Integrating healthcare services for people experiencing homelessness in Australia: key issues and research principles

Brendan Clifford, Lisa Wood, Shannen Vallesi, Stephanie Macfarlane, Jane Currie, Fiona Haigh, Katherine Gill, Andrew Wilson, Patrick Harris

BACKGROUND
In 2016, the Australian Census found approximately 116,000 people to be experiencing homelessness. People experiencing homelessness have higher morbidity and mortality than the general population, and so require meaningful access to quality healthcare, as well as integrated service responses across health, social and housing domains. Improving health outcomes requires understanding the complex role of structural determinants of homelessness, such as the availability of secure housing and employment, gender equality, racism, in addition to the funding and structure of health and social services. The requirement for health service responses that are tailored to people experiencing homelessness has been highlighted by the COVID-19 pandemic. People experiencing homelessness have few resources with which to support prevention measures from COVID-19, such as accommodation that enables social distancing and self-isolation or hygiene facilities, compounding the risk from higher rates of diseases such as chronic respiratory conditions. These factors require an integrated service response from health and housing in order to successfully protect health and reduce transmission risk.

In this article, we first present three key issues identified in our work for the integration of healthcare of people experiencing homelessness in Australia: the adequate recognition of homelessness in health services, the need to enhance access to healthcare, and the need for effective integration across health, housing and social services. We then outline some principles with which to underpin future healthcare service delivery and research for people experiencing homelessness.

CURRENT ISSUES
Recognising homelessness in healthcare services
Chamberlain’s definition of homelessness is composed of three categories: primary or street homelessness; secondary, in temporary shelters and refuges; and tertiary, referring to boarding houses or other accommodations that fall below community standards of privacy or amenity. Housing status is frequently inadequately assessed by health services, and so its prevalence is under-reported. Individuals who can provide an address and people who do not appear ‘typically homeless’ may not be asked about their housing status. Better recognition of homelessness in healthcare services requires the development of screening tools and processes, as well as systems that support healthcare workers in understanding and responding to homelessness.

Though issues exist with the use of administrative health service data for research purposes (eg, ‘no fixed address’ being shown to be a poor indicator of homelessness), there is potential for such data to better characterise the composition and the needs of this population. Data linkage also offers the opportunity of connecting health with other sectors. This is currently hampered by a lack of standardised terminology as definitions of homelessness and marginal housing are differ between Australian government agencies.

Optimising access to care
People experiencing homelessness face complex barriers to accessing care through traditional primary care or hospital settings. There may be more immediate needs than healthcare to meet (such as shelter and food) or a lack of means to remember or attend appointments. Experiences of stigma and...
discrimination in healthcare settings related to either homelessness or other factors, such as race, indigenous status or substance use, can also present a barrier, as well as compounding the high rates of lifetime and current trauma in this group.\(^8\) In addition to improving the accessibility of mainstream services and their capacity to provide trauma-informed care, there may be a role for homelessness-specific models of healthcare delivery, a number of which are currently being developed. Assertive outreach models proactively bring services to people in the community rather than waiting for individuals to self-present to services. The issues facing people experiencing homelessness are often complex, and their resolution requires multidisciplinary input to ensure an appropriately holistic response.\(^8\) In-reach models of primary care into hospital settings make use of the stability afforded by hospitalisation to effectively link people with housing, primary healthcare and other community services.\(^9\) Such models also require understanding of how the specific needs of different groups intersect with the experience of homelessness. Homelessness for women, for instance, is strongly related to family and domestic violence, a growing issue in Australia. Aboriginal and Torres Strait Islander peoples require both culturally safe mainstream services as well as culturally specific programmes.\(^10\) Young people; people who are lesbian, gay, bisexual, transgender or intersex; asylum seekers; and refugees also require particular attention to ensure access to services is equitable. A one-size-fits-all model of service provision is unlikely to be appropriate for all groups or across differing geographical and policy contexts. Evaluation of the strengths and weaknesses of models of healthcare for people experiencing homelessness would strengthen the ability of agencies to develop responses that are adapted to local needs and resources.

