have somewhere to go on discharge. Within hospital settings, some staff perceived that the NHS does have clear responsibility for making sure a patient's housing need was taken into account and addressed while they were being treated.
"That's really difficult isn't it, because of all the other priorities that hospital staff are having to

deal with…I'm not saying that we don't have responsibility because I think we do and you need to see the whole picture, and that's part of it." Hospital vulnerable adult lead (Homeless Link and St Mungo's, 2012)

People emphasised the need for better joint working between different sectors. This would prevent people from being "bounced backwards and forwards" between **services without anyone taking full responsibility for their welfare.**
We have to have two people. If this person has got mental health and alcohol issues, to me those two teams should be working together. Not going off to [name of location] to see one and into [name of different location] to see another one because you know you're going to get a little bit of help over there. It just doesn't work. I'd like those two services to come together.
Sharing risk and decision making is always better than just one service trying to go it alone and people are getting access to services because they don't feel isolated any longer. **So when we get someone into a service where people used to be dumped before and everyone used to run and think "you're it!", now everyone else stays around the person, so besides the fact that the person's got a better outcome because they've got lots of people supporting them** (Making Every Adult Matter Coalition, 2015)

People with multiple needs want to be placed at the centre of their own support. However, people felt that their needs and aspirations were not always seen as a priority, and that services' ability to provide support can be limited by the way they are designed and commissioned.
People also felt that targets or conditions attached to funding meant that practitioners weren't able to focus on the individual and decide what was best for them (Making Every Adult Matter Coalition, 2015)

… if the services are being funded by criminal justice to do say DRRs [Drug Rehabilitation Requirements] things like that, **they've got targets to meet, so the actual individual has got no say at all because they're there on the basis of "you're here because you need to be here. We're here to get our wages because we've been told by the government, courts, prisons, whatever to do what we need to do and actually your needs come second to what we're setting out to do…"**
We talked about ways of finding more co-ordinated and consistent ways to work together across different services and sectors, and what this may mean for the implementation of a new national focus on multiple needs (Making Every Adult Matter Coalition, 2015)

Participants across all six groups explained that often the structure of primary care services made it difficult to engage with and access them. One man summarised his thoughts on accessing the public health system by saying: 'I think [accessing] healthcare should be as easy as making a cup of tea!! But it's not' [Homeless participant 4 (C)]. Another participant wrote 'Access to the information (chaos!)' [Migrant participant 1 (C)] when describing the difficulty they had finding relevant information on appropriate services and entitlements. Across the groups there was resentment of the level of access and quality of care on offer to patients who could afford private care:
'The wealthy get more, [and] get better time from the doctors than people who haven't got the money for it.' Homeless participant 1 (T) (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

By default, government departments focus on their specific areas of interest, promoting a 'silo culture'. The need for joint working has generally been accepted across government, but despite attempts to address it, the problem remains (Page & Hilbery, 2011)

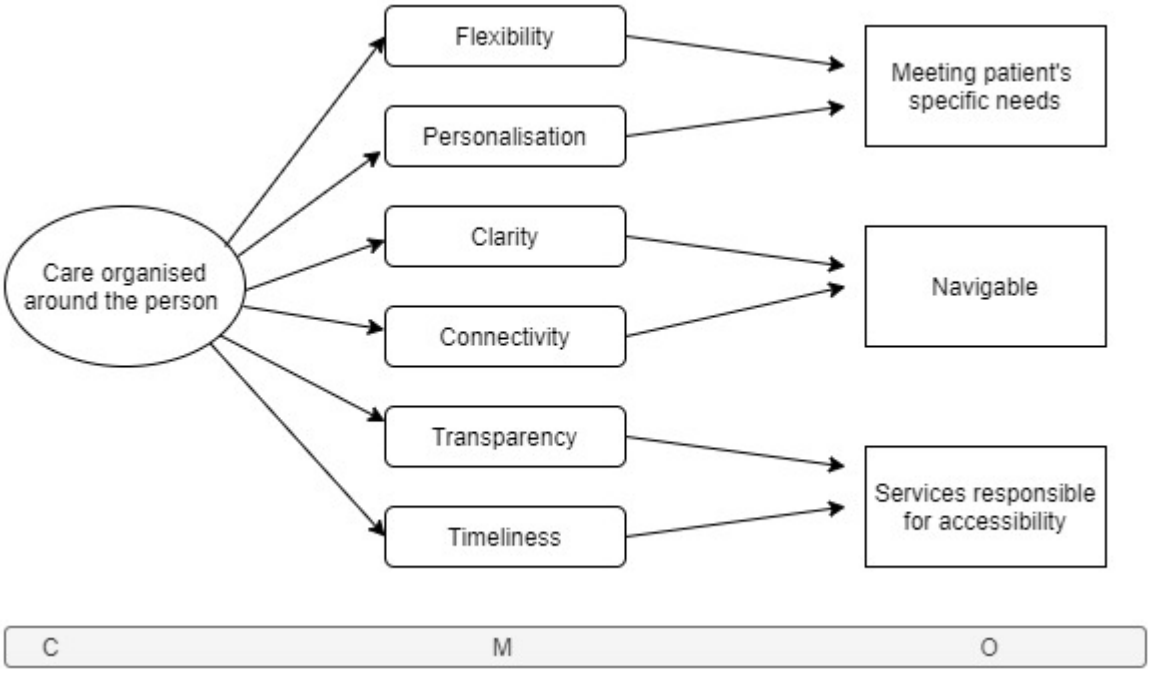
Commissioners are focused on outcomes which are narrow and specific to their sector. The approach of government departments filters down to local commissioners. This leads to them and the services they commission replicating the 'silo culture', **focusing on a narrow range of outcomes rather than on the wider set of issues that contribute to multiple needs and exclusions**. Joint

commissioning has grown over the past decade but needs to go further, with a specific focus on this group (Page & Hilbery, 2011)

Giving staff permission to flex the system and do the right thing enabled people sleeping rough to access effective support. Senior leaders helped to foster a safe, supportive, 'no blame' approach – one that asks staff to use reasonable flexibility in the client's best interests (The King's Fund, 2020)

Commissioners are responsible for the way services are designed and delivered. They can use their powers to bring people together, create partnerships and focus on the best response for meeting the complex health needs of people who sleep rough (The King's Fund, 2020)

Consolidated CMOC 4: Care organised around the person



Supporting data:

The second Australian paper described a community–based nursing role in caring for PLHIV that enhanced the care of PLHIV who have difficulty accessing health care. Located within a team of HIV specialist nurses in a not–for–profit community nursing organisation in Melbourne, Australia and operating within a flexible model of care, this new role complemented the existing program by providing HIV specialist nursing assessment and continuity of care to address the growing number of HIV clients with complex needs. This was primarily a descriptive study, within a post–positivist or constructivist paradigm. **The roles described involve assertive outreach, care–coordination and inter–agency collaboration. Using case studies and interviews with specialist HIV nurses, the authors highlight the importance of a client and family–centred approach, participatory care planning and care coordination, cultural competence, and adherence to principles of social justice and equity** (Crock, 2016)

Knowledge of services was also highlighted as central to access (French et al., 2003) which was often

provided by peers (Aviles & Helfrich, 2004; Hudson et al., 2010) **and assertive staff follow up** (French et al., 2003) (Dawson & Jackson, 2013)

This suggests that **targeted, co-ordinated networks of PHC and accommodation services that provide continuity of care** for homeless youth may have some benefits (Dawson & Jackson, 2013)

A lack of coordination between service providers according to some youth lead to the unavailability of 'one stop shopping' for health needs particularly in respect to accessing prescribed medications. Youth described the proliferation of agencies with endless bureaucratic requirements involving interagency referrals, the need for identification cards, time-consuming paperwork, and lack of continuity of care (Christiani et al., 2008) (Dawson & Jackson, 2013)

Keep treatment regimens as simple and straightforward as possible. Make follow-up procedures easier by having some walk-in appointments and evening hours. Learn about youth services in your community so that you can make prompt referrals and initiate collaborative care and support (Elliott, 2013)

There is an ongoing, urgent need for street-accessible medical clinics and youth agencies targeting this population, along with focused intervention programs for regular medical follow-up and on-the-spot testing for STIs and pregnancy**. Health care practitioners need to provide anticipatory guidance to reduce harm, prescribe medications at no or low cost, choose simple treatment regimens, and ease follow-up by offering walk-in appointments and care during evening hours** (Elliott, 2013)

A Pathway team is a simple intervention designed to break these cycles of failure and exclusion**. A Pathway team is a specialist medically led multidisciplinary homeless team based in the hospital. It works with and alongside a patient's medical team to enhance the quality of care offered during their time in hospital**. Teams include housing specialists working alongside clinicians so that before the patient leaves hospital a plan has been developed for their onward care. Teams are led by specialist GP's who bring their knowledge and skills of caring for homeless people in the community, as well as their expertise in prescription of methadone, personality disorder, and chronic disease management. Nurses manage team caseloads and bring vital clinical experience in homelessness, addictions and mental health, as well as practical knowledge of how to get things done in a hospital. Housing specialists bring their expertise to the bedside and help build links with voluntary sector services in the community. Some Pathway teams also include Care Navigators, paid staff who have personal experience of homelessness who focus on relationship building. Larger teams also include occupational therapists, social workers and mental health practitioners (FEANTSA, 2019)

The teams coordinate and host regular multidisciplinary team meetings, which are attended by key professionals within the hospital and by community services. They carry out ward rounds to review the care of all homeless patients within the hospital.

Pathway's research shows that multidisciplinary teams are most effective in addressing the multiple health issues homeless people face. National evaluations have shown that integrating housing and clinical staff leads to 'better outcomes and more positive working practice' (FEANTSA, 2019)

Patients need a holistic approach, as they are not experiencing their needs in isolation. Mental health, substance misuse and general health issues occur simultaneously with social and environmental needs (Gill et al., 2013)

Multi-disciplinary working should be encouraged from the beginning of clinical training, by stressing social inclusion aspects in formal education, as well as through secondments or volunteering (Gill et al., 2013)

Tier 0 – Awareness: This should represent a general standard of provision available across mainstream, generalist services, and particularly in primary care. It is based primarily around the ability of providers to spot patients who are potentially victims or at risk of social exclusion and being able to relate appropriately and referring to more appropriate providers. This should be the minimum standard expected from all providers.

• Tier 1 – Competence: Provision of a full range of primary care services in a generalist practice, with the appropriate elements of cultural sensitivity and the ability to provide some specialist resource, like a GP with a special interest (GPwSI) or a specialist practice nurse, or dedicated specialist sessions. Depending on levels of need, all localities with small populations at risk of social exclusion should have at least one practice with some specially trained staff who are able to provide a basic range of services.

• Tier 2 – Specialism: Services provided under this category should be specifically targeted for members of these socially excluded groups. Providers should be able to provide a full range of primary care services for moderately chaotic and distressed users, together with close links and the ability to signpost to other relevant services. This should also include inreach sessions from other more specialist services, including mental health counselling, specialist substance misuse, housing advice and similar services. Whilst specialist services of this kind should be available across the country, localities with a very low prevalence should cluster together and provide jointly with neighbouring commissioners.

• Tier 3 – Full Integration: This category defines highly specialised and integrated services, ranging from outreach and dedicated general practice to specialist intermediate care after discharge. Services of this kind are delivered by an integrated team of primary and secondary care clinicians working across boundaries. Given the high level of specialism, realistically those services can only be provided in densely populated urban areas, or in parts of the country with a very high numbers of any of the above groups. In other cases, commissioners should make appropriate arrangements with providers to guarantee access to referrals to the appropriate services based upon need on a case by case basis (Gill et al., 2013)

Overview of services Outreach: is a very important element, as it not only provides an opportunity for initial engagement on the streets, but also supports new rough sleepers before they become ‘entrenched’ in the lifestyle. ‘In-reach work’: provided by health professionals in the setting of hostels to preserve continuity of care and deliver care in a trusted environment. It should be a temporary measure to stabilise clients to help them subsequently to move on to lower intensity services.

Dedicated hospital pathway: it has been proven that a ‘transversal’ pathway, cutting across medical specialties has both a positive impact on the user experience and on the cost effectiveness of the care provided.

One-stop shop: is one of the key modes of provision for homeless people, combining basic facilities such as washing, with access to health services, housing, as well as Drug and Alcohol Services and various recreational and skill-building activities.

Peer-education: is a strong strategy to promote recovery and gradually empower disempowered individuals, while building up skills and capabilities to take up a place in society.

Cultural awareness training: is important for professionals, as it supports patients to build up confidence and self-respect, and be able to build a gradual road of recovery back into mainstream services.

Intermediate care: is one of the often overlooked grey areas between intensive in-hospital care and the community. The rationale is to provide appropriate step-down care in order to maximise recovery (Gill et al., 2013)

Diagnostic pathways required assessment in secondary care or public health departments. The RCT assessing completion of screening provided evidence that **peer support and incentives were of benefit**.19 An additional six observational studies reported uptake of diagnostic pathways. **In three studies in which arrangements were made for same-day assessment, or participants were escorted, supported or incentivised to attend, uptake was 70% to 92%.20,27,32 The other three studies reported following the usual referral pathways,22,27,36 and uptake of the diagnostic pathway was lower, at 44–57%.** Observational evidence thus supported experimental findings (Hamilton et al., 2018)

Homeless individuals believe health care is important, **but biomedical screening should incorporate a biopsychosocial response, with programmes adapted to the population's values,45 and which work holistically with programmes that address other health and social issues among the homeless. Screening programmes also need supported linkage to diagnostic and treatment pathways because progression beyond initial screening was often poor**. Some TB programmes adopt this holistic approach46 by combining ACF and case management (Hamilton et al., 2018)

We also find that HCV treatment access is also facilitated through a combination of low threshold treatment access alongside the delivery of supports in relation to adherence, treatment literacy, and social welfare**. Examples of targeted access support include: HCV treatment provision in OST services [45,60,61,93,123] and in conjunction with GP shared care [14]; relaxed eligibility requirements [14,45,60,61]; and flexible opening hours and appointment times [45,61,124**]. Targeted adherence supports include: electronic reminder systems [71]; coordination with pharmacies for medication dispensing [124]; directly observed therapy [59**]; respectful client centred continuity of care [**40,61,71]; nurse provided interferon injections [40]; improved phlebotomy services [45,61,124], including provision to use external jugular venepuncture [125]; and flexible OST provision, including access to take home doses [126] (Harris & Rhodes, 2013)

The highly compartmentalised nature of health care systems can create a barrier to comprehensive care for PWID whose needs are complex and may span multiple domains, such as drug dependency treatment, acute health care (wounds and infections), psychiatry and hepatology. Hospital-based HCV treatment is often not ideally suited to PWID due to: geographic distance; referral-associated delays [40]; inflexible appointment policies; lengthy waiting times [40,45,61,99,101]; limited infrastructure and psychosocial supports [46,90]; abstinence requirements [40,45]; and prejudicial attitudes of some staff to PWID [40,102]. **Barriers to HCV treatment access for PWID include a lack of continued engagement in medical care at the same site [37,61], with some PWID experiencing a lack of consistency in the management and monitoring of their HCV [8], and an accompanying confusion about HCV symptoms, test results and status [8,9**]. **Navigating health care systems and unfamiliar hospital settings can be daunting for PWID, particularly for those who may have had previous negative experiences with providers [8,45,74]** (Harris & Rhodes, 2013)

We lack the evidence to document here how, for instance, interventions targeting stigma reduction, stable housing, or systemic changes to treatment delivery, may impact upon HCV treatment access and uptake, and although having noted above some such examples [59-61], identify these as critical to future research. **Envisaging HCV treatment for PWID as socially situated implies that access is going to be best enhanced when treatment is designed in a combination intervention approach and when delivered through integrated multidisciplinary models** (Harris & Rhodes, 2013)

While less frequently documented or evaluated, evidenced targeted social supports include: peer support groups [128,130]; peer-workers integrated into HCV treatment provision [131]; improved psychological services [124]; and assistance with practical problems, such as transportation, accommodation and welfare benefit access [61,72,128]. The combination of social and structural supports facilitating HCV treatment access and engagement cautions against an overly narrow biomedical interpretation of combination intervention (Harris & Rhodes, 2013)

Barriers to HCV treatment access for PWID include a lack of continued engagement in medical care at the same site [37,61], with some PWID experiencing a lack of consistency in the management and monitoring of their HCV [8], and an accompanying confusion about HCV symptoms, test results and status [8,9]. **Navigating health care systems and unfamiliar hospital settings can be daunting for PWID, particularly for those who may have had previous negative experiences with providers** [8,45,74] (Harris & Rhodes, 2013)

