Title: The experiences of homeless and vulnerably housed persons around health and social services. A protocol for a systematic review of qualitative studies

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Abstract

Introduction: Homeless and vulnerably housed individuals often have less access to services compared to those in stable housing conditions. The experiences of homeless populations impact their engagement and retention in social programs and healthcare services.

Objective: The aim of this protocol is to outline the methodological process of a systematic review that will gather qualitative data on the factors influencing the acceptability and accessibility of health and social service interventions targeted towards homeless and vulnerably housed individuals.

Methods: This protocol adheres to the PRISMA-P reporting guidelines. We will search MEDLINE, EMBASE, PsycINFO, and ERIC via Ovid; and ProQuest Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts and Sociology Database for qualitative studies published from 1994 to 2018. Articles will be screened by title and abstract, and subsequently by full-text. Sex, gender, and diverse genders will be considered in data extraction a priori framework. Methodological quality of qualitative studies will be assessed using the CASP checklist for qualitative studies. Sex, gender, and other data will be analyzed and key findings identified using framework analysis method. Confidence in key findings will be assessed using GRADE CERQual.

Discussion: The systematic review outlined in this protocol will help to identify key evidence to inform recommendations on providing social programs and healthcare services to homeless and vulnerably housed populations in high-income countries like Canada.

Introduction

The perceptions of people who are homeless and vulnerably housed can affect their participation, engagement, and retention in social and healthcare interventions. Different groups, such as women, youth, and people susceptible to substance abuse, are faced with different emotional, environmental, financial, and structural barriers when trying to access healthcare services.[1] For example, homeless women report that their decision to leave their abusive partner is associated with their social environment, networks, and ability to reach and access shelter services.[2] The views of people experiencing social exclusion should be used to guide practitioners and ensure that services are not only effective, but also inclusive and equitable.[3] Such information is best collected and analyzed through qualitative research, which allows for the study of complex systems and experiences, and provides an in-depth understanding of stakeholder perspectives.[4]

Homeless and vulnerably housed individuals often have worse health outcomes because they have less access to health and social services compared to those in stable housing conditions.[5] For instance, homeless and vulnerably housed individuals have higher risks of chronic diseases, serious mental illness, cognitive impairment, substance abuse, homicide, and suicide.[5,6] This is a significant public health problem in all countries.[7] A growing need for interventions and health policies addressing the risks and effects of homelessness has been recognized in the last ten years.[5,8]

There exists one systematic review of qualitative studies examining the perspective of homeless people and those working to support them towards palliative care access and provision.[9] However, it does not focus on a broad range of interventions which are likely to affect overall biomedical, behavioral, and structural vulnerability factors described by UNAIDS[10]. Our

protocol outlines the methodological process of a qualitative systematic review of the perception of homeless and vulnerably housed individuals on enabling factors influencing the acceptability and accessibility of health and social interventions. The interventions under review include: housing, care coordination, income, mental health and addiction, and women and youth interventions. To our knowledge, there has not yet been a systematic review published on qualitative studies on all our interventions of interest. The systematic review resulting from this protocol will complement a concurrent review, examining the effectiveness and cost-effectiveness of these interventions,[11] to develop evidence-based guidelines for providing social programs and healthcare services to homeless and vulnerable housed persons.

Methodology

The systematic review aims to address the following research question: What do homeless and vulnerably housed populations perceive as biomedical, behavioural, and structural enabling factors that influence the accessibility and acceptability of health and social interventions?

The literature search will conform to the PRISMA for systematic review protocols (PRISMA-P)[12] as closely as possible. The interventions reviewed include: housing, care coordination, mental health and addictions, income, and women and youth interventions. (See Table 1: Description of interventions). These interventions were identified through a Delphi Consensus process[13] involving a working group of health experts, researchers, and people with lived homeless experience.

Homeless and vulnerably housed individuals are susceptible to biomedical, behavioural, and structural factors, described by the UNAIDS[10] vulnerability framework. These enabling factors

can positively influence interventions leading to improved physical, mental, and social health, as well as improved social inclusion and health equity. However, unintentional adverse outcomes may also result from these interventions. For example, service users may experience stigmatization or discrimination when interacting with service providers. Additionally, providing services which do not target the most vulnerable could further increase the health equity gap. (See Figure 1: Logic Model).

