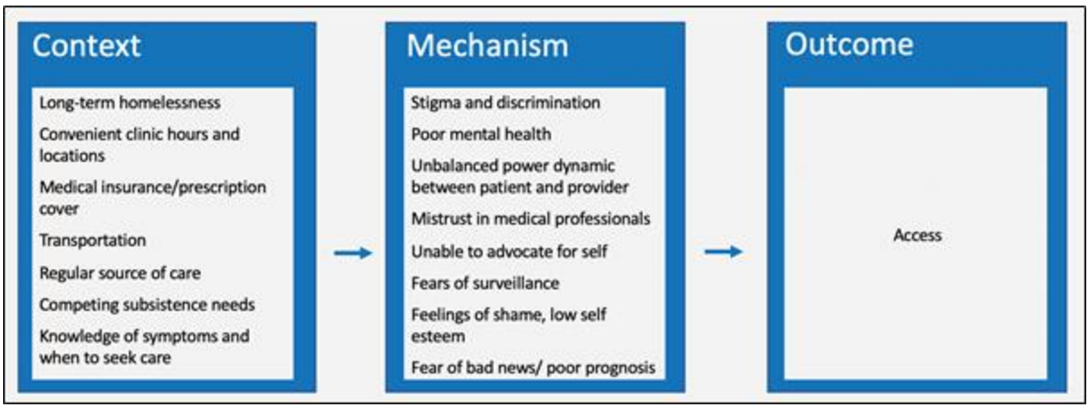
Siersbaek et al *Contexts and mechanisms that promote access to healthcare for populations experiencing homelessness: a realist review*

Supplementary data

1. Initial rough programme theory



2. Systematic literature searches

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

3. Glossary of terms

Context: environments, settings, circumstances or structures that trigger mechanisms. Anything which triggers, impedes or blocks the action of a mechanism[1]

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[1]

Mechanism: apre-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[1]

Outcome: impact, change or action arising when a particular mechanism is activated in a particular context[1]

Programme theory: a combined set of theoretical explanations of how a particular process, intervention or programme is expected to work[1]

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[1]

Relevance: the determination of whether a particular study, report, article etc is relevant to the research question[1]

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[1]

4 Illustrative examples of included data

CMOCs	Examples of supportive data
CMOC1: In a context where mainstream health practitioners and staff (in hospital and primary care settings) are expected to treat long term homeless populations without being provided adequate resources and incentives while also having inadequate expertise in the particular needs and life experiences of this group (C), practitioners and staff feel professionally challenged (M) with feelings of professional inadequacy (M) and a lack of confidence (M) and display an unwelcoming attitude toward patients (M). As a result, patients' experience of the care environment is a negative one which influences them to choose to not seek care at an appropriate time (O). This outcome becomes a new context where patients wait to seek care need is emergent (M) and they feel desperate (M). The result is an exacerbated, more costly need for care (O)	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) 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.** [2] 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** [3] 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**.[4] "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**."[5] **"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 [2]
CMOC2: In a context where funding comes from multiple sources and where funding cycles are short and unreliable(C), staff members employed on short term contracts experience instability (M) and a lack of a feeling of job security (M) because they are in a series of continual contract renewals. The precarious sustainability of the services they work for lead to staff being asked to do more with less but job satisfaction is low (M) because services are permanently in a state of flux making it difficult to achieve good outcomes for people who need extra time and attention. Because they work for organisations with important missions they are expected to not care as much about pay and conditions as they care about helping. The outcome is difficulties hiring and retaining highly skilled and experienced staff members.(O)	**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) [6] 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**. [7] 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**. 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".** [8] 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) [8] **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**.[9] **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. [10] **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.** [10]

CMOC3: In a context where various parts of a health system operate in silos with narrowly defined goals (C), staff engage in organisation-centred thinking (M) and prioritise the goals of the health system over those of the patient. As a result, healthcare is organised around the needs of providers and the system not the person (O).	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**[3] **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.[4] … 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…"** [11] **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.[9] 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**.[11] **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; inflexible appointment policies; lengthy waiting times; limited infrastructure and psychosocial supports; abstinence requirements; and prejudicial attitudes of some staff to PWID. **Barriers to HCV treatment access for PWID include a lack**

	of continued engagement in medical care at the same site, with some PWID experiencing a lack of consistency in the management and monitoring of their HCV, and an accompanying confusion about HCV symptoms, test results and status. **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.** [12] **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** [13]
CMOC4: In a context where care is organised around the person, mechanisms of flexibility and personalisation are triggered allowing for the patient's specific needs to be met. Further mechanisms of service connectivity and making pathways understandable are triggered leading to the outcome of enhanced health system navigability. Also mechanisms of transparency and timeliness in the delivery of services enable the outcome of placing the responsibility for access on services themselves providing services in an opportunistic way using shared and transparent decision making to fit with the patient's particular wishes and needs at the time they arise.	**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**. [14] 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. [15] **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 [5] 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. [5] **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%.** [16]

	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, setting goals that are realistic in the context of homelessness and removing discrimination and stigma from health care interactions**. [2] **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.** This may well be a model that could be extended for homeless people with advanced ill health. [2] **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**. [17] 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**.[17] **Outreach models made it easier for young people to contact services, along with colocated services, and being able to drop in. Waiting times, opening hours (a lack of afterhours services), and eligibility for the service (including age and other intake criteria) were also noted as access barriers. Service availability for priority health conditions, perceived or actual, also affected access**. [18] **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**. [18] 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.[10] **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.[10]

	Allow for patients to have "unscheduled" space to share their life stories and to acknowledge those stories **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 [19]
CMOC 5: In a context where leadership emphasises a culture of inclusivity and explicitly commits to and promotes values of inclusivity and whole organisation policies and processes, services are provided in non-stigmatising, respectful, empathetic ways which builds trust between practitioners and patients. As a patient/provider relationship develops a positive feedback loop is created resulting in deepening trust which compounds and facilitates ongoing engagement which leads ultimately to ongoing appropriate access to health services at the right time and right place.	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**. [20] **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). [21] **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** [2] **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 [19] **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**. [19] 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. [22] **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. [23]

	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. [10] 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**. 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**.[10]
CMOC 6: In a context where healthcare services are delivered with a high degree flexibility in terms of appointment length, availability of walk-in appointments and self-referral, opportunistic add-on services such as vaccinations and screenings etc (C), practitioners and staff with expertise and experience (M) with the population group are able to anticipate (M) the common interventions that may be needed, to adapt (M) to the particular needs of the patient in front of them, and to use their expertise provide the treatment that is most needed in the current situation. As a result, patients' needs are identified (O) this becomes a new context in which patients experience less frustration and fear (M) because they do not have to fit into a mould of a health service which is difficult to navigate. As a further outcome, patients feel seen and understood (O) which again becomes a new context activating engagement from both ultimately leading 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.	**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. [24] **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.** [14] **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. [2] 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. [25] A free clinic in Los Angeles was identified by youth as a model for best practice**. 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). [25] **The ability to develop an ongoing personal connection involved rapport with service providers, continuity of therapeutic relationships, and a usual source of care.** [18] **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 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. [13]

Bibliography

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