In recognising HCV treatment need as relative, we caution against unrealistic expectations of treatment uptake. Initiatives to enhance treatment access and uptake among PWID are increasingly promoted in population terms, with modelling studies illustrating the cost effective prevention utility of HCV treatment for PWID [5]. Data demonstrating potential decreases in morbidity, mortality and health system spending are compelling in policy environments where treatment support and care for PWID are generally de-prioritised. **Against this impetus, it is important to recognise HCV treatment need as a product of 'situated rationality' wherein PWID are positioned as entitled to access any treatment available as well as entitled to defer or refuse such treatment. A population-based impetus to increase treatment access and uptake among PWID may place an unwelcome onus on already marginalised individuals to undertake treatment for which they may not be ready or willing. The promotion of universal treatment uptake (including for prevention effect) in the absence of developing concomitant social and structural interventions is a fragile and at best medium-term strategy. This also runs the risk of locating responsibility for low treatment uptake with affected individuals rather than with the social institutions and conditions generative of treatment access obstacles** (Harris & Rhodes, 2013)

Case Study 2 Greater Manchester: shared responsibility from the sub-regional to local level The Greater Manchester Hospital Discharge (Prevention of Homelessness) Protocol was launched in October 2011.
Initially the group sought a single protocol for the whole area but this proved too inflexible to local conditions and a more adaptable model was chosen. This model, launched in 2011, consists of two sections. Part one is a single overarching framework which sets out the principles that all participating bodies will adhere to. Part Two is locally developed by each local authority and hospital trust and sets out simple steps for all agencies to take which will help to prevent homelessness. This enables the protocol to take into account local variations in each of the 10 Greater Manchester housing authorities.
Staff we spoke to from Greater Manchester during the course of this research stressed how important it was for the protocol to clarify responsibility among different sectors and agencies at a broader level, with more localised policies to guide staff through the practical steps. 'We feel this protocol will help plug the gap in feedback and communication. It's now down to our regional

areas, but it's also individual to our type of patients that we get through our trust' (Nurse) (Homeless Link, 2014c)

The barriers to palliative care drawn from the data cover three broad areas (1) the chaotic lifestyles sometimes associated with being homeless, (2) the delivery of palliative care within hostels for the homeless and (3) the delivery of care within mainstream health care systems. **Much work is needed to promote trust between homeless people and the services that serve them, and collaboration between services to promote an integrated approach to care. Health care systems need to incorporate a greater degree of understanding and flexibility in order to be accessible to the homeless population and staff may require greater support and training in order to manage the emotional and practical burdens associated with their work** (Hudson et al., 2016b)

Suggestions for overcoming the complex needs and irregular lifestyles of homeless people in the delivery of palliative care included **taking a pragmatic, person-centered approach [6, 34], setting goals that are realistic in the context of homelessness [6] and removing discrimination and stigma from health care interactions** [33, 36, 37, 42] (Hudson et al., 2016b)

One suggestion for achieving this was the use of peer mentors, or experts by experience who could accompany, mentor or advocate for homeless people as they try to access health care services. Previous work from Groundswell in the UK has found that the use of peer mentors can be effective in increasing the confidence and motivation of homeless people to access health care and in decreasing reliance on unplanned secondary care services [57]. This may well be a model that could be extended for homeless people with advanced ill health (Hudson et al., 2016b)

The ability to work holistically was cited as the key to nurses' success when working with vulnerable patients in an evaluation of PMS schemes (PMS National Evaluation Team, 2002). Another key was the ability to work flexibly, which may help to break down the barrier of rigid working practices mentioned earlier. Even if they adopt an holistic approach, it is important that nurses are able to collaborate with other professionals and agencies as it is not within the capacity of one practitioner to meet all the needs (John & Law, 2011)

The attitudes of healthcare providers towards homeless persons proved to be a major theme, e.g. building and establishing relationships of trust [25, 32, 35, 37]. The treatment of homeless people was also reported to be an important theme as facilitator, e.g. a pragmatic and flexible approach from staff [25, 37, 45] (Klop, de Veer, et al., 2018)

To engage with the mental health problems of people from hard to reach groups when they do consult in primary care**, GPs must understand the patient's view of self and world and demonstrate this to the patient in negotiating the meaning of symptoms, diagnosis and treatment options** (Lamb et al., 2012)

To make services effective and inclusive, participants expressed that this often involves "going above the call of duty" **and "meeting people where they're at".** These opinions indicate that working with inclusion health target populations **requires active engagement and might necessitate service providers going beyond what might be expected from their role** (Luchenski et al., 2018)

Multicomponent interventions with coordinated care are most effective and should include both health and nonhealth services. Partnership working and service design around the whole person is necessary to achieve the best results (Luchenski et al., 2018)

The following were key principles of services that were valued by participants: **provide ample time and patience to really listen; strive to develop trust and acceptance; provide supportive,**

unbiased, open, honest, and transparent services in inclusive spaces and places; encourage clients to accept personal responsibility for health; allow clients to take ownership, have choices, and participate in decisions; and above all, promote accessibility, fairness, and equality (Luchenski et al., 2018)

People emphasised the need for better joint working between different sectors. This would prevent people from being "bounced backwards and forwards" between services without anyone taking full responsibility for their welfare (Making Every Adult Matter Coalition, 2015)

One of the ways people suggested this could be achieved was through a central point of contact, responsible for linking all of the different services together on behalf of the person concerned.
One person spoke of how using the MEAM Approach developed by Making Every Adult Matter has fulfilled this role in their local area, and the benefits it has brought.
Sharing risk and decision making is always better than just one service trying to go it alone and people are getting access to services because they don't feel isolated any longer. So when we get someone into a service where people used to be dumped before and everyone used to run and think "you're it!", now everyone else stays around the person, so besides the fact that the person's got a better outcome because they've got lots of people supporting them.
We recommend that: Commissioners should be accountable for ensuring local areas have joined-up services, and identify where people with multiple needs fall through the gaps (Making Every Adult Matter Coalition, 2015)

It is the **responsibility of the health education providers** to ensure their graduates attain the necessary skills, knowledge and attitudes that will enable them to deliver culturally responsive care. This includes **providing clinical experiences** that expose them to the unique needs of Aboriginal and Torres Strait Islander populations.
It is the responsibility of the health service provider to demonstrate culturally responsive leadership and build governance structures and environments that ensure health professionals are encouraged, expected and able to respond to the needs of Aboriginal and Torres Strait Islander people effectively. The processes and supportive structures around health service delivery are equally as important as actual health outcome measures when determining the overall effectiveness of health service delivery.
It is the responsibility of the health professional to deliver culturally responsive healthcare. Being culturally responsive places the onus back onto the health professional to appropriately respond to the unique attributes of the person, family or community they are working with. Self-reflection and reducing power differences are central to being culturally responsive; therefore making assumptions based on generalisations about a person's ethnic, cultural or social group is unacceptable. Part of the challenge of becoming culturally responsive health professionals is learning to reach beyond personal comfort zones and being able to comfortably interact and work with people, families and communities who are both similar and markedly different.
IAHA asserts that all health professionals need to be both clinically competent and culturally responsive to positively affect the health and wellbeing of Aboriginal and Torres Strait Islander people (McMillan, 2013)

This feeling was echoed by others who noted that GPs often wanted very brief consultations, and even then they were not listening to the health problems being explained to them. This was described as:
'A conveyer belt; just in one door and out the other … get your prescription and of out the door with you.' Homeless participant 2 (T) (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

Collaborating with a key worker seemed to remove some of the impediments to accessing primary care discussed previously. Other participants mentioned having transport to clinics,

and attending services that offered a comprehensive approach to healthcare for their needs. One example mentioned a location where medical and harm reduction services were co-located: 'It's easy to get to because they [key workers] come and collect you, and bring you to A, and get you back here. Because that's a big part of stopping you from getting there as well as the, is trying to get there so you know what I mean. It's easier to be picked up and brought … so you have your [addiction] counselling or whatever, the doctor there and your one to ones [needle exchange] all in the one.' Drug using participant 2 (T)
The roles of peer advocates and key workers serve as important facilitators to reengagement with the primary healthcare system. It is not surprising then that the homeless group, drug users, sex workers and Traveller participants all mentioned these types of support as priorities (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

In this study, homeless veterans accessing a population-tailored open-access primary care model had significantly more primary care visits and fewer medical admissions than did those homeless persons attending a traditional general internal medicine clinic (O'Toole, Buckel, Bourgault, Blumen, Redlhan, et al., 2010)

Outreach models made it easier for young people to contact services [27,64,69], along with colocated services [72], and being able to drop in [65]. Waiting times [23,28,30,35,38], opening hours (a lack of afterhours services) [23,28,34,45,65], and eligibility for the service (including age and other intake criteria) [38,65,71] were also noted as access barriers. Service availability for priority health conditions, perceived or actual, also affected access [26,28,31,39,41,42,47,61] (Robards et al., 2018)

Navigation can be improved by reducing duplication, simplifying referral and appointment systems, strengthening services partnerships and linkages, and improving clarity about service roles and colocated services. Navigation support is also worthy of further exploration (Robards et al., 2018)

Theme 6. **Ability to navigate the health system is hindered by complex, fragmented bureaucratic health systems. Young people face challenges in knowing how to access services [59,75,78,81] and navigating complex, bureaucratic, and fragmented health systems [30,70]. Young people dislike retelling their story [24]. Bureaucratic referral and appointment systems can make navigation of the health-care system more difficult [64,65,69]. Navigation was aided by services partnerships [64] and linkages [67], clarity about service roles [69], and colocated services** (Robards et al., 2018)

The included studies suggest that ACP, PC, and EOLC interventions for homeless persons need to be intensive, comprehensive, and accommodating toward their unique situations. As this population experiences unpredictable, inadequate housing, and limited social and family supports, interventions must attempt to compensate for these gaps by delivering an array of health and social services. Interventions tailored for homeless persons, such as support homes, shelter-based PC, and harm-reduction programs may be effective in addressing these needs. **Providing professional support with a flexible approach is important, especially regarding distinct psychosocial needs, history of substance abuse, and barriers to accessing care** (Sumalinog et al., 2017)

People who sleep rough are often characterised as 'difficult to reach'. **However, staff working in this field were quick to challenge this label. They argued instead that local authorities and the NHS had a responsibility to design services that people who sleep rough could easily access**. They wanted to create opportunities to find and connect with the population who sleep rough (The King's Fund, 2020)

Leaders should be committed to collaboration – and to taking responsibility. Multi-agency working to tackle rough sleeping requires a commitment to collaboration across the system. But someone needs to take the lead, someone has to drive the strategy and someone has to have the authority to call people to account for delivering their individual responsibilities for improving outcomes for people sleeping rough. Particular attention needs to be paid to where responsibilities intersect or stop (The King's Fund, 2020)

Is there a shared understanding of what 'doing the right thing' for a person sleeping rough looks like, with staff confident they have the permission to flex the system to achieve this?

Examples of approaches that local areas valued:

• Senior leaders raise the profile of rough sleeping and set high expectations about service delivery.

• Staff use reasonable flexibility in the client's best interests; recognising that there is no easy way to manage sometimes incompatible eligibility criteria.

• Opportunities for staff to develop a shared understanding about different professional approaches, and how to work effectively together (The King's Fund, 2020)

Improving capacity and capability
There is a wide range of health services nationally, but a far smaller pool of experienced nurses focused on holistic and integrated healthcare for people experiencing homelessness. This type of healthcare is time and labour intensive. **It is vital that commissioners understand the complexities around engaging and building relationships and trust with people who are homeless as one of the crucial elements of delivering healthcare** (The Queen's Nursing Institute, 2018)

Homeless Health Nurses in their own words: The following selected quotes indicate the type of comments made by HHNs regarding improving the quality of local health and housing systems:

Collaboration:

- **'A multidisciplinary team comprising of doctor, occupational therapist, physiotherapist, social worker, peer mentors, health navigators, and outreach drug and alcohol workers for each hostel.'**
- **'Better resourced and coordinated multi-disciplinary health and social care team, with an emphasis on psychological services and therapeutic arts.'**
- 'Easy access to dedicated multidisciplinary team to include health, social care and housing.'
- **'To have a contract with the local GP so that we could link to NHS services to enable me to prescribe, refer directly, link to the hospital courier to enable on-site phlebotomy and smears. This would improve timely interventions.'**
- 'Support integrated working with adult social services, substance misuse services and mental health services.'

Improvements in holistic care pathway:

- '**Integrate health and social care services to create a single pathway that is holistic.'**
- **'Streamlining of processes and a compassionate response from staff. Looking at cases individually.'**
- 'Linking with intense support services to enable support and concordance.'

(The Queen's Nursing Institute, 2018)

Using integrated primary care models provide optimal continuity of care for veterans' multiple

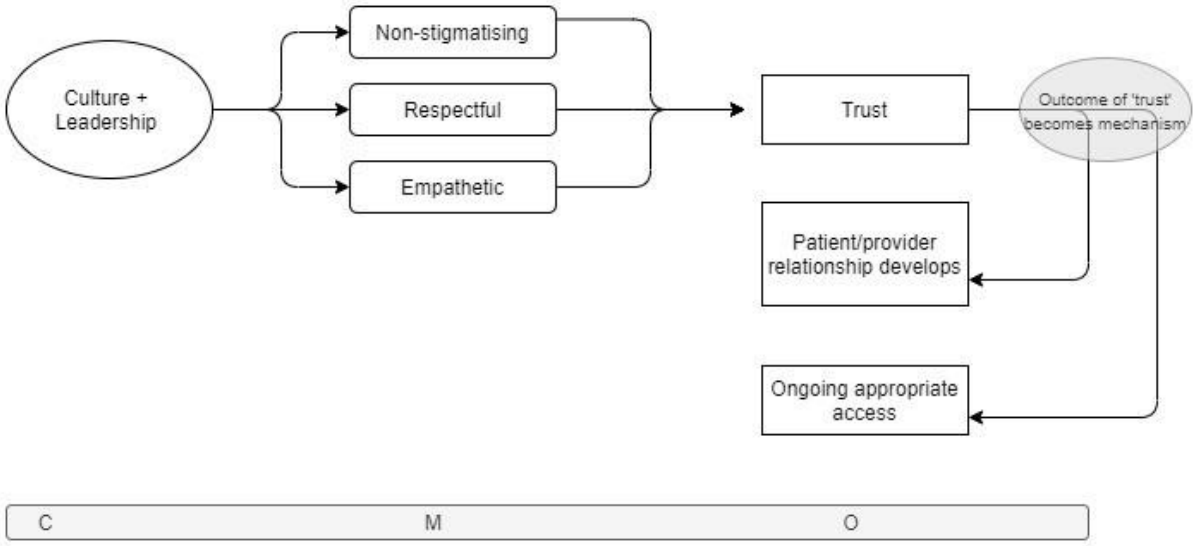
comorbidities and potentially specialized situation. The majority of these recommendations are tailored to the VA system (McGuire et al., 2009; O'Toole et al., 2013), but could also be applicable to other civilian healthcare systems. Since the VA is nationwide, it is able to represent our country's diverse population and the various frameworks can simply be modified to fit the needs of other healthcare institutions. **The most noteworthy recommendations to improve the health of the homeless requires combining resources in one location and using a comprehensive integrated primary care approach that can be generalizable across all homeless populations (Kertesz et al., 2013; McGuire et al., 2009; O'Toole et al., 2011, 2013).** Moreover, working to provide continuity of care for homeless veterans may increase their own personal engagement in their health and improve their overall quality of life (J. Weber et al., 2017)

Various studies have looked at new models for providing integrated health care to homeless veterans. The first study (McGuire, Gelberg, Blue- Howells, & Rosenheck, 2009**), investigated whether a clinic integrating homeless, primary care, and mental health services for homeless veterans with serious mental illness or substance abuse would improve medical care access and physical health status. Outcomes indicated that veterans in the integrated care group received primary care appointments more quickly, had higher levels of preventive care, and lower levels of ED use than veterans in the traditional group** (McGuire et al., 2009). These findings suggest that an integrated model can improve the quality of medical care for the homeless and particularly those with serious mental illness (J. Weber et al., 2017)

An integrative and comprehensive approach is needed to improve and optimize diabetes outcomes for people experiencing homelessness. This includes delivering tailored and socially appropriate care and building partnerships with key stakeholders such as healthcare providers, social workers, homeless shelter staff, and those experiencing homelessness (White et al., 2016)

McGuire et al22 assessed the effect of an integrated primary care clinic for homeless veterans with serious mental illness and substance abuse disorders, on primary care access and overall physical health**. The integrated clinic provided primary care, mental health, substance abuse, and social services in one location; the standard clinic linked homeless veterans to primary care and social services located in separate facilitates**. Patients were followed for 18 months, with interviews occurring at baseline, and months 6, 12, 18 after enrollment. Homeless veterans at the integrated clinic had shorter wait periods for their initial primary care visit compared to patients at the standard clinic (0.3 vs 53.2 days). In addition, during the 18-month period, patients at the integrated clinic had more primary care visits per patient compared with patients at the standard clinic (7.4 vs 4.7 visits) (White & Newman, 2015)

Consolidated CMOC 5: Inclusive culture and leadership



Supporting data:

The authors speculated that success was based on the development of reciprocal, caring relationships between outreach workers and clients, stating that 'in some cases, the relationship with the outreach worker may have been the most meaningful one in the client's life' (Crock, 2016)