1 Inclusion and Exclusion Criteria

1.1 Study designs

The review will consider studies that focus on qualitative data including, but not limited to, ethnography (direct observation of study participants), grounded theory (face-to-face interviews or interactions such as focus groups to explore a research phenomenon), and phenomenology (similar data collection methods as grounded theory, but focuses on understanding how human beings experience their world).[4] Studies which analyze and report their results quantitatively, including mixed-methods studies, will not be considered in this review because such study designs often do not provide in-depth analysis of qualitative data.

1.2 Participants

The review will examine perceptions of unspecified homeless and vulnerably housed populations, defined as individuals experiencing a range of physical living situations including those who are unsheltered, emergency shelter, provisionally accommodated, or at risk of homelessness.[14] Subpopulations of interest include women, youth, and people with acquired brain injury, intellectual, or physical disabilities, which were identified as priority groups in the

Delphi Consensus.[13] The perceptions of additional priority groups, Indigenous peoples and refugees/migrants, will be covered in separate reviews. Equity considerations to be noted are as follows: place of residence, ethnicity/ culture/ language, gender/sex, religion, education, socioeconomic status, social capital, and disability.

Gender-based analysis

We will use a gender-based analysis to examine the intersection of sex and gender with other identity factors. The research will look at studies on the perception of women, men and gender-diverse people. We acknowledge that gender is a social construct that attributes roles, responsibilities, norms, aptitudes, behaviours, and expectations to individuals. The analysis will seek to understand the complexity of different aspects of identity or different socio-economic factors so as to mitigate or eliminate differential negative impacts. Our indigenous health research groups will be examining and making conclusion on indigenous populations.

1.3 Interventions

The intervention groups of interest include: housing, care coordination, income, mental health and addiction, and women and youth interventions.[11] (See Table 1: Description of interventions). We will include studies that have multi-component interventions.

1.4 Review outcomes

Descriptions of primary outcomes are listed below:

- ***Identification of enabling biomedical, behavioural and structural factors*** that affect the target population's participation, engagement, and adherence to specific interventions.

- ***Valuation of positive and negative outcomes of interventions***: The importance placed upon the positive and negative outcomes directly related to the interventions of interest.
- ***Acceptability of interventions***: The willingness of the individual to participate or adhere to the intervention based on their subjective attitudes, preferences, and perspective toward the intervention itself or the process of receiving it (e.g. cultural appropriateness and fears about the intervention)
- ***Accessibility of interventions***: The opportunity or ease with which individuals utilize an intervention in proportion to their needs. Determinants of accessibility include barriers and facilitators such as policies, community factors, healthcare service organization, or the delivery of the intervention itself.

1.5 Duration of follow-up

No duration of follow-up will be excluded.

1.6 Settings

Interventions to be included are those occurring where the primary care of people who are homeless or vulnerably housed takes place. Primary care is the "entry point to the larger health care system" [15] and can be provided by professionals from many disciplines such as family physicians, psychiatrists, emergency physicians etc. For example, we will include primary care interventions provided in the community, private or non-private clinics, hospitals, street care, etc. Studies conducted in middle or low-income countries will be excluded from the review to prevent disparities in intervention provision or outcome variability related to the country's resource availability and gross national income. This will also ensure that the data collected is

applicable to a Canadian context, as the findings of this review will inform an evidence-based Canadian guideline project.

1.7 Date and language restrictions

Publication dates will be limited to the range of January 1994 to January 2018. This reflects the date in which the Canadian government cancelled new long-term investments in social housing,[16] thereby exacerbating homelessness in Canada to present day. We will not exclude studies on the basis of publication language.

2. Search Strategy

A search strategy will be developed and peer-reviewed by a librarian with expertise in systematic review searching. The following electronic databases will be searched for qualitative studies: MEDLINE, EMBASE, PsycINFO, and ERIC via Ovid; and ProQuest Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts and Sociology Database. The search will be restricted from 1994 to 2018. There will be no language restrictions set for the search. The search strategy will use a combination of indexed terms, free text words and MeSH headings (See Table 2: Search Strategy). We will consider primary studies of relevant systematic reviews which come up in our search. If more than one version of a study or systematic review is identified, we will select the most recent version. If the two versions report on different outcomes, both studies may be included.

In addition, we will search specific grey literature for published guidelines and reports at relevant organizations websites. Some examples are: PHAC, WHO, CDC, UNDP, Canadian Agency for Drugs and Technologies in Health, the Institute of Health Economics, the National Institute for

Health and Care Excellence, EuroScan, ECDC, UNAIDS, and the Centre for Reviews and Dissemination database. The literature search results will be uploaded to a reference manager software package to facilitate the study selection process.