Previous experience of services and positive perceptions of counselling affected health care seeking behaviour (French et al., 2003) and the availability of a case manager and/or youth worker (Aviles & Helfrich, 2004) (Dawson & Jackson, 2013)

Research indicates that HCV treatment fears, or disinterest, at the level of individual PWID can be exacerbated by**: low patient and provider treatment literacy** [9,27,41-43]; fear of medical investigations, particularly involving biopsy and phlebotomy [37,40,44,45]; concerns about potential relapse to, or exacerbation of, injecting drug use [31]; **communication problems with providers** [36,46]; **and previous stigmatising and negative experiences with health care systems and providers [27,40,45,47,48]. At the outset then, it is clear that individual level concerns have a context, in that they interplay with both social as well as systemic factors (such as stigma and mistrust of treatment delivery systems)** (Harris & Rhodes, 2013)

At a macro level, stigma related to injecting drug use and HCV can result in political inaction – with community and government antipathy to issues affecting PWID impacting on funds allocated to resource HCV testing, treatment and care [82,83] (Harris & Rhodes, 2013)

HCV treatment access requires social intervention
In recognising HCV treatment access decisions as a relative concern, it becomes clear that individual-level concerns are shaped by, as well as reproduced through, a variety of social factors which interact as barriers to accessing treatment. This means that PWID who are both in need and eligible for treatment may be unable to realise their treatment opportunity. We have identified social stigma, housing, criminalisation, health care systems, and gender as key domains in the conditionality of HCV treatment access, and thus also, as important targets for social and structural change (Harris & Rhodes, 2013)

b) Monitoring
"We don't collect data because we don't report on discharge." Local Authority

To underpin this work, some staff felt that more needs to be driven at a management level. They also felt more can be done to record and collect data to enable them to routinely monitor the outcomes for their homeless patients. **Some expressed that the work they do was despite, rather than because of, formal policies for homeless people.**
Some areas had systems in place to monitor outcomes for homeless clients. In one, for example, homeless clients are entered onto a database. If a client is readmitted this gets highlighted so that the case can be reviewed. However 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. Many staff said they would welcome the system to do this.
"There needs to be a way of how we monitor, how we know that what we're doing is actually working or not. We need to look at our coding." Nurse (Homeless Link and St Mungo's, 2012)

In facilitating access to palliative care, building or rebuilding trust between homeless people and health care professionals was considered vital by homeless people [33, 35, 42] and those supporting them [6, 9, 37, 38]. It was recognised though that this would not be easy:

> **"You have to earn it. You have to show that you want to do something for them [homeless people]. You have to be respectful and treat people with the same kind of treatment that you would want. It's often word of mouth. One client will say, "Listen, you can trust her" - Harm reduction outreach worker [38]** (Hudson et al., 2016b)

The development of trusting relationships between health and social care services and homeless people was identified in this review as a potential mechanism through which to facilitate access to palliative care for homeless people (Hudson et al., 2016b)

Contrasting with the previous theme, a lot of studies in the theme 'relating to the interaction between homeless people and healthcare professionals' described facilitators and substantially fewer studies described barriers between homeless people and professionals. The attitudes of healthcare providers towards homeless persons proved to be a major theme, e.g. **building and establishing relationships of trust** [25, 32, 35, 37**]. The treatment of homeless people was also reported to be an important theme as facilitator, e.g. a pragmatic and flexible approach from staff** [25, 37, 45]. Furthermore, providing activities and therapies was also often mentioned as facilitator for the interaction between homeless people and healthcare professionals, e.g. counsellor-guided advance directive completion [41, 42, 46]. **Feelings of being ignored, discriminated against and disrespected by healthcare providers and a lack of trust were often mentioned as barriers** [26, 33, 35–38, 45] (Klop, de Veer, et al., 2018)

Trustful and respectful relationships were also mentioned as a recommendation for delivering care; as well as attention for different domain of concerns of homeless people compared to healthcare providers, flexible programs and availability and support after death (Klop, de Veer, et al., 2018)

Efforts to enhance access need to account for the symbolic and social boundaries that marginalised citizens' experience, in addition to more obvious physical and institutional boundaries to accessing health services. (Klop, de Veer, et al., 2018)

Findings raised the importance of talking to somebody else who would listen, and be understanding. **Trust and confidentiality were often considered paramount** (Chew-Graham et al., 2002; Palmer and Ward, 2007). Less explicit though perhaps equally important was that the person who was listening respected the boundaries set by those disclosing (Luoma and Hakamies-Blomqvist, 2004; Rother and Buckroyd, 2004; Tierney, 2008) (Lamb et al., 2012)

Our prior theoretical review suggested that we focus on understanding the problems of access from the perspective of potential service users, their perceptions and their interactions with health providers. We discovered that a number of groups did have what could be regarded as more traditional problems in accessing treatment: transport difficulties; residential instability; lack of time to engage with the health system; questions over their eligibility for primary health care; and a lack of understanding of the health care system. **However, the most powerful barriers to access related to personal, cultural and social beliefs about the appropriateness and legitimacy of addressing issues they regarded as appropriate emotional responses to adverse social conditions within the health care system** (Lamb et al., 2012)

They also emphasised the need to reduce language, communication, and cultural barriers as well as fear, poor awareness, and judgmental attitudes of service providers. Participants felt that the media should be encouraged to promote positive messages about people experiencing exclusion to reduce stigma and stereotyping, which were perceived as barriers to accessing effective interventions (Luchenski et al., 2018)

It is the responsibility of the health service provider to demonstrate culturally responsive leadership and build governance structures and environments that ensure health professionals are encouraged, expected and able to respond to the needs of Aboriginal and Torres Strait Islander people effectively. The processes and supportive structures around health service delivery are equally as important as actual health outcome measures when determining the overall effectiveness of health service delivery (McMillan, 2013)

Culture can be defined as complex beliefs and behaviours acquired as part of relationships within particular families and other social groups
Culturally responsive care can be defined as an extension of patient centered-care that includes paying particular attention to social and cultural factors in managing therapeutic encounters with patients from different cultural and social backgrounds
IAHA views it as a cyclical and ongoing process**, requiring health professionals to continuously self-reflect and proactively respond to the person, family or community with whom they interact** and can predispose people to view and experience health and illness in ways that can influence decisions, attitudes and beliefs around access and engagement in healthcare. This may include acceptance or rejection of treatment options, commitment to treatment and follow up, success of prevention and health promotion strategies, perceptions of the quality of care and views about the facility and its staff (McMillan, 2013)

Discrimination and prejudice experienced by some participants led to feelings of isolation from the rest of society, and this in turn contributed to poor mental health. Anger and despondency were the emotions some participants described when faced with these prejudices. Some participants experienced multiple challenges and forms of marginalisation, as this quote from a participant who was drug using and also sex working shows:
'I'm on heroin, and I've been struggling with that since I'm fourteen, so I've been dealing with things on the street [sex working] then as well, which is really hard, and I got mixed up with that all through my addiction, which I'm not proud of but it's kind of… I mean when you sit at your bed at night like you're thinking, I've all these health issues and you're kind of scared to go [for help] about them. And then when you do go about them, there's no one that actually wants to listen, that's the way you feel.' Sex working participant 2 (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

Participants in the homeless, drug using and sex worker groups spoke about the support of key workers in helping them to try to understand the complexities of the primary care system. Examples of practical supports with making telephone calls, reminders for medical appointments and the

provision of transport to appointments were all described in these groups**. One said of the supportive relationship she had developed:**
'I personally deal with a man called B and he's just great, he knows all about the addiction; why would you start on it [heroin] and I mean he meets me and we'd go anywhere for a cup of coffee, sit down. And I notice when you leave [the meeting] then … it's kind of like a breath of relief you know; you say to yourself– that was really nice.' Sex working participant 2(T) (O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

Nonjudgmental attitudes of professionals, including being welcoming, open-minded, and unassuming [23,24,29–33,35,36,40, 45,53,57,69,84], and trust, including building trusting relationships [22,24,29,33,53,63,72] and trust in services [46,51,65, 66,69,71,75,84], were strong themes (Robards et al., 2018)

Theme 5. Service environments and structures need to be welcoming and respectful of all groups of young people. Welcoming, respectful, and nondiscriminatory service structures and environments are especially important in engaging marginalized young people. . . .**Inclusive language and resources [56,59] and the use of welcoming signals [53] to create an atmosphere of respect and trust were important in creating inclusive services for a range of marginalized groups** (Robards et al., 2018)

Health disparities and lower quality care are exacerbated when health care organisations fail to address the links between ethnicity, culture and language in health service provision (Wilson-Stronks, et al., 2008). Moreover, there is strong evidence that people from diverse backgrounds, particularly patients with low English language proficiency, can receive poorer quality health care compared to mainstream patients, and are more likely to experience a 'trajectory of accident opportunity' and/or adverse events in their journey through the health system (Rural and Regional Health and Aged Care Services, 2009)

Leaders should be committed to collaboration – and to taking responsibility. Multi-agency working to tackle rough sleeping requires a commitment to collaboration across the system**. But someone needs to take the lead, someone has to drive the strategy and someone has to have the authority to call people to account for delivering their individual responsibilities for improving outcomes for people sleeping rough. Particular attention needs to be paid to where responsibilities intersect or stop** (The King's Fund, 2020)

Leaders should work to gain political buy-in and support. The problem of rough sleeping evokes a range of views about how individuals should be treated. As a group, they may not be afforded the same sympathies as other groups of patients who also have poor health outcomes. Local leaders can play a crucial role in developing a shared narrative – and a common purpose. This framing can set powerful expectations about how the local area will respond to meet the needs of people experiencing rough sleeping (The King's Fund, 2020)

Is there a shared understanding of what 'doing the right thing' for a person sleeping rough looks like, with staff confident they have the permission to flex the system to achieve this?

Examples of approaches that local areas valued:

• Senior leaders raise the profile of rough sleeping and set high expectations about service delivery.

• Staff use reasonable flexibility in the client's best interests; recognising that there is no easy way to manage sometimes incompatible eligibility criteria.

• Opportunities for staff to develop a shared understanding about different professional approaches, and how to work effectively together (The King's Fund, 2020)

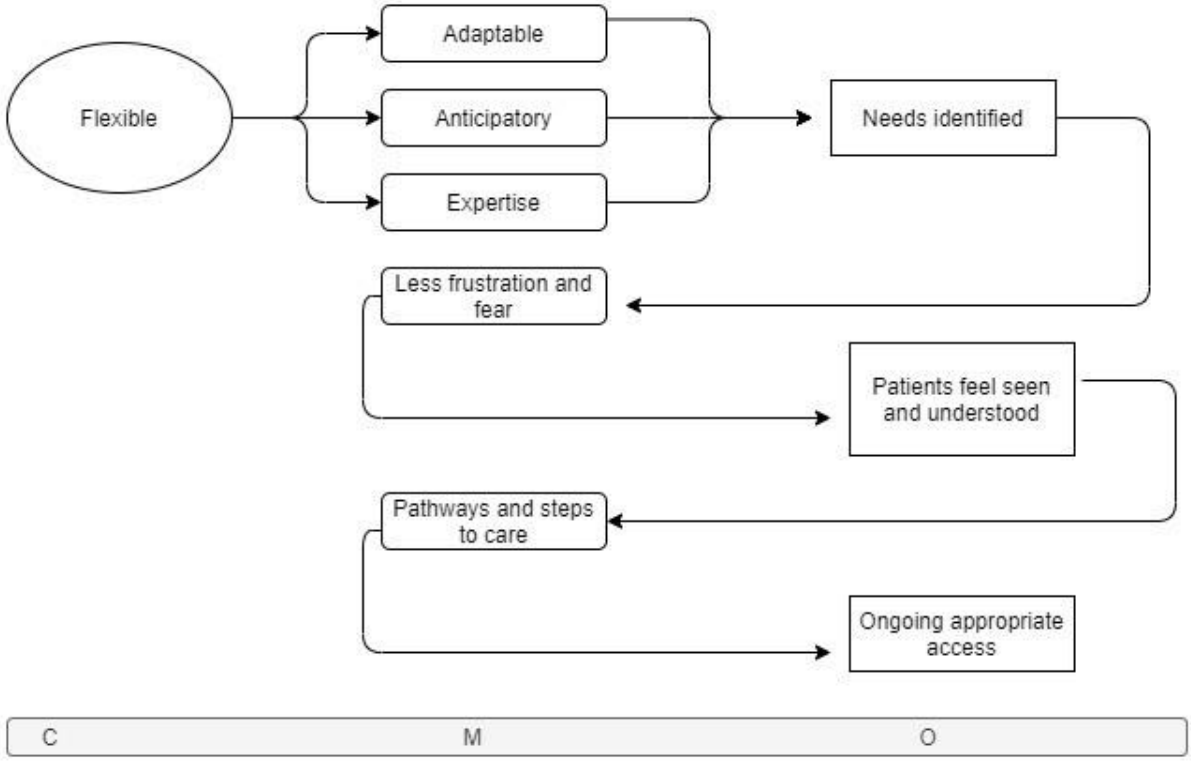
The King's Fund has published extensively on what makes for good system leadership, **with distributed responsibilities and a culture of compassion and inclusion being key** (Naylor and Wellings 2019; Timmins 2019). Much of this work has focused on leadership across a health and care system and the importance of having **a shared narrative, relationships built on trust, deep engagement of staff and communities and strong partnership working across organisational and professional boundaries** (The King's Fund, 2020)

Local areas are not yet functioning in a way that fully meets the needs of people sleeping rough. Staff therefore often have to work around systems, rules and procedures rather than through them. There are high levels of passion and knowledge among staff working with this group in the NHS, local authorities and the VCSE sector. Systems need to work to nurture, sustain and capitalise on this.
• Developing a shared sense of purpose across a system can bring people together and act as a basis for integrated working. **We saw senior leaders raising the profile of this issue and setting high expectations about service delivery**. Different services came together to agree a common vision and approach, **and this set the tone for staff delivering services to work together towards a shared goal.**
• Giving staff permission to flex the system and do the right thing enabled people sleeping rough to access effective support. **Senior leaders helped to foster a safe, supportive, 'no blame' approach – one that asks staff to use reasonable flexibility in the client's best interests** (The King's Fund, 2020)

Peer and lay worker roles show a high degree of closeness to community, with boundary spanners encouraged to engage their family and social networks for their health promotion activities or to extend their community-based networks through their role. **The predominant characteristics of the peer and lay roles are trusted, supportive, empathetic and non-judgemental**. As the titles suggest, the lay and peer boundary spanners were valued for their closeness to community and willingness to work with citizens. Only two of six lay examples noted lay workers had prior health knowledge or experience [40, 53] and none of the six peer examples mentioned prior health knowledge or experience as a requirement (Wallace et al., 2018)

Important factors in the experience of satisfaction of primary health care among the homeless was investigated in 1 study (n = 17).**21 Participants wanted health care providers that were committed to their care and engaged them respectfully. Also vital to satisfaction with care were interpersonal interactions that demonstrated empathy, sensitivity, and acceptance. Additional satisfaction care delivery factors that were critical included homeless persons having confidence and trust in their providers, as well as the knowledge that they would not be stereotyped or prejudged because of their housing situation** (White & Newman, 2015)

Consolidated CMOC 6: Flexible healthcare delivery



Supporting data:

Street clinic, residential, less structured setting

Free service with extended opening hours

Treatment drop-in (familiar, accessible) places - Open-door policy - Nonjudgmental and supportive therapists (Brown et al., 2016)

The second Australian paper described a community–based nursing role in caring for PLHIV that enhanced the care of PLHIV who have difficulty accessing health care. Located within a team of HIV specialist nurses in a not–for–profit community nursing organisation in Melbourne, Australia and **operating within a flexible model of care, this new role complemented the existing program by providing HIV specialist nursing assessment and continuity of care to address the growing number of HIV clients with complex needs**. This was primarily a descriptive study, within a post–positivist or constructivist paradigm. The roles described **involve assertive outreach, care–coordination and inter–agency collaboration. Using case studies and interviews with specialist HIV nurses, the authors highlight the importance of a client and family–centred approach, participatory care planning and care coordination, cultural competence, and adherence to principles of social justice and equity** (Crock, 2016)

Common themes in providing appropriate services to help overcome these barriers include a flexible approach; longer appointments to enable assessment and investigation of complex healthcare needs; assertive outreach; offering support in a range of settings including street-based support, and a triage approach where different health needs are prioritised and addressed through a structured health programme46,85 (Davis & Lovegrove, 2016)

Health care practitioners need to provide anticipatory guidance to reduce harm, prescribe medications at no or low cost, choose simple treatment regimens, and ease follow-up by offering walk-in appointments and care during evening hours.
Health care workers should administer applicable vaccines at any available opportunity. Ask all youth about their immunization status. Advise how to access 'catch-up' or new vaccines. Better yet, be prepared to provide them 'on-the-spot' in any office setting.
Keep treatment regimens as simple and straightforward as possible. Make follow-up procedures easier by having some walk-in appointments and evening hours (Elliott, 2013)

Given the high rates of mental health diagnosis – including addictions – in SIY, at least an initial mental health screening should be integrated into various health care settings, focusing on suicide risk, self-harm and whether an individual is a risk to others (Elliott, 2013)

Previous research has highlighted the barriers homeless people experience in accessing primary care and the importance of steps such as **flexible appointment times, having services based in homeless agencies, and training to help medical staff understand homeless people's needs** (Homeless Link, 2014c)

Community based staff may also be in a position to advocate for homeless people in health care situations, due to their longer term relationship and thereby understanding of the individual's needs;
"Three or four of these clients since I've started working here have been recognized by the workers at [harm reduction program]. They know to call us and that we'll follow through with helping with appointments and referrals to the [EoLC]" – Health care professional [38] (Hudson et al., 2016b)

The barriers to palliative care drawn from the data cover three broad areas (1) the chaotic lifestyles sometimes associated with being homeless, (2) the delivery of palliative care within hostels for the homeless and (3) the delivery of care within mainstream health care systems. **Much work is needed to promote trust between homeless people and the services that serve them, and collaboration between services to promote an integrated approach to care. Health care systems need to incorporate a greater degree of understanding and flexibility in order to be accessible to the homeless population and staff may require greater support and training in order to manage the emotional and practical burdens associated with their work** (Hudson et al., 2016b)

The ability to work holistically was cited as the key to nurses' success when working with vulnerable patients in an evaluation of PMS schemes (PMS National Evaluation Team, 2002). Another key was the ability to work flexibly, which may help to break down the barrier of rigid working practices mentioned earlier. Even if they adopt an holistic approach, it is important that nurses are able to collaborate with other professionals and agencies as it is not within the capacity of one practitioner to meet all the needs (Synoground and Bruya, 2000) (John & Law, 2011)

Patients prefer to use a GP who specializes in the care of the homeless [32] (Klop, de Veer, et al., 2018)

Allow for patients to have "unscheduled" space to share their life stories and to acknowledge those stories [37]
A pragmatic approach by staff, facilitating flexible care solutions, such as the choice where to die and accepting that planned activities may not happen or need to be cancelled [25, 37, 45] (Klop, de Veer, et al., 2018)

Contrasting with the previous theme, a lot of studies in the theme 'relating to the interaction between homeless people and healthcare professionals' described facilitators and substantially fewer studies

described barriers between homeless people and professionals. **The attitudes of healthcare providers towards homeless persons proved to be a major theme, e.g. building and establishing relationships of trust** [25, 32, 35, 37]. **The treatment of homeless people was also reported to be an important theme as facilitator, e.g. a pragmatic and flexible approach from staff** [25, 37, 45] (Klop, de Veer, et al., 2018)

Findings raised the importance of talking to somebody else who would listen, and be understanding. **Trust and confidentiality were often considered paramount** (Chew-Graham et al., 2002; Palmer and Ward, 2007). Less explicit though perhaps equally important was that the person who was listening respected the boundaries set by those disclosing (Luoma and Hakamies-Blomqvist, 2004; Rother and Buckroyd, 2004; Tierney, 2008).
This was linked to the perception that health professionals were unable or unwilling to engage with the patients' understanding of who they are and how they relate to the worlds they inhabit. This emerged as fundamental to people's understanding of aetiology, the way they framed their problems, their decisions to seek help and the behaviours they adopted in living with chronic mental health issues (Lamb et al., 2012)

In contrast, a free clinic in Los Angeles was identified by youth as a model for best practice (Christiani et al., 2008**). Here youth appreciated staff that did not keep them waiting, listened and discussed health care options with them**. Homeless youth were not 'hassled' when they lost their patient identification cards and were reissued cards without a lecture. In addition their preference for healthcare delivery was accommodated at sites already known to and frequented by homeless youth (such as drop-in shelters) (Lamb et al., 2012)

There are few data on homeless people's perceptions of services for mental health problems. Bhui et al. (2006) conducted a literature review of homeless service users' perceptions of services for homeless mentally ill people and was supplemented by a qualitative in-depth survey of 10 homeless people. **Mismatch between expectations and provision, disputes with healthcare providers, dissatisfaction with the degree to which they have choice in their care, and suspicions about the intentions of health professionals demonstrate the extent to which powerlessness and social exclusion are replicated in healthcare economies. The inadequacy of hostels and their staff are also emphasized. They were particularly concerned about stigma, prejudice and the inadequacy and complexity of services that they have to use** (Bhui et al., 2006). (W. H. J. Martens, 2009)

Collaborating with a key worker seemed to remove some of the impediments to accessing primary care discussed previously. **Other participants mentioned having transport to clinics, and attending services that offered a comprehensive approach to healthcare for their needs. One example mentioned a location where medical and harm reduction services were co-located: 'It's easy to get to because they [key workers] come and collect you, and bring you to A, and get you back here. Because that's a big part of stopping you from getting there as well as the, is trying to get there so you know what I mean. It's easier to be picked up and brought … so you have your [addiction] counselling or whatever, the doctor there and your one to ones [needle exchange] all in the one.'** Drug using participant 2 (T)
The roles of peer advocates and key workers serve as important facilitators to reengagement with the primary healthcare system. It is not surprising then that the homeless group, drug users, sex workers and Traveller participants all mentioned these types of support as priorities
(O'Donnell, Tierney, O'Carroll, Nurse, & MacFarl, 2016)

The ability to develop an ongoing personal connection [48] involved rapport with service providers [85], continuity of therapeutic relationships [65,72,76,84], and a usual source of care [80] (Robards et al., 2018)

The included studies suggest that ACP, PC, and EOLC interventions for homeless persons need to be **intensive, comprehensive, and accommodating toward their unique situations.** As this population experiences unpredictable, inadequate housing, and limited social and family supports, interventions must attempt to compensate for these gaps by delivering an array of health and social services. Interventions tailored for homeless persons, such as support homes, shelter-based PC, and harm-reduction programs may be effective in addressing these needs. **Providing professional support with a flexible approach is important, especially regarding distinct psychosocial needs, history of substance abuse, and barriers to accessing care** (Sumalinog et al., 2017)

Substance misuse services should above all be flexible and able to provide individualised care. Requirements for entry into treatment, particularly opiate substitution therapy, should be reviewed on an individual basis; for example, rigid requirements to provide multiple urine samples or attend pre-treatment groups may result in some clients being unable to access treatment. Clients with complex prescribing needs should be seen by clinicians with sufficient expertise and authority to be able to override treatment protocols when necessary.
2.94 Flexible entry requirements and prompt access are particularly important for clients directed into treatment by the criminal justice service (The Faculty of Homeless and Inclusion Health & Pathway, 2018)

Where there are significant numbers of homeless or other excluded people, specialist services may be necessary; in other areas enhanced access to mainstream services may suffice. In both situations, services should be provided to the standards outlined. A willingness to work around relatively high rates of non-attendance at appointments will help to ensure that patients are not further excluded. It is crucial that mental health services are integrated with other health services and that there is good communication between them (The Faculty of Homeless and Inclusion Health & Pathway, 2018)

Appendix 5: Study 2 Realist interview guide

Realist interview and focus group guide

Realist interview technique aims to test specific programme theories about how a complex intervention works for whom and in what setting. According to Manzano (2016): "Theories are placed before the interviewee for them to comment on with a view to providing refinement. The subject matter of the interview is the researcher's theory and interviewees are there to confirm, falsify and basically, refine the theory. This relationship - described as a teacher-learner cycle - is distinctive of realist evaluations. It starts with teaching the interviewee 'the particular programme theory under test' and then 'the respondent, having learned the theory under test, is able to teach the evaluator about those components of a programme in a particularly informed way' (Pawson and Tilley, 2004, p.12). Therefore the roles of teacher and learner are not static but become interchangeable between the interviewer and the interviewee during the process of thinking through the complexities of the programme."

Below are some questions which may be useful for testing the initial theories for the current study but which may also be refined, added to, and/or partially discarded during the individual interview or as the set of interviews progress as needed to best inform the theory testing and further theory development.

Interviews with professionals working in homeless healthcare

Introduction: Explain the study and tell them about the goal of understanding health system factors that promote healthcare accessibility for populations experiencing homelessness

Questions:

1. Contextualising the role of the interviewee:

Asking the interviewee about their involvement in providing healthcare access or healthcare services to homeless adults.

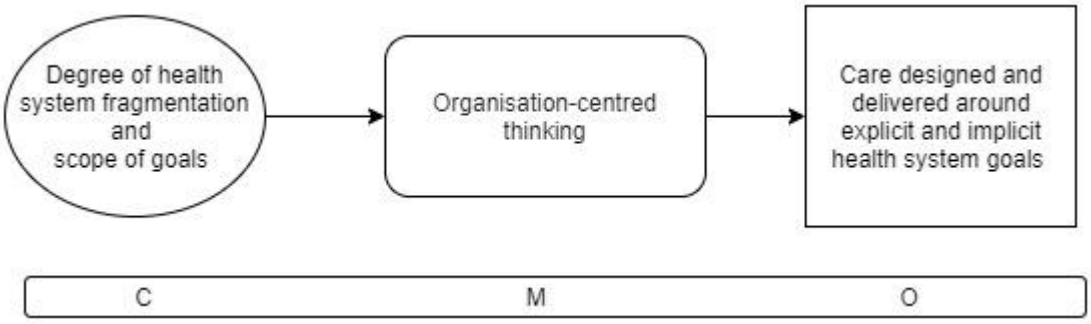
2. Theory testing and refinement:

a. Some of the research that I have read about health system factors shows that funding cycles in health services for homeless populations are often short and unstable. Is that your experience? Could you tell me more about that?
b. I have also read that funding is sometimes earmarked for a specific project which may interfere with or take time away from other established services. Is that your experience?
c. I've read that the length of funding sources and the number of funding sources has an impact on stability and sustainability of services and as a result their ability to hire and retain good staff. What is your experience of that?
d. In what other ways do funding arrangements affect service stability?
e. In what other ways do funding arrangements affect staff satisfaction?
f. Perhaps show CMOC to show how I have synthesised my findings from other research. Does this look right based on your experience? What is missing? What are examples where this

doesn't happen this way? What happens next? Is this cyclical or does it only happen sometimes?

[Follow up questions depending on how the first exchange goes (eg What have you seen of the effect of funding cycles? What happens when there are a number of funders of services versus a few? What happens when some services are specifically funded by grants intended only for a specific service or activity? What happens if funding cycles are short vs long? For whom do current funding arrangements in your organisation work? And not? Why?) responding to interviewee and digging deeper into interesting parts]

g. Additionally, I have read research which shows that providing access to health services for homeless population is difficult because services are fragmented and disconnected. For example, health services are fragmented and not well connected and it makes it difficult for providers and staff to see the big picture of how to provide comprehensive care for each patient. Is that your experience?
h. How does the fragmentation affect patients?
i. How does it affect providers? You might expect providers to focus on a small part of the patient journey? Are they able to provide linked, comprehensive services?
j. Who might fragmentation be working well for and who does it work poorly for?
k. Why?
l. I have also read and been told by others in interviews that the performance benchmarks providers and staff have to meet and the rules they have to follow impact the way services are provided. For example, if a provider has to meet certain goals or targets within their organisation it may be difficult to align those goals with the needs of the patient. What is your experience of this?
m. How does this affect patient care?
n. How does it affect providers?
o. Who might it be serving well?
p. Why?
q. How is performance management done? Measured? Etc?
r. Is performance management, targets or goals ever intended to translate into good healthcare access for homeless populations? How? In which instances?
s. Perhaps show CMOC if helpful. Does this look right based on your experience? What is missing? What are examples where this doesn't happen this way? What happens next?



[Follow up questions depending on how the first exchange goes (eg How connected or fragmented do you think services are for this population? What is the effect of that on the ability of providers to meet patients' needs?) responding to interviewee and digging deeper into interesting parts]

3. Wrap up and assistance with further study

Interviewees will be asked for help in identifying sources of information such as grey literature and organisational policy and operations documents, as well as identifying other potential interviewees who may have something to add to the study.

Focus group with experts by experience:

At least one focus group with the Depaul panel of experts by experience will also seek to test and refine programme theories but in a less directed manner to allow the participants to take ownership over the process.

Similar to one-to-one interviews, several theories will be presented to the focus group arising from the data collected in interviews and from the findings of the totality of realist evaluation up to that point. For example, a preliminary programme theory might again look as follows:

> In a context where healthcare services are located in different places and patients have to go to different appointments at different places to fully address a given issues, people experiencing homelessness might experience healthcare as being inaccessible because it takes too much work and resources to complete treatment.

A question to test that theory might be as follows:

'I have heard that if someone needs a health treatment and they have to go to different clinics or different places in a hospital and sometimes have to attend multiple times. Have you experienced this? How might it impact whether someone actually gets help for their problem? Do you have any examples of where services have been organised in a way to be easy to navigate where you didn't have to go multiple times? Who do you think that the services are organised for? Why?'

References:

Manzano, A (2016) The craft of interviewing in realist evaluation. Evaluation, 22 (3). pp. 342-360. ISSN 1356-3890 https://doi.org/10.1177/1356389016638615

Appendix 6: Study 2 interview participant information leaflet

Participant Information Leaflet

Study Title: Delivering equitable healthcare access for homeless adults in Dublin

Name of Investigator: Rikke Siersbaek, PhD student, Centre for Health Policy and Management, Trinity College Dublin
Name of Supervisor: Prof Steve Thomas, Director Centre for Health Policy and Management, Trinity College Dublin

This study is conducted in partial fulfillment of the PhD degree at Trinity College Dublin.

1. **Research purpose and procedures:**
   This research is a case study to describe and appraise the current landscape of healthcare access for homeless adults in Dublin, and to make policy recommendations to deliver better access. The research will be based on in-depth documentary analysis and a series of one-to-one semi-structured interviews.

2. **Risks and discomforts**: None expected

3. **Potential benefits**:

   <u>For participants:</u>
   Participants may find empowering to talk about experiences they have had and to be able to pass on their particular expertise and insight into an area they are well familiar with.

   <u>In general:</u>
   The hope is that this research will be used to inform future resourcing, planning and delivery of healthcare access for homeless individuals to both their gain and more broadly to the gain of the health service and society as a whole.

4. **Provisions for confidentiality**: Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the research team.

5. **Voluntary participation and the right to discontinue participation without penalty:**
   You have volunteered to participate in this study. You may withdraw at any time without having to give a reason. If you decide not to participate, or if you withdraw, you will not be penalised.

   If any significant new findings arise during the course of the study that might affect your willingness to continue participation, you will be informed.

6. **Contacts for additional information:**

If you have any questions or concerns, please contact Rikke Siersbaek, Centre for Health Policy and Management, Trinity College Dublin at rsiersba@tcd.ie or 0838390374

7. **Termination of participation by the investigator:** You understand that your Principal Investigator may stop your participation in the study at any time without your consent.

8. **Permissions:** The study has obtained ethical approval from the HPM-CGH Research Ethics Committee at Trinity College Dublin. The investigator has also obtained permission to conduct the study with assistance from the Inclusion Health team in St James's Hospital, from its lead Dr Clíona Ní Cheallaigh.

9. **Access to transcripts:** Copies of the transcript of their interview will be made available to you and, where appropriate, you will be given the opportunity of deleting any wording that you may perceive as identifying you.

Appendix 7: Study 2 informed consent form

Informed consent form

PROJECT TITLE: Delivering equitable healthcare access for homeless adults in Dublin

PRINCIPAL INVESTIGATORS: Rikke Siersbaek, PhD student.

Supervisors:
Steve Thomas, Trinity College Dublin
Sara Burke, Trinity College Dublin
Clíona Ní Cheallaigh, Trinity College Dublin and St. James's Hospital
John Ford, University of Cambridge

BACKGROUND:
This research is a case study to describe and appraise the current landscape of healthcare access for homeless adults in Dublin, and to make policy recommendations to deliver better access. The research will be based on in-depth documentary analysis and a series of one to one semi structured interviews. Interviews will be asked to give an hour of their time. Anonymity of participants is assured.

DECLARATION: I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: _____
CONTACT DETAILS: _____
PARTICIPANT'S SIGNATURE: _____
Date: _____

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE: _____
Date: _____

Please return to Rikke Siersbaek, PhD scholar, Centre for Health Policy and Management, Trinity College Dublin, 3-4 Foster Place, Trinity College, Dublin 2 (Keep the original of this form in the investigator's file, give one copy to the participant, and send one copy to the sponsor (if there is a sponsor).