3. Study Screening and Selection

Two review authors will independently assess all the potential studies identified as a result of the search strategy for inclusion using inclusion and exclusion criteria (See Table 3: Summary of eligibility criteria). Full reports will be obtained for studies that appear to meet the criteria and studies where the title and abstract alone are insufficient to determine eligibility. The criteria will be piloted on a sample of studies using a calibration exercise before being applied. We will resolve any disagreements through discussion or, if required, we will consult a third review author. The full texts of potentially eligible citations will then be screened independently in duplicate.

4. Data Extraction

We will develop a standardized extraction sheet informed by the "Risk and Vulnerability Framework" described by UNAIDS[10] (See Table 4: Data extraction sheet). The data extraction sheet will be piloted by two independent reviewers. Teams of two reviewers will then extract data from included studies in duplicate and independently. The two reviewers will compare results and resolve disagreements by discussion or with help from a third reviewer. At a minimum, we will extract results as they apply to the framework.

5. Quality assessment of included studies

The quality of primary studies will be assessed using the Critical Appraisal Skills Programme (CASP) for qualitative studies. CASP is a tool that assesses the validity, results, and applicability of results of clinical research.[17] Quality assessment criteria will not be used to include or exclude studies but will be used to assess confidence in the findings.

6. Confidence of the evidence of included studies

We will use the Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool to assess the confidence of our findings.[18] This tool is a new method for assessing the strength of qualitative review evidence, similar to how the GRADE approach assesses the strength of quantitative evidence. CERQual bases the evaluation on four criteria: (a) methodological limitations of included studies supporting a review finding, (b) the relevance of included studies to the review question, (c) the coherence of the review finding, and (d) the adequacy of the data contributing to a review finding. Key findings will be presented in a CERQual Summary of Findings Table.

7. Qualitative Analysis and Synthesis

We will use the framework method as a systematic and flexible approach to analysing qualitative data[19] and group ideas of acceptability, values, preferences, and accessibility across key populations. Addressing homelessness relies on the combination of evidence-based behavioural, biomedical, and structural intervention strategies. Combination intervention programmes operate on different levels (e.g. individual, relationship, community, and societal levels) to address the specific and diverse needs of vulnerable populations at risk.[10] The "Risk and Vulnerability Framework", adapted from UNAIDS,[10] will be used to identify factors (causes of risk and

vulnerability) and patient preferences which influence intervention access, use, and acceptability. This framework will additionally identify biomedical, behavioural, and structural factors that act as enabling factors and influence corresponding causes of risk and vulnerability to homelessness. (See Table 5: Risk and vulnerability framework descriptions). As previously mentioned, we will utilize a gender-based analysis to discern any differences in results on the basis of gender.

Dissemination

We will use the findings of this systematic review, findings of a separate quantitative synthesis on the effectiveness and cost-effectiveness of interventions for homeless and vulnerably housed individuals, systematic reviews on the prevalence of disease burden, and specific grey literature to create a guideline document for family practitioners. This document aims to inform practitioners and allied health professionals of evidence based recommendations and resources for homeless and vulnerably housed persons. We will publish the completed systematic review in as an open access document in the Canadian Medical Association Journal.

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Conflicts of Interest

There are no reported competing interests.

Author Contributions

KP conceptualized the work. OM, AS, QA, AG, AR, VK, VYL drafted the manuscript. DP, KP provided content expertise. All authors revised and approved the final manuscript.

Table 1: Description of the interventions of interest

Intervention	Category	Description
Housing interventions	Housing First	An evidence-based supportive housing intervention for homeless populations experiencing mental illness and substance use
Mental health interventions	Assertive Community Treatment (ACT)	Offers team-based care by a multidisciplinary team of healthcare workers that provide services tailored to the needs of each person
	Intensive Case Management (ICM)	Helps service users maintain housing and achieve a better quality of life through the support of a case manager
	Pharmacological interventions for psychosis	Effectiveness of injectable antipsychotics as a first line of treatment for homeless individuals in precarious situations
Addictions interventions	Supervised consumption facilities	Legally sanctioned facilities where people who use intravenous drugs can inject pre-obtained drugs under medical supervision
	Managed alcohol programs	Includes shelter, medical assistance, social services and the provision of regulated alcohol to help residents cope with alcohol dependence
	Pharmacological interventions for opioid therapy	Injectable medications for opioid use disorder (eg: Naloxone)
Interventions for care coordination and case management	Peer-support	Provision of encouragement, affiliation and services by or with an individual who has experienced a similar background to the service user
	Non-intensive case management	Including Clinical Case Management and Standard Case Management which allow for the provision of an array of social, healthcare, and other services with the goal of helping individuals maintain good health and strong social relationships
Interventions for income assistance	Direct Income assistance	Benefits and programs offered by individuals or institutions that increase income with the goal of improving socioeconomic status
	Cost Reduction	Addresses critical social determinants of health needs for which

	Support/Indirect Income Assistance	a person would otherwise be paying out of their basic income
Interventions for women and youth	Women	Motivational interview counselling, structured education sessions, therapeutic communities, and multimodal interventions
	Youth	Place-based interventions, youth and family focused therapy interventions, parental monitoring interventions, and street outreach and addictions services

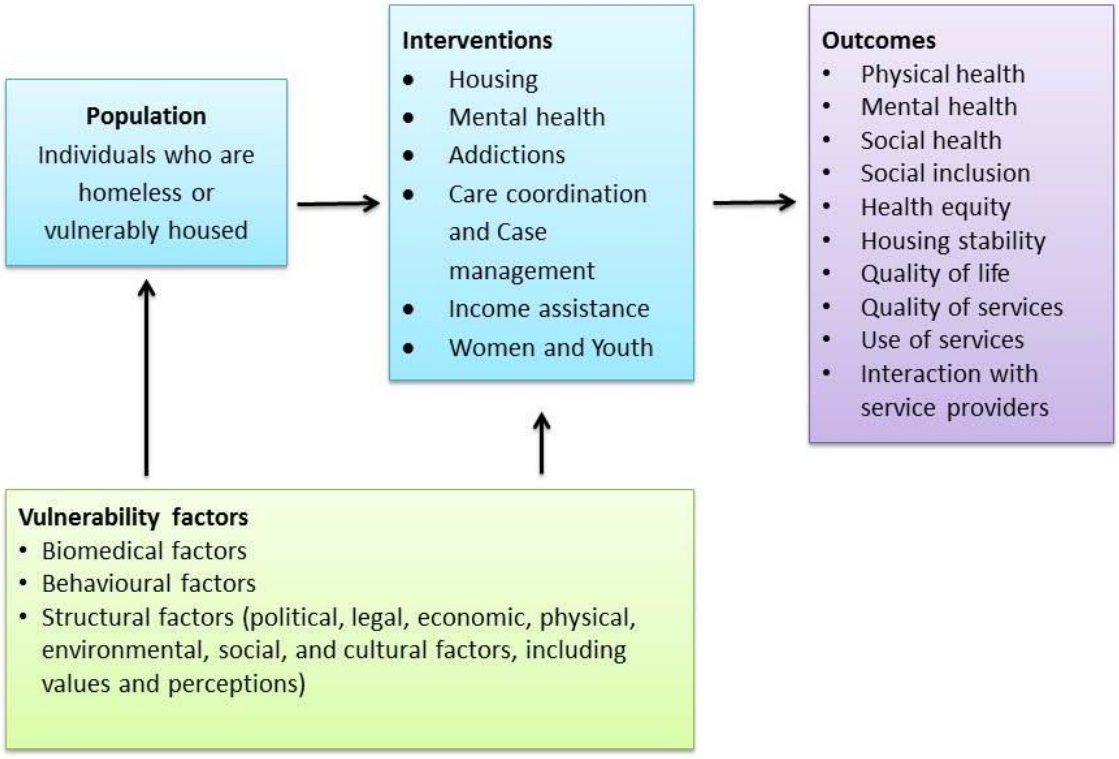

Figure 1: Logic Model related to vulnerabilities and interventions

Table 2: Search Strategy

Step	Indexed terms, free text words and MeSH headings
1	exp homeless persons/ or exp homeless man/ or exp homeless youth/ or exp homeless woman/
2	(homeless* or underhouse* or roofless* or unhouse* or squatter* or shelter* or unsheltered).ti,ab.
3	("no fixed address" or "seeking shelter" or "street involved" or "sleeping rough" or "unstable housing" or "housing instability" or "precarious housing" or "precariously housed" or "lack of housing" or "rough sleep" or "vulnerably housed").ti,ab.
4	(((homeless or street or transient* or marginal* or vulnerabl*) adj2 (population or person or persons or people* or individual or individuals or adult or adults or child* or youth* or men or man or women or woman)) or ((temporary or unstabl* or vulnerabl*) adj2 (hous* or accommodation* or shelter* or hostel* or dwelling*))).ti,ab.
5	1 or 2 or 3 or 4
6	exp health knowledge, attitudes, practice/ or exp patient satisfaction/ or exp patient preference/ or exp health services accessibility/ or exp health equity/ or exp Attitude to Health/ or exp self efficacy/ or exp Adaptation, Psychological/ or exp health education/ or exp Health Risk Behaviors/ or exp social behavior/
7	(patient adj3 (value* or preference* or belie* or attitude? or perspective* or view*)).ti,ab.
8	((access or accessib*) adj5 (care or health*)).tw.
9	(acceptable or acceptabilit$ or prefer$ or satisf$ or useful$ or utility or value$ or perspective* or view* or perceived or belie* or knowledge or expect*).ti,ab.
10	((biomedic* or behavio?r* or structur* or physical or environment* or social or politic* or econom* or cultur*) adj5 (factor* or barrier* or facilitator*)).ti,ab.
11	6 or 7 or 8 or 9 or 10
12	((("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth

	or "face-to-face" or structured or guide) adj3 (interview* or discussion* or questionnaire*)) or (focus group* or qualitative or ethnograph* or fieldwork or "field work" or "key informant")).ti,ab. or interviews as topic/ or focus groups/ or narration/ or qualitative research/
13	5 and 11 and 12
14	limit 13 to yr="1994 -Current"

Table 3: Summary of eligibility criteria

Population	We will consider studies of homeless and vulnerably housed individuals of high income countries.
Setting	Primary care setting in high-income countries. Studies conducted in low- and middle-income countries will be excluded. No restriction on rural or urban settings.
Interventions	Interventions of interest include interventions for housing, care coordination, income, mental health and addiction, and women and youth described above. However, studies will be included in our review as long as the intervention is related and/or generalizable to the six topics of interest.