Appendix 8: Study 2 (realist evaluation) conceptual codes

Codes

Name	Files	References
Advocacy	2	5
Behaviour	2	4
Catchment area	2	2
Clinical supervision	2	7
Committment	1	1
Coordinated care	9	35
Coping mechanism	2	2
COVID-19	3	9
Culture	6	20
Decision maker	5	5
Duty of care	2	3
Education	2	5
Empowerment	2	3
Enabling supports	2	7
Exclusion	5	12
Expertise	1	2
Flexibility	5	18
Fragmentation	8	22
Funding	7	19

Codes

Name	Files	References
Funding tied to goals	6	17
Gaps	4	6
Goals	7	24
Short-term	2	3
Governanace	5	17
Clinical guidelines	2	5
Risk assessment	1	3
Health systems approach	9	23
Hierarchy	4	13
High level leadership	7	21
Incentives	3	3
Inclusion health	3	7
Individually driven	6	24
Information flows	6	14
Interagency communication	8	24
Leave before attend	3	5

Codes

Name	Files	References
Opportunistic	3	8
Organisational structure	4	6
Pathways	3	6
Person-centredness	10	38
Policy	5	6
Proactive	6	14
Professionalism	4	9
Frustration	2	2
Professional insecurity	1	6
Protection - licence	1	4
Uncertainty	2	3
Punitive	3	5
Quality of Access	5	19
Reflective practice	1	1
Relationships	6	19
Rules	3	9
Safetynet services	2	3
Secondary trauma	2	4
Segregation	5	9

Codes

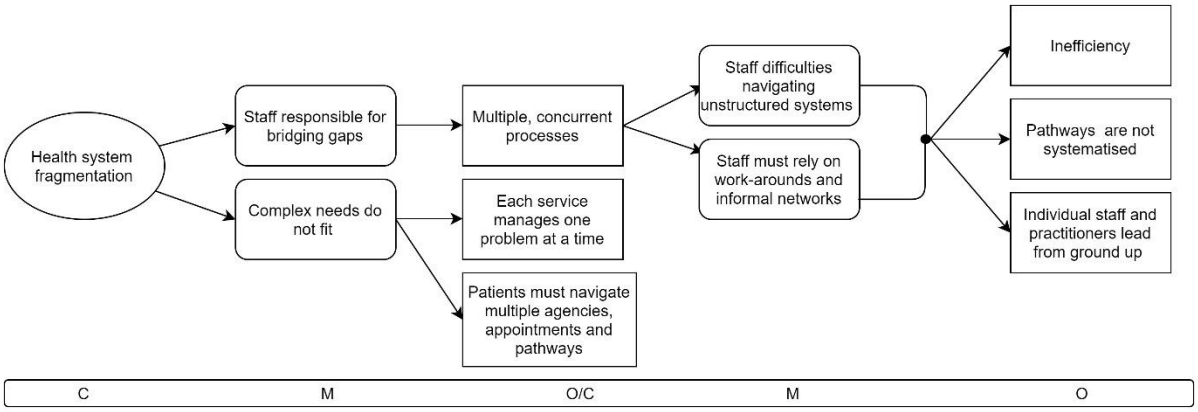
Name	Files	References
Service design	10	31
Innovation	4	7
Social determinants	4	8
Specialised	5	8
Specialised homeless care	9	31
Staff wellbeing	3	8
Staffing	2	5
Stigma	4	9
Structure	8	15
Training	4	7
Trauma	4	8
Trust	1	3
Waiting lists	1	1
Workarounds	6	18
Workload	2	9

Codes

Name	Files	Referen
Level	0	0
Community	3	8
Inpatient	2	3
Outpatient	3	4
Primary	4	10
RIght level of complexity	1	3
Secondary	5	10
Mainstream	9	23
Exposure	5	7
Family support	2	3
Lessons from homeless care	4	5
Stretch	1	2
Multidisciplinary	5	19
Need	3	5
Health vs other needs in person's li	1	1
Patient vs practitioner	5	20
Norms	7	11
Nurse role	4	12

Appendix 9: Data used to construct study 2 (realist evaluation) consolidated CMOCs

Consolidated CMOC 1



Supporting data:

“And usually, I think that's not intentional, but it's unintentional, but just that their complexity and the way that we think I suppose the biomedical model where it's one disease that you're treating doesn't fit in very well with social exclusion, where people have multiple diseases, multiple things going on, I would actually argue that that one disease at a time fits very few cases that very few people, but particularly in socially excluded people, and it goes right through so in terms of service delivery, how the services are delivered, to what time the clinic is at where it is, how you accesses it how you make appointments, health workforce, in terms of training in terms of who, from which social groups doctors” – Interviewee 1

"And I think the more we set up this, this idea that, and support and resource, a safety net, rather than primary care and non-fragmented general practice, I think the more fragmented healthcare, you get. And I would be of an opinion that we need to do more to fix the fundamental issues and gaps, as we've been articulating, with the first port of call, rather than buttressing up a safety net, that can just fragment care further, and cause more division. And I think for a variety of reasons therefore, it is imperative to support primary care and general practice first, to absolutely call it stigma amongst healthcare professionals and say it's uprofessional and have sanctions. And then, after and in parallel with that obviously support a safety net. And then in the safety net to actively support someone getting back into general practice, which I don't believe is really happening. I think there are malincentives". – Interviewee 3

“It has cost me a lot of fall out professionally with other clinicians trying to access care for my population because mainstream services, follow the guidelines and they follow strict appointment times and well you didn't show up three times so now you have to go back to the doctor and I'm like, grand, I'm writing the referral right now, no you give them another appointment like you're just making me go through a process that doesn't need to happen because somebody said that you needed to do it. But why are you doing it? . . . Does it affect the behaviour of the person, does it actually increase the availability of the service, or your waitlist to be addressed? Like, it's just an arbitrary rule. And I think that more mainstream services that do that continue to exclude our

population and what we try to do, is we adapt the guidelines. You know, we consider the guidelines and use them to the best of our ability to meet the needs of a population that the guidelines aren't written for." – Interviewee 4

"It is so much easier when I have one contact in this department, I have one contact here and you have the people that you contact and they know where you're coming from and they know where you're coming from". – Interviewee 4

"I think specifically the hospital and this has always been something that I've done, because I've worked with people, for a long time that don't go to hospital don't go and like traditionally it's the epilepsy clinics, the hepatology clinics, the HIV clinics. So, for about 10-15 years I have colleagues in those sites. Now so I have the networks, I have the experience". – Interviewee 4

"As much as it like has seen huge amazing, amazing progress in terms of awareness and things like that but, it is very much based on individuals, and those individuals when they're not there, you know. . . And I suppose it shouldn't be like that because that's how it fails, you know. Because it's. . .maybe I'm being too harsh, but I feel like if it's based on me or [name of nurse] or [name of nurse] or [name of doctor], I think you know I think there has to be driving forces in leadership. They should be able to function without us and I worry that wasn't the case. Because the healthcare hasn't really taken it on as part of their system. It relies a lot on going okay, would you fix that grand, push it over there. . . I think they're happy to have people that are doing these system pieces. You know they can get outcomes, even better, and if we don't have to finance much, even better. And we can show improved health, great, but if those people aren't there you'd wonder, are the systems there to keep it going?" – Interviewee 5

"So okay, so systems like that. I find the MDT [clinician/staff-led multi-disciplinary meeting with staff and clinicians from across Dublin health, housing and social care services], I find what it is, is that you have a lot of like-minded, various experiences around a table. And I find it works and I've kind of adapted that, we've adapted that to other areas. So like what I was saying like the diabetic foot service, like we have a little MDT every week. And it's not that we're going to change the world with it but all our eyes on this particular person for that, for that be it five to 10 people in various circumstances, opportunistically. So eventually when that person lands in the ED, there's a note on the system, it's like you know, get the podiatry service over to them you know, as when you can because they've been trying for it and then if they can, at that point, they'll come over". – Interviewee 6

"And I can see when it works, I can see where if you had more time, you could do more work, erm but very much the system, you know, you've said, it's been said so many times, but now I'm starting to quote it, you know, erm you break your leg or whatever, and you come into hospital, that you have somebody who's going to drop in your stuff to you, you've someone who's going to pick up, you're going to have a phone, you're going to have contact, even in COVID times . . .you leave the hospital on the day, someone's going to pick you up or will organise it and you have a pharmacy to go to you, have money to collect them. And it's just all those simple things. . . the cohort, particularly I suppose the emergency accommodation people that we would be looking after or even those, it's very overused, the word chaotic, I suppose. But people who have a lot of things going on in their lives. They even more so have more things to be thinking about while they're in here and more worries. And they just don't deal with that system. The system just is not made out for them. So just off the bat, which I know you've heard, but working here you see it.' - Interviewee 6

". . the concern is if you have someone who, with a disability, for example, who's homeless, or they've always had a disability, and then they become homeless, and then the next minute, they're serviced by the homeless, erm homeless health teams, which doesn't make sense, because just because they lose their home, it doesn't mean they can't still access disability services. It's that kind of so it's kind of like, you know, the mental health addiction thing. You can't fit into one box, I think every service is overlapping and comorbid conditions, I think every service has to be aware and considered of those and also of the kind of social determinants". – Interviewee 7

“So for me, everything in terms of systems come from the top down. Because we're an acute system we're not a grassroots organization that are starting something and changing something. Whereas Inclusion Health are trying to be a grassroots organization within a hierarchical structure. So for me, it's all around the culture of the organisation, and how that sets up things for the whole population group. So, for example, the leadership within the hospital system would not necessarily be well versed in the additional needs, some patient groups have . . .” – Interviewee 8

‘If I'm working with a client [in mainstream health services] they'll know me, they'll build up a relationship with me - I'm [name] I'm their [practitioner]. . . That doesn't happen with homeless people that you work with because they have so many people involved . . . like oftentimes they will, but there'd be a portion of them that will get confused - who are you again?” – Interviewee 9

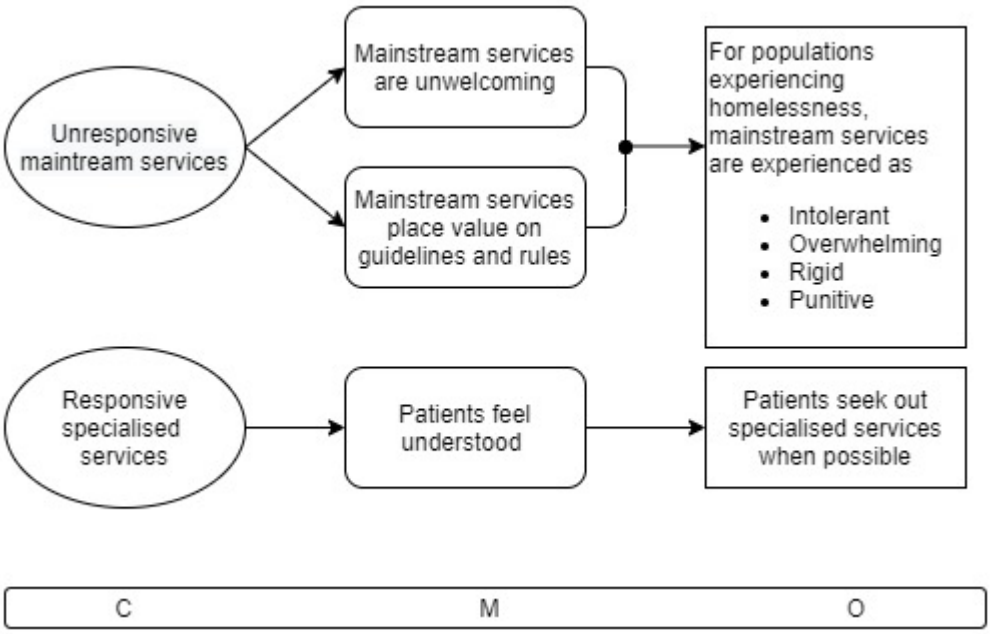
“I think one of the stand out aspects of this sector is the interagency work. So that collaboration is different to what you see in other mainstream health services. And I think purely because it has to be. Erm I think the need kind of leads us a little bit but it's a good approach to have" – Interviewee 9

“Yeah, I think that the way we prioritise our service delivery model is based on what's good for, what works for the 70% of society, who go to work, and can keep appointments. Erm obviously, the people who design things come from that cohort. . . appointment times, 10 minute consultations, type of clinic, the way even a clinic looks is built for the 70% of society. It's not built for the drop-outs of society. So obviously, it doesn't meet their needs. Erm they can't keep appointments, don't prioritise healthcare. Erm the system we have built, they weren't involved in . . . They weren't involved in commenting on the design. So obviously, it doesn't work. It works for the 70%. Erm, and excludes the others. So that's the problem. That's a barrier in the service delivery” – Interviewee

“Erm I found that by following [in research work], you know, the primary care practitioners, public health nurse, GP, the different services, by hanging around I actually saw the same person, that's how I know, when I say to the person who looks like seven people to the system I saw the same person coming in, in this domain. And then I was in another domain, the actual same person, and the two services had never spoken, and the three services and then in another domain, so that the problem of that homeless person or the drug user looked far more complex from the fragmented service because it was fragmented.” – Interviewee 12

“You know, homelessness is being looked at from an accommodation point of view which is all ridiculous. And, and accommodation isn't married with health. [Inaudible] there is a whole problem with the system at the moment is erm it's reactive . . . and if something goes wrong and a workaround is created and work arounds are talked about as if they're positive things. And the whole thing is now clogged up, because so many workarounds you can't even see what the system, the thing's supposed to be in the first place. And it's weighed down with the workarounds and then work arounds on top of the work arounds.” – Interviewee 12

Consolidated CMOC2



Supporting data:

"So I think so there is a huge piece around the philosophy or the psychology of the health system and how it decides who's worthy of care and the way that it responds to addiction or certain behaviours. . . And I think that probably is a systems thing, because it's built into the system and it's reflected through the system, but then also a lack of flexibility. So I think sometimes people who design healthcare see it as like a factory, a conveyor belt, erm, but that model doesn't fit to people who have a lot of other issues going on. And so that would be another big barrier. But to be honest, I think actually probably the most important pieces around who deserves what and how, how our perception on some level that feeds very much in at a system's level that if you punish people, or if you help people that or make it easier for them to access things that you're rewarding bad behaviour, and they're going to engage in more of it. And I think that's partially why the system is very punitive". – Interviewee 1

"I do think there are certain skills in managing, you've got, this is a highly traumatized population. And so a lot of their issues are behavioural issues. . . so you build up a set of skills for working with those people. But . . . you have to be really careful that people get caught up with your service. So in other words, if someone is attending a homeless service, and then they go back, they get accommodation in the community. Over the next year, you should wean them off your service". – Interviewee 2

"It has cost me a lot of fall out professionally with other clinicians trying to access care for my population because mainstream services follow the guidelines and they follow strict appointment times and well you didn't show up three times so now you have to go back to the doctor and I'm like, grand, I'm writing the referral right now, no you give them another appointment like you're just making me go through a process that doesn't need to happen because somebody said that you needed to do it. But why are you doing it? What's it based on how? Does it affect the behaviour of

the person, does it actually increase the availability of the service, or your waitlist to be addressed. Like, it's just an arbitrary rule. And I think that more mainstream services that do that continue to exclude our population and what we try to do, is we adapt the guidelines. You know, we consider the guidelines and use them to the best of our ability to meet the needs of a population that the guidelines aren't written for". – Interviewee 4

"And I think that's where, cause there's some practitioners in homeless health that aren't accessible. There's some that don't demonstrate the values that or the same commitment or the same approach. It's definitely on a spectrum even within our services. There's some people that have terrible times with nurses and doctors and there's some that they would prefer to go to because they know they're met with a certain approach. But what I've learned is that… It took me a long time to really realise is that it's not my agenda. It can never be what I think they need to do and as soon as you step back from, you know, well, if you stop drinking then you won't have this bleed and you won't end up in hospital, and therefore you won't die . . . as soon as you step back from erm, you know, thinking that they need to, it's task oriented for you as a clinician, and that somebody needs to stop doing this so that they become healthy. Then, I felt that it relieves all that pressure and all that anxiety on me to make that person change. . . My job is to just support them to understand the impact of those things. And to provide them with alternatives should they want them, but also provide them with alternatives to keep them as healthy as possible while they still do the thing that's detrimental to their health. So, regardless of the fact that you're still drinking alcohol, and that it's really bad for you, we're also going to look after you know your nutrition, we're also going to look after, you know, we're going to give you your flu vaccine and we're going to do all these things for you. The focus isn't always going to be on the one thing that is, is the bad thing that you're doing . . . Healthcare providers need to be flexible, opportunistic. It takes like 5000 more tries to do one thing. And it's those little little wins that are the success stories. People always ask me isn't it sad that people never stop or that they never get better, and you know it's little things like oh my gosh they actually went to that appointment today. That took me nine, that's nine months of not nagging them but gently, you know, you could have six failed attempts to get somebody to this one place and then they finally go, and it's just about the fact that you need to be creative, that the usual pathway that you follow or how things are supposed to happen. You need to understand that that's not going to happen that way. You need to be really creative in how you bring that support to the person or how you get that person to the support and it takes a long time". – Interviewee 4