Comparison	No intervention or other intervention comparison.
Outcomes	Identification of biomedical, behavioural and structural factors affecting patient perspectives, views, attitudes and beliefs regarding the intervention(s) and the barriers and enabling factors to implementation and use; valuation of positive and negative intervention outcomes; views about acceptability and accessibility of interventions.
Study Design	The review will focus on the values and perceptions of homeless and vulnerably housed persons, which is most appropriately answered through qualitative research. Qualitative methods may include, but is not limited to, ethnography, grounded theory or phenomenology. Any study which utilizes survey data or statistical reporting of results will be excluded, as will commentaries or discussions on the subject. Qualitative data from a mixed methods study will be excluded.
Restrictions	Date of publication limited from January 1994 to January 2018. No language restrictions.

Table 4: Data Extraction Sheet

Bibliographic Details	**Author**	
	Year	
	Title	
	Publication information	*Journal name, volume, issue, page numbers, doi.*
Methods	**Population and Setting**	*Description of geographic context (country, city), intervention context (ex: primary care setting), and target population*
	Study Objective	*As reported in the study*
	Study Methodology	*Data collection and analysis methods*
	Sample size and Characteristics	*How many participants were included, what was the response rate/lost to follow up, characteristics of population (ex: age, sex, education, employment, etc)*
	Length of Follow-up	*If applicable*
	Intervention Description	*Describe the intervention(s) included in the study. What is implemented, how is it done, by whom, for whom, etc.*
Key Findings	**Biomedical**	*Themes and concepts identified in the study, including supporting quotes and author interpretations*
	Behavioural	
	Structural - Social and Cultural	
	Structural - Political, Legal, Economic	
	Structural - Physical Environment	

	Other	
Conclusions	**Evidence Summary**	
	Source of Funding	*Source of funding and role of the funder*
	Other Information	*Ethical considerations, if applicable, other.*

Table 5: Risk and Vulnerability Framework level descriptions (adapted from UNAIDS)[10]

FRAMEWORK LEVEL	DESCRIPTION
Biomedical	• Bodily states that can contribute to the development of chronic disease • May also be influenced by behavioural risk factors
Behavioural	• Individual lifestyle-related factors that influence health and may lead to development or prevention of disease or disability • May include alcohol and drug use, inactivity, or care-seeking behaviours
Structural	• Environmental conditions outside of the control of individuals that influence their perceptions, their behaviour and their health • Activities designed to alter specific environmental factors to create a more enabling environment for treatment, care and support • May include features of the social, cultural, economic, political and physical environment

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