"I could pick out a few individuals that still come in and the staff will still say oh, they're asking for you and it's not about me, like I know that it's not about me but they, they know that I know their whole story, you know, they don't have to explain themselves. You know, I think you know the needs and there a lot of sort of yeah that trust is really important. And I think, it's being really adaptive. I think in health care, in the hospitals anyway, we're very focused on rules, and it doesn't work for this group . . . like if you're saying 'you have to sit there until you're called', like, it's like a red rag to a bull. If you've got somebody if in an ideal situation, if you had somebody to deal with individuals or even two or three individuals, it would definitely would help and it takes away from the triage nurses or the nurses on the floor taking huge amounts of stress and workload on them because just sorting out their methadone, that's what they feel is their biggest need, and if you can sort that out then you might get another hour out of them". – Interviewee 5

"From my perspective, I think there's a big gap in terms of accessing mainstream services, because the homeless sector is very responsive. And there are some really, really good people and really good teams doing really good work. Yes, I think that there could be more coordination across the system. And I think with the resources and the secure funding, we can get there. I do I feel optimistic

that we're on the right track. I think that concern, from my perspective is that often the, if there's an issue, and it's related in any way to homelessness, it's lumped on Social Inclusion. So what you have is then the other parts of the HSE, not responding to certain minority groups. And this is not just homelessness, it's across all social inclusion groups. And I think that's where there's a real gap, because there has to be more sort of policies and mandatory kind of training and mandatory responses to ensure inclusivity to ensure that mainstream services are inclusive, and that just because they're homeless, they shouldn't be sent to a homeless team, because that's not necessarily needed. And it can create exclusion". - Interviewee 7

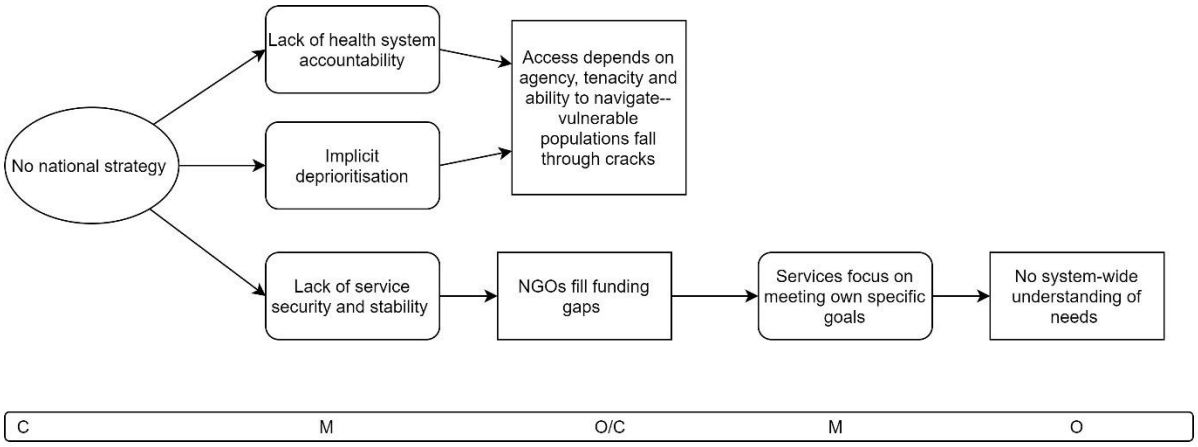
". . the concern is if you have someone who, with a disability, for example, who's homeless, or they've always had a disability, and then they become homeless, and then the next minute, they're serviced by the homeless health teams, which doesn't make sense, because just because they lose their home, it doesn't mean they can't still access disability services. It's that kind of so it's kind of like, you know, the mental health /addiction thing. You can't fit into one box, I think every service is overlapping and comorbid conditions, I think every service has to be aware and considered of those and also of the kind of social determinants. – Interviewee 7

". . you don't want someone being trapped in a specialised service and being kind of excluded, in a way, I suppose. And not being able to go back and access mainstream services". – Interviewee 7

"So, erm the other, one other thing I suppose that we find is a massive barrier, and when it works it works so well, is interagency working. So in homelessness [services] by its nature, you usually have a lot of services involved. So whether it's your outreach workers on the streets, the people who serve the food in the soup kitchens, it could be the drug treatment workers, then you've got the mental health workers which are us, the accommodation providers. So there often be about maybe 10 different organisations involved. If those organizations communicate with each other, it can work really, really well. When they don't communicate with each other, it can be so difficult, because you've got different things like people doing the same kind of work from two different angles, particularly if you've got somebody with a mental health condition where they maybe have traits of personality disorder or something like that . . . where they're not fully erm capable of managing their own affairs. They could have two or three different organisations working towards the same piece of work with them. And if those two or three organisations aren't communicating with each other, it can become really chaotic." – Interviewee 9

". . it shouldn't be a separate homeless service until it comes very far down the line. And you have to be very careful... But if you are going for funding for erm your specialised services, which is for homeless as a separate thing . . . obviously it's not going to work perfectly and you're going to need additional funding. But you should never be setting up erm parallel systems or structures for homeless people. Erm it should always be erm with the intention that erm, you know, or the acknowledgement that homeless people are not separate from the community because otherwise you'll end up with an apartheid system and another apartheid system - two-tier: public, private and then homeless." – Interviewee 12

Consolidated CMOC 3



Supporting data:

"[Medical cards], they are whilst it is notionally free and accessible erm the long waiting lists to access psychological services, counselling... I got someone who was recently shot nine months ago, recently, bereaved when his brother died, addiction, multiple traumas he needs to get counselling and its never available ever for that person. So, so I think all other persons who have medical cards, may have the resource and the sticking power in terms of, you know, the psychological capability to be able to stick with it. But these persons can't advocate and I think that the absence of those services renders wider primary care services notionally present but practically absent". – Interviewee 3

“Healthcare providers need to be flexible, opportunistic. It takes like 5000 more tries to do one thing. And it's those little little wins that are the success stories. People always ask me isn't it sad that people never stop or that they never get better, and you know it's little things like oh my gosh they actually went to that appointment today. That took me nine, that's nine months of not nagging them but gently, you know, you could have six failed attempts to get somebody to this one place and then they finally go, and it's just about the fact that you need to be creative, that the usual pathway that you follow or how things are supposed to happen. You need to understand that that's not going to happen that way. You need to be really creative in how you bring that support to the person or how you get that person to the support and it takes a long time". – Interviewee 4

"I think on a national level or even an international level when you look at all the documents and the policies thoroughly, they all talk about homeless populations as a vulnerable group, and the emergency medicine program in 2012, I think it was, they identify homeless people as a vulnerable cohort. And yet, like, what, what do we do about it then? Like if you call something vulnerable and say that their needs need to be met. I think you have to ask them those things”. – Interviewee 5

"And that's where I think, certainly, if there was an inclusion health strategy, or a social inclusion strategy, or whatever you want to call it some strategy, or public health strategy, where there is also that kind of expectation that it's the responsibility of the entire system, to recognise, be aware of the social determinants of health, be aware of certain risk factors or vulnerabilities that people would have, and how to ensure that systems and their services are set up to respond to that, and to ensure that everyone feels included. I mean, beyond homelessness, there's issues like

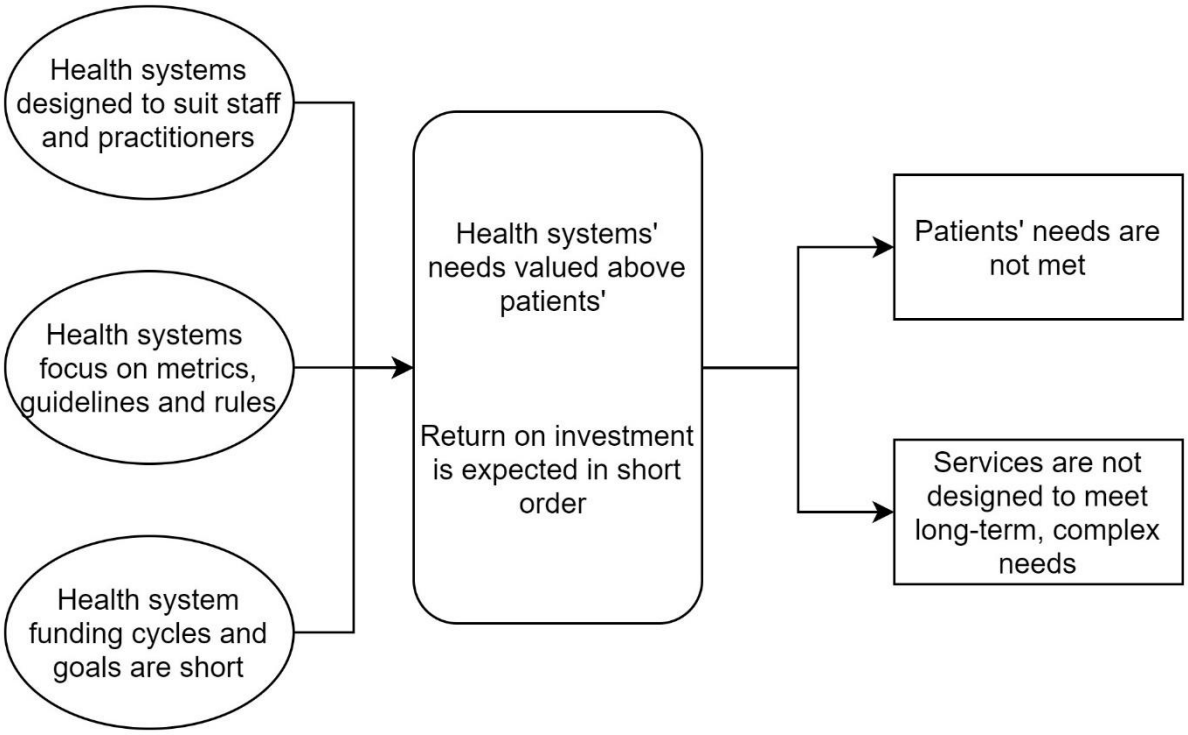
interpretation, having access to interpreters in some services, and yeah, there's a lot of things that you know, services aren't set up always to support these minorities and they should". – Interviewee 7

"It would be accurate for that time that I've been there that the funding stream, a lot of the funding will be once off. It's not attached to any sort of long-term strategy". -- Interviewee 7

"Yeah, NGOs? I mean, the HSE will, the majority of our funding will go to like section 39 [organisations], which is voluntary agencies . . . so to some extent, you have some oversight about how the system is coordinated, so to speak. But having said that, you know, some of these organisations now, like, [name of NGO] . . . the bigger homeless agencies, they have really good fundraising. So there's naturally going to be additional resources in the system. And [the mainstream system] doesn't have any understanding of where that, you know, where what kind of services will be set up. It's entirely independent, I suppose of the public health system". – Interviewee 7

"No. There's no big overall thing. There's no targets no goals and no evaluations. There aren't. No. And that's, that's what's needed". – Interviewee 11

Consolidated CMOC 4



Supporting data:

"And then financing is a huge part of it and we've talked about this before but the way that budgets are set up so that health is in one place and social care is in another, the way that decisions are made on financing based on very short term erm recuperation, whereas, as we've talked about, you might invest now in early childhood interventions erm and you might see the benefit of that in terms

of health 40 years down the line, and we don't capture that. And we look at health as a unit of a person rather than the health of the community, which is probably another really important way to be able to look at it. And then that all feeds into there's, it's a system that isn't fit for purpose, I would argue, in treating people, let alone people who are complex". – Interviewee 1

" . . the mainstream services are not designed for homeless people, they're designed for housed people. And they suit the needs of housed people. They do appointments, they do, you drive in, parking places, you keep regular times, people whose behaviours are not chaotic. And anyone who goes into that system, who feels out of that system, outside that system, will automatically find it difficult. You will find a number of GPs who will make it accessible. But to make the whole service accessible... And in reality, I don't know of any city that has made, able to provide proper healthcare to homeless people through making general practice things. – Interviewee 2

"I think the whole process of applying for a medical card . . . it needs to be framed within the context of what a service user needs and that's quite doctor centric, form heavy . . . So I would often get a call from someone saying 'can you take on these two patients they're both homeless?' And I would say like no problem just tell them to ring my mobile. And they say, no they don't have a home, they don't have a mobile. Well can they call at the practice? No. So, for them to sign up, I have to meet them". – Interviewee 3

"There are things that need to be provided in the hospital, and there's probably 70% of that stuff can be provided in the community, where the person lives with the practitioner that they know, over a period of time. You know, bloodwork doesn't need to be done in the hospital, it can be done here and it can be sent. You know investigations can be done. You know, you don't need to spend eight hours in the hospital waiting for a chest X ray and an ultrasound. You can plan to do them on different days and then collate all the information and then discuss it. So, you know, I think, the next step is the outpatient clinics." – Interviewee 4

". . clinical guidelines are exactly what they are, they're guidelines, they're not. They're like they're, they're the best available evidence possible but they don't fit every population, they don't fit every person and they don't fit every situation. And I think as a practitioner, especially as a nurse, you know it's slightly down the hierarchy in terms of the medical field and it's a predominantly female profession. So, I think there's a lot of anxiety there about oh my license, I be a can't be innovative, or I can't flex from the guidelines or I can't do this" - Interviewee 4

"I think that so there's a two prong, there's another approach which is okay, maybe next time or okay, I have to go back to the drawing table and find something more creative or I have to work on my relationship with you over the next seven months before you engage with me on this thing. And I think, you know, especially GPs and some nurses as well. They don't have that time. So it's always an agenda, whether it's a time agenda or an anxiety agenda. Or maybe that person falling through the cracks and becoming very, very unwell and you not having done enough persuade them . . . Accessibility to me, isn't just about putting a clinic in the hostel. It's not just about giving you a taxi to go there. It's about empowering people to understand, giving them the space, giving them the attention so that they can take in the information, and also making sure it's not about your own shit". – Interviewee 4

"It has cost me a lot of fall out professionally with other clinicians trying to access care for my population because mainstream services, follow the guidelines and they follow strict appointment times and well you didn't show up three times so now you have to go back to the doctor and I'm like, grand, I'm writing the referral right now, no you give them another appointment like you're just

making me go through a process that doesn't need to happen because somebody said that you needed to do it. But why are you doing it? What's it based on how? Does it affect the behaviour of the person, does it actually increase the availability of the service, or your waitlist to be addressed. Like, it's just an arbitrary rule. And I think that more mainstream services that do that continue to exclude our population and what we try to do, is we adapt the guidelines. You know, we consider the guidelines and use them to the best of our ability to meet the needs of a population that the guidelines aren't written for". – Interviewee 4

“They [some staff and providers in mainstream health services] also take it as a personal affront. And then it's like, oh, well they didn't come so we're gonna put them to the bottom of the pile. Cause there's other people that need the service and we're very busy”. – Interviewee 4

"I think a lot of these things can also be translated to the care provider - less frustration and fear. Yeah, I think, definitely. I mean I've noticed anxiety amongst healthcare professionals because the person didn't want to see me today and I have the results of a blood test"". – Interviewee 4

“. . there is obviously a limited pool of money and resources and these patients definitely take a huge amount time and that's why I think the specialist roles have just been amazing because I found so willing to engage with me erm when I was in the role because suddenly you are saying, 'I can help you with this'. And you know from being on the floor that, you know what the person might need or what you could do for them, but you just don't have time and I know that sounds really, really dismissive or like you know it's a throwaway comment, but it's really hard when you've got people in resuss or who are really critical or you've got 20 people on screen for triage and you've got somebody shouting at you for their methadone, which is really important we know. And I think that the way they, the way I'm not generalising but the way a lot of patients interact erm because they have really poor relationship with authority and hospitals and they have a really bad experience. And a lot of it's not their fault. I think that comes into every conversation. You know, the minute they come in a lot of people they want things, you know. Erm and I think they feel they're being treated unfairly and inevitably sometimes that happens". – Interviewee 5

"And I think, it's being really adaptive. I think in health care, in the hospitals anyway, we're very focused on rules, and it doesn't work for this group, you know, and if you say you can't do something. So . . . like if you're saying you have to sit there until you're called. Like, it's like a red rag to a bull. If you've got somebody if in an ideal situation, if you had somebody to deal with individuals or even two or three individuals, it would definitely would help and it takes away from the triage nurses or the nurses on the floor taking huge amounts of stress and workload on them because just sorting out their methadone that's what they feel is their biggest need and if you can sort that out then you might get another hour out of them. It may be not why they attended but really they felt their needs are different to what we see as their need. I think we're sometimes very good at telling people what their needs are when actually it's not always the case and you manage to around the back way, you get there a bit easier and you've less arguments and that trust definitely builds so I think that's a really good one. There's definitely less frustrations." – Interviewee 5

"It is and its a lot of like patting ourselves on the back I think, you know and you hear it at the moment, more than ever. And its like come on, like everyone's doing good job. So I think if people feel like that about themselves before, you know, I think before they even go into a person. If you're really focusing on what, what do you think is important, then, and your needs, and I need to be able to discharge the person without any problems and I don't want to get into a report and don't have to call the guards. And I don't want to have to do all of those things. And if you leave I have to do all of

those things. And that's like that's your focus which is crazy. So, I don't know - person centered care is very abstract, isn't it?" – Interviewee 5

"I think a lot of time we're taking on the responsibility of this is really important because you have this and this condition and that's not a priority to the patient. But we know it's a priority and services know what's the priority and they're really worried about it. And I think if they've somebody to talk to about it and we know we can talk to them about it I think the right thing, does probably happen for the actual patients but they might be so focused on one part of the puzzle that's not actually improved for them. Erm I think that's a hard one to do because people's priorities are different". – Interviewee 5

"I think identifying their needs is massive. And it's not what we think their needs are. You know, I think we're really good at that as nurses and doctors. We're really good at saying this is what you need but actually maybe it's not. It goes against your instincts". – Interviewee 5

“I mean, [it’s] obvious to me just straight from the bat, that [the way health services are delivered] doesn't work for our clients, unless you have something like an inclusion health [service] and that needs to be bigger". – Interviewee 6

"The issue here is that we haven't had secure kind of recurring funding. It's been once off funding. So it hasn't been mainstreamed, which is it does create uncertainty for organisations and it does create that instability, I think in the system". – Interviewee 7

". . there is a number of different funding streams in homelessness, it's quite complex. We were fortunate enough to get a decent budget this year, through the winter plan and through the National Service Plan. So I suppose everything that we have been pitching for every year, we've finally received, which means that we now have recurring funding. So I mean, like, it'll be interesting to see where that takes the system. And how that will, how that will support the system and improve, potentially, hopefully improve access. But then you, then we still have the same issue where next year, we have to pitch for funding, again, because you have projects like the hospital, not hospital discharge, I think that's mainstream now. But like the housing first project, which is somewhat funded on a recurring basis, but the project will end 2022. And then we need to ensure that that funding is mainstreamed. And programs like that's really important. Because you're, I mean, essentially the project is around time-unlimited support. So if you pull the supports away, or if there's that kind of insecurity that this is supposed to be time-unlimited, I'm supposed to have a house forever. But that no one's really sure of whether that funding is going to just end or not. Of course, that's an issue". – Interviewee 7

"For some of it, I'd say it's the appointment basis of outpatients. So lots of people that have experienced homelessness might be in a little bit of a better setup and might be in a longer term hostel. And . . . they might come ED, and be given a follow up appointment for a different team to maybe follow up with a fracture or just don't know, whatever the healthcare need might be. Those appointments are often a bit, a good bit in advance, a very minimum time slot, so if you don't present at the time you're not getting that, erm, written in illegible handwriting on an outpatient card for people that may have very very poor literacy skills, erm with no directions to where that place is necessarily on it, and also at a very early timeframe. So if you're say homeless and either rough sleeping or in the emergency hostel accommodations where you're out from early in the morning. So you mightn’t have, you mightn’t know where you're waking up that day. Erm you might have to go and try and get your methadone, you might have to go and try and get your payment to ensure you have, if you don't have methadone, we can get another substance that will not force you

into withdrawal very quickly. And, and you might have to also avoid lots of people that things have been challenging with around the place. So your day is very busy. People think homeless people are just sitting idle, they're busier than me and you, going about the place trying to ensure their daily needs are met on a daily basis because they've nowhere to put, they've nowhere to store the bag of mementos or whatever it might be. So, I think, a barrier is often those outpatient appointments that might be fine if you were gone into work and saying oh actually I'm going to be an hour late because I have an appointment, and you give your cert and it's on the sick and all of that's fine. Erm, but if you're getting off a bed, getting off the floor at Merchants Quay after sleeping all night on something that is possibly two inches thick like a yoga mat you mightn't be able to mobilise anywhere, you mightn't be able to make it to the bus stop, you don't have the funds to get yourself a taxi. You mightn't have a shower in a couple of days, you might be conscious of how to how you feel, to think I'm not, I don't, I don't look well enough physically to actually walk into a and sitting in a literally be sat on top of each other in an outpatients while waiting to be seen. Erm, like, so there, everything is set up to meet the system's needs to ensure that there's a registrar sitting in the clinic for x amount of hours getting through x amount of patients. That the secretary has put through on the system to give a time slot for 15 minutes each, that's all you get. So if someone is late the doctor has to be there late, and the doctors aren't able to because there aren't enough of them to go around. So I think there's a huge amount of barriers that are not being seen by the medical systems but that are very much very real for people. So for example, if you're homeless and you don't have a watch, do you know what time it is? If you wake up in the morning you and it's bright out you mightn't know what does it get bright out? Very simple things but very impactful. Or you might find yourself okay well I decided last night it was more appropriate for me to sleep on go sleep on a bus because I didn't want to go to hostel because I was afraid of xy and z person, and I end up in a bus, the bus went out to the depo in Swords and now I'm in Swords and how do I get back? Do I even know what day it is?" - Interviewee 8

"So in the hospital at the moment, what I've seen in terms of the homeless population is that it's very challenging for someone that does not see themselves as worth any care to then be able to engage in a care system that is individual. That is the individual that needs to attend for an appointment once or twice, and then they're off the list. Erm or it's the individual that needs to understand the language that is used by the doctor or the nurse or the caregiver who are looking after them. Because unfortunately, a lot of the people in homelessness have very low levels of education, very low levels of literacy, have high levels of early childhood neglect which results in different areas of the brain not functioning as well as they might need to, to be able to take on that level of information. So what I see in terms of in the healthcare side of things is because for me, everything is very much embedded on top of each other. So I can't talk about healthcare without thinking about early childhood care and what was received for the person because no matter whether you're homeless or housed, your early childhood care and attachment with your caregivers will predicate how you're were able to look after yourself. So for me, it's more so about people that aren't able to engage in a system that don't take into account where they're coming from, where they're at. . . If we can get system to understand where people are coming from, and have a system that meets people's needs, instead of the person having to fit into the system." Interviewee 8

"So it's well understood within the hospital system that when people have cancer, they should not be taking public transport and they need to be ferried from wherever they are to wherever they need to get for the treatment erm whereas it's not understood so much that same level of support might be required for someone to be able to walk from the hostel outside into the hospital for healthcare. They need some someone to support them to get to that point. Erm, and the culture very much in at times in the acute hospital setting can be very corporate. It can be very much inputs

are patients and beds, outputs are bed days and what the cost [inauble]. . . that can be across medical systems, across the medical specialities so. And the culture sometimes can be that the leadership are kind of levels from middle up can be 'this person is in this bed for this length of days. They need to get out of that bed'. But blocks to them being able to go anywhere else are not seen. Because the understanding is not there because if you have a home, you can go home and convalesce for three weeks. If you're going into a hostel that's closed for 12 hours a day, that's not happening. So I think a lot of time it's when you're at that level of leadership and governance and you haven't had maybe that direct practice work that the healthcare professionals might have had, like, say for social work or OT or physio might have had direct contact with people." – Interviewee 8

"So funding is allocated through what we would call a grant allocation and the grant allocation is under because we are Section 38 hospital, it's under a service level agreement. So there are a number of hospitals who are called Section 38. There's hospitals such as the [major Dublin hospital is a Section 38, because that's a pure voluntary hospital and then you've got HSE hospitals. So for us for instance, is that we get a funding allocation each year . . . there's a budget allocation to meet the existing level of services . . . And then if there's new services being developed, they go in through what we would call an estimates process. So every year does the estimates process where you submit a number of service developments that you want to get funded and the estimates process then goes into the HSE and then the HSE and the Department of Health go through it. And there's a cull as you can imagine of all the estimates and then just normally a few top priority programs then actually get funded".- Interviewee 10

". . as you can appreciate, if you're running a health system, there's a number of different priorities that's all at the same time competing for funding. And there was a number of different priorities that would have been through the process an awful lot longer than a homeless one. And that that one actually got [funded]... And I think it's all about having the right advocates. And [name of doctor] would be very good, very good, strong advocate, Having the, you know, the ear of the minister, having a minister who understands the needs and having, you know, having a health system that can relate to it. And then often such things like covid or a crisis, actually can anticipate funding erm as well. So that that was one that actually was quite opportune, in relation that it did have the right conditions. And then there was a short-term funding made through the winter money. So winter money comes, but it's very short-term funding, you only get about six months funding but em because that was such a high demonstrated project . . So that's that's how new money comes into the system". – Interviewee 10

"I think it's very, it's very ad hoc. And every funding that comes is sought for, for a long time. So the kind of lead is given by the voluntary sector, it grew up that way. And so each thing that emerges, it has to be pursued. So there isn't that kind of system at all. No, no, no, no, it's really it still is the Cinderella of government funding, you know, it's not long in existence". - Interviewee 11

"And even like for the so the funding model. So even on an abstract level, where does it where does the person start and end? The person starts and ends, in their home, in their family, in their community. They don't start and end erm marginalized, you know, and isolated as a, as a homeless person disconnected from everyone. They start and end in some home, in some family, in some community. And that's where the funding if you want to get really simple, should be targeted". – Interviewee 12

Appendix 10: Study 3 (policy analysis) conceptual codes

Codes

Search Project

Name	Files	References
Access	0	0
Co-design	1	2
Patient involvement	1	1
Peer-support	1	1
Barriers	0	0
Competing priorities	2	4
Complex needs	1	6
Distance to treatment	1	1
Limited community care	1	1
Moving around a lot	1	1
Need for referral	1	1
Prescription costs	1	1
Trauma	1	2
Waiting	1	1

Codes

Search Project

Name	Files	References
Care organisation	0	0
Department of Health	1	1
Discharge planning	4	11
HSE	5	12
Identification of homeless patient	1	1
Information flow	1	7
Integrated care	3	11
Inter-agency	8	33
Key worker_case management	5	11
Multi-disciplinary	7	18
NGOs	3	9
Partnership approach	3	8
Pathways	7	20
Re-admission cycles	2	4
Responsibility	4	6
Staff roles	2	4
Definitions of homeless	1	1

Codes

Search Project

Name	Files	References
Definitions of homeless	1	1
Governance	3	3
Competency framework	2	6
Formal working arrangements	1	6
Funding	4	16
Infrastructure	5	13
KPIs	4	11
Leadership	5	8
Statutory	4	11
Health needs	1	1
Infrastructure	1	1
Catchment area	1	5
Training	2	2
Philosophy of care	0	0
Holistic	5	12
Policy goals and recommendations	4	21
Snow ball	4	17

Codes

Search Project

Name	Files	References
Types of care	0	0
Addiction	5	13
Aftercare	1	1
Community based	1	1
Complex	1	1
Dual diagnosis	6	13
Emergency Department	3	4
Inpatient	2	3
In-reach	3	4
Mental health	5	15
Palliative	1	1
Primary care	2	5
Step up_step down	2	4
Supported housing	3	9
Housing First	1	3

Appendix 11: Ethics application

Health Policy & Management / Centre for Global Health Research Ethics Committee

Ethical Approval Application Form

PLEASE NOTE THE FOLLOWING:

Incomplete and/or late applications will not be processed and will be returned to the applicants.

Forms without the following signatures will not be processed: Applicant(s) signature, Research Supervisor signature (applicable in student application).

Forms without the checklist completed will not be processed.

Applicant Details

Name of Principal Investigator:	Rikke Siersbaek
Status (delete as applicable)	Postgraduate Student
Staff / Student Number:	17342706
Email address:	rsiersba@tcd.ie
Contact address and telephone number:	Centre for Health Policy and Management 3-4 Foster Place Dublin 2 M: 083 8390374
Primary Supervisor's name and contact (if applicable):	Steve Thomas Tel: 01 8963880 thomassd@tcd.ie
Project Title:	Delivering equitable healthcare access for homeless adults in Dublin

For Which REC Meeting:	Meeting Date:_____ (Month / Year) Other (Emergency / Re-submission)
Level of Submission (tick as appropriate):	New Application (Full Protocols) ☒ Amended Application (Full Protocols) ☐

Please complete the application form and return three signed hard copies to

Ms. Sheena Cleary

Secretary, HPM/CGH Research Ethics Committee

Please also email your application in full (application and appendices) to

hsmsec@tcd.ie

by 5pm of the Application Submission Deadline Date.

LATE SUBMISSIONS WILL NOT BE ACCEPTED.

To process your application form efficiently you are required to fill in the checklist below. Do not leave any blanks. If this checklist is not completed, your application will not be processed.

		Yes	No	N/A
1.	Is the rationale for the study clearly stated?	☒	☐	☐
2.	Is the project design fully explained?	☒	☐	☐
3.	Are the inclusion and exclusion criteria complete?	☒	☐	☐
4.	Are members of a vulnerable population being studied?	☒	☐	☐

If yes, please tick the vulnerable population being studied (please refer to section 3.4):

☐ Children under 18 Years	☐ Persons in Restricted Environments (e.g. psychiatric facilities, nursing homes)	☐ Persons with Diminished Capacity (e.g. cognitive impairment, learning disability, communication difficulties, etc.)
☐ Elderly	☐ Prisoners / Youth Offenders	☒ Others (Please Specify: adults who experience or have experienced homelessness

a. Is the justification for studying this vulnerable population adequate?	☒	☐	☐
b. Have adequate provisions been made to ensure that the vulnerable population is not being exploited?	☒	☐	☐
Have the risks vs. the benefits for the research participants been discussed in the research protocol?	☒	☐	☐
When appropriate, do provisions exist in the protocol for counselling research participants during and after the research?	☒	☐	☐

Have adequate provisions been made to ensure the confidentiality of data ☒ ☐ ☐

and its ongoing protection throughout the study?

IF APPROPRIATE TO THE STUDY YOU SHOULD ATTACH THE FOLLOWING:	Attached	N/A
the consent form you propose using	Y	
the letter(s) to prospective participants seeking their co-operation with the study	Y	
the participant information leaflet you propose using	Y	
for the purpose of your proposed study, if you require access to: (i) a site outside your home department/School, and/or (ii) the person who is responsible for the welfare of your proposed participants, please attach the letter seeking access	Y	
If the study requires ethical approval by ethics committees of any other institutions, outside of the HPM/CGH committee, please attach a copy of the responses received from these committees		N/A
If the project involves the use of a questionnaire, phone survey, focus group discussion and interviews please attach a copy of the tool(s) of data collection you propose using (Questionnaire / interview schedule / observation schedule/other	Y	

DETAILS OF RESEARCH STUDY & PARTICIPANT SELECTION

2.1 Working title of proposed study

Delivering equitable healthcare access for homeless adults in Dublin

2.2 Dates & Duration of Study

Proposed Start Date:	1 December 2018	Proposed End Date:	1 September 2021

What are the primary location(s) for data collection? (e.g. classroom, participant's home, hospital/clinic, laboratory, place of convenience for participant – specify likely locations)

For interview subjects: Place of convenience for partipant eg their place of work or other neutral venue	
For experts by experience: St. James's Hospital or other place of convenience to them eg homeless shelter or their accomodation	

State concisely the research aim(s) and objective(s), research question or specific hypothesis to be tested (as appropriate)

The aim of this research is to identify international evidence for improving access to healthcare for socially excluded populations, to describe and appraise the current landscape of healthcare access for homeless adults in Dublin, and to make policy recommendations to deliver better access.

Provide brief outline of the project (maximum 500 words, must include background, research approach, design, data collection methods, sampling – size of target population and if applicable indicate the method of sampling you intend to use and the sample size, data analysis and expected research outputs)

Introduction

The link between social status and health is well established: populations who experience deprivation and lower socioeconomic status have poorer health outcomes. Homelessness is the most extreme expression of social exclusion, experienced by people lacking a stable and secure place to live. In Ireland, homeless people use relatively less primary care compared with housed populations and often make their first contact with the health service through the ED. There is a much higher rate of utilisation of unscheduled secondary care among homeless individuals in Dublin compared with housed individuals. Enhancing accessibility of services for homeless populations will ensure treatment at the right level of complexity and promote earlier intervention with the likely outcome of better health and better use of scarce resources.

Study design – research questions and methods

Study	Topic	Methods
1	How do we best deliver healthcare access for socially excluded populations?	Realist review
2	How accessible are health services for homeless adults in Dublin?	Case-study methodology using: Documentary analysis; Semi-structured interviews; Focus groups
3	How did we get to where we are today? How do we move on from here?	Policy analysis using: Documentary analysis; Semi-structured interviews

Study 1 will review the current international evidence to answer the question: How are healthcare services best conceptualised, organised, resourced and delivered to provide equitable access for socially excluded populations? Realist review methodology will be used because it is designed for reviewing complex interventions for broader questions such as the one in this study and because it seeks to explain how complex programmes work in particular contexts and settings, or why they fail (Pawson *et al.*, 2005). The review will include the following sources: health data, commentaries, grey literature, and peer reviewed studies.

Study 2 will answer the questions: What healthcare services are available to homeless individuals covered by the Dublin Region Homeless Executive catchment area? How are these services structured, organised and resourced in the domains of preventive care, primary care and secondary care? How well are the various health services performing? What are barriers and facilitators of access to care?

Study 3 will seek to answer the questions: what is the historical background to the policies and practices that have led us to the current situation of inequitable healthcare access for the homeless? Which health system features can be improved to promote equitable access for the homeless in the opinion of the stakeholder?

Participant identification and selection

Interviewees for studies two and three will be selected using purposive and snowball sampling with the assistance of my supervisors (Prof Steve Thomas, Dr Sara Burke, Dr Clíona Ní Cheallaigh).

People with lived experience of homelessness will be primarily recruited from the homeless health peer advocate training programme being established by De Paul Ireland. Additional people with lived experience

will be recruited through gatekeeper organisations (De Paul Ireland, Merchants Quay Ireland, Dublin Simon). Members of the gatekeeper organisations who are independent of the study team will make initial approaches to people with lived experience to avoid any undue pressure that might be experience if initial approaches were made by the study team. Only people with lived experience who give consent to be contacted by the study team will be contacted directly by the study team. Independent individuals in the gatekeeper organisations will also be responsible for ensuring follow-up for any potential psychological distress experienced by participants. Panel participants will be selected and vetted by clinicians and social workers with significant experience to protect participants and select those most appropriate for research purposes to allow for their voice to be heard but without putting individuals at undue risk.

I aim to recruit around 15 interviewees in total with some being interviewed for both studies.

Data collection and data analysis

Primary data collection will take place at several stages in the second and third studies. Interviews with key informants representing health and NGO sectors will be used in study number two to be followed by focus groups with homeless individuals.

A mixed methods approach will be used because comprehensive exploration of healthcare accessibility requires an understanding of both system level supply factors and individual level demand factors, and because the demand side of the equation in this instance is in an understudied and underrepresented population of socially excluded and homeless individuals.

Does your study involve gathering data from surveys, interviews, focus groups or service user records?

YES	X	NO		If No, please go to section 5.1

List your exclusion/inclusion criteria for participant selection:

Two groups of participants:

Professionals who work in: preventive, primary and secondary healthcare sectors focused on homeless populations in Dublin, NGOs that provide services to homeless, the HSE National Office for Social Inclusion, government departments including Health and Housing, the Dublin Region Homeless Executive, as well as relevant experts and academics

Service users of healthcare services who have experienced homelessness (Experts by experience)

Inclusion criteria for a:

Work in one of the professional areas listed

Have significant experience working with or on projects benefiting homeless populations

Inclusion criteria for b:

Used or tried to use a health service in Irelend in the past three years

Access services within the Dublin Region Homeless Executive catchment area (comprised of Dublin City Council, South Dublin County Council, Fingal County Council and Dún Laoghaire-Rathdown County Council)

Exclusion criteria(for exclusions additional to not being in the inclusion criteria):

Aged 17 or younger.

Inability to provide informed consent.

English language difficulties.

Moderate to severe cognitive impairment.

2.8 State number of participants to be selected for each study within the project and reasons for choosing this number:

Study participants for studies two and three will be selected using purposive and snowball sampling with the assistance of my supervisors. Based on the advice of my supervisors, I have estimated that I will need to talk to about 10 people for the second study and about five for the third study to reach saturation.

If appropriate please identify how participants will be recruited and what steps you will take to

access the sample, specifying details of people who will be contacted during this process:

Initially I will rely on the assistance of my supervisors in connecting with key people and using snowball sampling will hope to be connected with further participants though early interviewees.

Experts by experience (people with lived experience of homelessness) will be primarily recruited from the homeless health peer advocate training programme being established by De Paul Ireland in Q1 2019. If required, additional people with lived experience will be recruited through gatekeeper organisations (De Paul Ireland, Merchants Quay Ireland, Dublin Simon). Members of the gatekeeper organisations who are independent of the study team will make initial approaches to people with lived experience to avoid any undue pressure that might be experience if initial approaches were made by the study team. Only people with lived experience who give consent to be contacted by the study team will be contacted directly by the study team. Panel participants will be selected and vetted by clinicians and social workers with significant experience to protect participants and select those most appropriate for research purposes to allow for their voice to be heard but without putting individuals at undue risk. Independent individuals in the

gatekeeper organisations will be responsible for ensuring follow-up for any potential psychological distress experienced by participants.

Will payment be made to research participants?

YES	NONE OTHER THAN MINIMAL EXPENSES TO COVER TRAVEL COSTS ETC	NO
		x

If you answered YES to question 2.9, please specify for what purpose the payment will be made,

the estimated amount per participant and the funding source for such payments (including travel

reimbursements).

CONSENT, CONFIDENTIALITY (INCLUDING DATA PROTECTION)

3.1 Please provide information on how consent will be obtained from the research participants -

Give details of who will take consent and how it will be done.

(Please attach a copy of letter, consent form (if required) and information leaflet. See guidelines on how to prepare these documents in Guidelines and adapt examples accordingly to suit your study and participants)

Participants who work in the field:

Potential participants will initially be approached by either myself or one of my supervisor. Individuals who express an interest in participating, will be emailed a copy of the consent form and information leaflet, with a week given for them to consider their participation. I will follow up with them after that time. If they choose to participate, a date will be scheduled for the interview, and written consent will be obtained by me at the interview date prior to starting the session.

Participants with lived experience:

My co-supervisor Dr Clíona Ní Cheallaigh will liase with gatekeepers in De Paul Ireland, Dublin Simon and Merchant's Quay Ireland who will identify potential participants, give them a brief introduction to the study and ask them whether they would be interested in participating in the study. Initial recruitment will take place from the individuals undergoing training as homeless health peer advocates by De Paul Ireland (commencing Q1 2019). of which will be ideally suited to the research proposed. If the potential participant agrees contact, either myself or Dr Ní Cheallaigh will contact the participant by telephone or in person to arrange a meeting and seek initial consent, explain the study and give them a copy of the participant information leaflet and consent form with a week to consider their participation. The participant will be fully informed of the nature of the study and that their participation is voluntary. If they choose to participate, a date will be scheduled at least one week later to meet with myself and written consent will be obtained before the interview/focus group.

The current plan is to have arrange a focus group with the panel though individual interviews may be arranged if more appropriate or if focus group participants prefer to have a one-on-one interview.

Will participants be given an interval of seven days or more between receiving information and giving consent?

YES	x	NO		If No, please justify

Is deception involved at any stage of the study? If so, what are the justifications, how will it be done and what safeguards are in place for research participants?

No

Will the targeted participants be members of any of the following groups (tick as appropriate):

(In many studies it is important to include participants from vulnerable populations. Where this is the case we require information on how this will be managed and reassurance that risks of harm are minimised.)

	Targeted Participation	
	YES	NO
Children under 18 years of age		x
Adults with learning disabilities	x	
Adults with communication difficulties	x	
Adults with cognitive impairment (e.g. dementia)	x	

Adults who are unconscious or severely incapacitated (though not terminally ill)		x
Adults with a terminal illness		x
Adults with mental illness	x	
Adults in restricted environments (e.g. psychiatric facilities, nursing homes, etc.)	x	
Prisoners	x	
Young Offenders		x
Those who could have been considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, students, service users under the direct care of the investigator, or subordinates to the investigator in the organisation/service in which they work	x	
Other groups who may be considered vulnerable (Please specify below) Adults who have experienced homelessness or are currently experiencing homelessness	x	

3.5 If participants are to be recruited from any of the potentially vulnerable groups listed above, please give details of:

The way(s) in which the participants are considered vulnerable for the purpose of research participation: People with lived experience of homelessness are central participants in this study because the study seeks to understand how access points to the healthcare system are experienced by them, and which structural, psychosocial and knowledge-based factors impede and promote accessibilitiy. Without the voice of service users represented the validity of the study is in jeopardy. It is important to recognise that people with lived experience of homelessness and social exclusion are vulnerable due to many factors and there is the risk of a significant power imbalance arising between these individuals and myself as a researcher asking questions that are at times personal in nature. Having an experienced clinician (Dr Ní Cheallaigh)

who regularly treats individuals experiencing homelessness as well as the structure of the vetted Experts by Experience panel being created in St. James's will protect potential participants against feeling pressurised to provide information about themselves they are uncomfortable disclosing.

The extra steps taken to ensure that participants from any of these vulnerable groups are as fully informed as possible about the nature of their involvement:

Recruiting people in training as homeless health peer advocates adds an extra level of protection because individuals on the panel are chosen based on a list of criteria that are designed with their welfare in mind, including not being in active addiction. They will have already agreed to participate in research and will be trained to understand why and how their voice is important in the production of research to benefit individuals experiencing similar struggles to ones they may have experienced.

Dr Ní Cheallaigh will explain verbally the purpose of the study and the nature of the participation requested of participants and a specific script will be used highlighting the voluntary nature of participation, their option to withdraw at any point, confidentiality and that their participation (or not) will not impact on their care.

Potential participants who express an interst in participation will be given a copy of the participant information leaflet and and consent form and given a minimum of seven days to consider their participation.

After a minimum of seven days, participants will be asked to meet with me in St. James's in a location familiar and comfortable to them. The voluntary and anonymous nature of their participation will be stressed at this stage. Before commencing the focus group, participants will be asked to sign the consent form.

Time will be made available at the end of the focus group session, and at a later stage if required, for any participants to discuss any issues that may have arisen.

Participants will have an opportunity to review findings and to contribute to co-design of future research.

Who will give consent (and/or assent as appropriate):

Participants themselves will provide written consent.

How consent will be obtained (e.g. will it be verbal, written or visually indicated?):

Written consent will be obtained with information about the study given verbally and in written form.

When consent will be obtained:

Consent will be obtained at the time of the interview sessions/ focus groups before the interview or focus group begins, at least one week after initial contact by the study team.

The arrangements that have been made to inform those responsible for the care of the research participants of their involvement in research:

The project will be publicised and results disseminated through existing clinical and advocavy networks.

3.6 During and after the study, what steps will you take to protect the confidentiality of:

Participant identities?

Prior to commencing the interviews and the focus group session, participants will be given a number to ensure anonymity. Participants will say their number at the beginning of the recording and be asked to not say their name or any identifying information during the interview. Any information mistakenly mentioned will be redacted from the recording.

Data collected (in particular, patient/client records if these are accessed)?

N/A

(c) Hardcopy records?

N/A

3.7 If your data are to be held electronically at any stage of the study, how will they be protected?

All survey data and transcripts will be stored on a password protected computer, in a password protected document and secured in an encrypted drive. Data will not be transferred from one computer to another.

What other person(s) other than the researcher/team as listed will have access to the data collected

and what steps will be taken to protect confidentiality?

My supervisors, Prof Steve Thomas, Dr Sara Burke and Dr Clíona Ní Cheallaigh might be given access to data collected for supervisory purposes and for assistance with analysis and coding if the need should arise. They will all adhere strictly to the confidentiality of the research participants and the data collected.

3.9 If the study involves audio taping interviews, you must allow the participant access to the transcript, if they so wish. This must be included in the Informed Consent Form and Participant Information Leaflet (if these forms are being used). Will the participant be given access to a transcript of the audio tape interview?

YES	NO	N/A	IF NO, PLEASE EXPLAIN WHY
X			

RISK, BENEFIT AND HARM

Describe any foreseeable risks to the participants?

Participants could experience emotional discomfort from recalling prior experiences.

In focus group settings, intergroup conflict may arise.

Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews/group discussions, or use of screening tests for drugs)?

If Yes, give details of procedures in place to deal with these issues

There are no plans to disucss topics or issues of a sensitive nature however any negative experiences with accessing appropriate healthcare on the part of service users or with not being able to provide the optimal kind of care on the part of healthcare providers may prove upsetting to some participants. A list of mental health supports and counsellors available in the Dublin area will be made available to any study participant who may need support arising from their participation.

Additionally, other concerns that could arise include:

Any concerns or issues relating to children's welfare will be managed in accordance with Children First policy.

Any concerns relating to fitness to practice / professionalism of clinical staff will be raised with Dr Ní Cheallaigh who will escalate as appropriate.

4.3 What is the potential for benefit for research participants?

Participants may find empowering to talk about experiences they have had and to be able to pass on their particular expertise and insight into an area they are well familiar with.

Information will be used to inform future resourcing, planning and delivery of healthcare access for homeless individuals which will hopefully benefit some of the research participants directly and others may feel satisfaction in having a role in improving the service they work in or have a stake in professionally or personally.

5. Data Access and Disposal

If anonymous secondary data is collected as part of this investigation, have you obtained the necessary permissions from the relevant data controller(s) to access data for the purpose of this investigation?

YES	NO	N/A	IF NO, PLEASE EXPLAIN WHY
		X	

Is there any potential confidentiality issue through identification of the study location?

For the professionals I'll be interviewing, they will be identified as 'professional 1', 'professional 2' etc and no identifying charateristics will be supplied.

Regarding experts by experience there is less of a risk because a large majority of homeless individuals in Ireland live in Dublin and the population size in total numbers is large.

5.3 How will information be retained and/or disposed at the end of the study?

After seven years, all electronic data will be deleted and any physical copies destroyed.

FUNDING

6.1 Outline sources of funding for the study if applicable and how you will manage any possible conflict between the funders of the study and the aims and results of the study if applicable?

I am funded by a HRB SPHeRE programme stipend and I do not foresee any conflicts arising from those sources.

6.2 Please disclose any interests outside of research funding (financial or otherwise) that may give rise to potential concerns regarding research integrity. How will you manage such concerns?

N/A

ETHICAL APPROVAL FROM OTHER COMMITTEES

Ethical approval from the HPM-CGH Research Ethics Committee, if granted, does not supersede any requirements that outside bodies may have that similar applications be made to local ethical approval bodies in advance of the study commencing.

7.1 Has ethical approval been sought from any other organisation(s) in which the study will take place?

YES		(If you answer YES go to question 7.2)
NO	X	(If you answer NO go to question 7.3)
N/A		(If N/A please explain why below)

If you have answered YES to question 7.1, where has approval been sought from and has ethical approval been given? (Please supply a copy of relevant protocols and approval / exemption letters to the HPM-CGH Committee Secretary)

Name(s) of external ethics committee(s):				
Approved	Exempted from Review	Awaiting Reply	Rejected	*If EXEMPTED FROM REVIEW OR Rejected, please explain Why*

If you have answered NO to question 7.1, is it your intention to seek ethical approval from the organisation(s) in which the study will take place?

YES	NO	IF NO, PLEASE EXPLAIN WHY

DECLARATION OF APPROVAL AND SIGNATURES

LEAD INVESTIGATOR

The lead investigator must provide all data below and sign:

LEAD INVESTIGATOR DECLARATION:

I confirm that the information provided in this protocol is correct, that I am not aware of any other ethical

issue not addressed within this form and that I understand the obligations to and the rights of participants (particularly concerning their safety and welfare, the obligation to provide information sufficient to give informed consent, the obligation to respect confidentiality and all the obligations as set out in the Declaration of Helsinki (appendix attached) governing the conduct of research involving human participants) and/or other relevant guidelines (please refer to your Head of Department/School)

NAME: (BLOCK CAPITALS)	Rikke Siersbaek		
STAFF / STUDENT I.D. No.	1734206		
SCHOOL / DEPARTMENT:	Centre for Health Policy and Management, School of Medicine		
COURSE OF STUDY: (if appropriate)	PhD	YEAR	2019
SIGNATURE:		DATE:	

PLEASE NOTE THAT IF THERE IS MORE THEN ONE APPLICANT, ALL APPLICANTS MUST SIGN THE APPLICATION FORM.

NAME: (BLOCK CAPITALS)	

STAFF / STUDENT I.D. No.			
SCHOOL / DEPARTMENT:			
COURSE OF STUDY: (if appropriate)		YEAR	
SIGNATURE:		DATE:	

NAME: (BLOCK CAPITALS)			
STAFF / STUDENT I.D. No.			
SCHOOL / DEPARTMENT:			
COURSE OF STUDY: (if appropriate)		YEAR	
SIGNATURE:		DATE:	

NAME: (BLOCK CAPITALS)			
STAFF / STUDENT I.D. No.			
SCHOOL / DEPARTMENT:			
COURSE OF STUDY: (if appropriate)		YEAR	

SIGNATURE:		DATE:	

NAME: (BLOCK CAPITALS)			
STAFF / STUDENT I.D. No.			
SCHOOL / DEPARTMENT:			
COURSE OF STUDY: (if appropriate)		YEAR	
SIGNATURE:		DATE:	

RESEARCH SUPERVISOR

Student applicants are required to have their Research Supervisor complete this section.

Name of Primary Supervisor:_____

(BLOCK CAPITALS)

Position: _____

State the educational value of this research:

As the student's supervisor, I have read this application and accept responsibility for the ethical conduct of this project:

Signature of Primary Supervisor:_____

Date: _____

Office Use Only:

REFERENCE NUMBER	
HPM-CGH Research Ethics Committee Meeting Date	
Recommended fast track application procedure	
Approval / Conditional Approval / Rejection	
To be resubmitted	
Date	