**Integrating healthcare services**

It is clear that permanent housing is the long-term solution for someone experiencing homelessness. Permanent supported housing approaches such as *Common Ground* and *Housing First* emphasise the role of ‘wraparound’ health and social services in both helping people to exit homelessness and maintaining tenancy once rehoused.\(^5\) Such wraparound support is essential to people who may have past experiences of trauma, disability, persistent mental illness or substance use dependency. In Australia, implementing the healthcare component of such wraparound support is complicated by a complex health system with differing state, federal and ‘out-of-pocket’ funding mechanisms and a blended public and private service delivery model. Primary care systems centred on an episodic primary care model and a crisis-oriented hospital model result in a ‘missing middle’ of services for people with moderate, persistent health conditions. Siloed healthcare services present a challenge to a population with high rates of comorbid mental illness, substance use disorders and other long-term health conditions,\(^11\) so people can be continually referred between systems without receiving treatment. A lack of suitable supported housing options can leave hospitals as the accommodation of last resort, particularly for people with high levels of unmet psychosocial need, and can result in people being discharged into homelessness.

Models of healthcare that integrate ongoing primary and specialist healthcare services in the community and that articulate with non-health sectors such as housing and justice would be better able to meet the needs of people experiencing homelessness. This also means equipping health professionals with the knowledge and skills to understand and work with and advocate to partners outside of the healthcare system. The sharing of data between agencies is vital to preventing people from falling through gaps in the system, which requires robust data governance mechanisms to ensure privacy and dignity. How such integrated care models are funded is key, and so health economic studies should shift from counting the costs of caring for people experiencing homelessness in acute systems to how funding models can be built, which support the provision of healthcare where it is most needed—in primary care, in the community and in partnerships.

**HOMELESSNESS & HEALTH RESEARCH**

The priority of each of the aforementioned issues depends on local needs and resources and so varies across jurisdictions in Australia. Their complexity requires moving beyond traditional biomedical research paradigms to build an appropriate evidence base for intervention.\(^12\) In this section, we provide an overview of key concepts that underpins a person-centred, rights-based approach to health services and research that accounts for the complexity of intersectoral working.

**Human rights approach**

People experiencing homelessness tend to experience an intersection of human rights vulnerabilities (eg, right to health, education, liberty and security of the person, privacy, social security, the freedom from discrimination and violence). A rights-based approach to research presents a duty to researchers to produce evidence on how these rights may be better achieved, broadening the focus of research to understanding how violations of these rights intersect to produce poorer health outcomes, and what interventions might better support their fulfillment.\(^13\) A human rights framework informs not only the focus of research but also how research is conducted. Such procedural rights include the right to access information and to participate in decisions, the right to non-discrimination and the requirement for accountability mechanisms. A human rights-based approach to homelessness research incorporates people with lived experience in research coproduction, devises more effective methods of communication, and addresses stigma and discrimination, as well as holding researchers accountable to the community with which they are undertaking research. In addition,
better understanding of the intersection between health and human rights may enhance the capacity of healthcare professionals to recognise the importance of structural determinants and the need to advocate for health equity through structural change.

**Coproduction**

Coproduction is a well-established principle of conducting health research and essential to producing findings of relevance to marginalised communities. Research funding bodies have recognised the value of coproduction and are increasingly mandating the active involvement of consumers. Such mandates also need to be supported with clear practice guidelines and funding structures. Coproduced research requires the input of lived experience at all stages of research—development, implementation and dissemination. It also requires that traditional researcher–subject power imbalances be overcome in order to achieve meaningful partnership. Adequate time and resources need to be dedicated to enable effective participation of people with lived experience in research, as well as inducting researchers new to coproduction into trauma-informed research practice.

**Strengths-based**

Research describing rates of disease or disadvantage is important in understanding the needs of a population but also risks reinforcing negative stereotypes of ‘deficient’ individuals. Strengths-based approaches recognise people’s agency—their capacity to overcome structural challenges and constraints—and directs research towards exploring mechanisms which facilitate personal empowerment. For people experiencing homelessness, these may include trauma-informed, person-centred practices such as psychologically informed environments, lived experience peer workers culturally specific services such as Wongee Mia and harm reduction facilities such as managed alcohol programmes.

**Intersectoral working**

Homelessness requires not only an integrated healthcare response but also that healthcare effectively partners with other sectors at both a service level and at a policy level. This type of intersectoral working requires models of network governance that balance efficiency with inclusivity and stability with flexibility to ensure effective operation. Examples of network approaches to addressing healthcare and homelessness, such as the Sydney Intersectoral Homelessness Health Strategy, provide useful opportunities for empirical research in this area.

**Complex systems approach**

Both homelessness and healthcare service delivery are complex, and a systems lens is required to understanding the intersection of both. Systems approaches are well suited to understanding the multiple, non-linear pathways of causation in homelessness, and new techniques in modelling could also be applied to the complex interventions needed for integrating healthcare responses. Such approaches may allow for the assessment of the effect of changing one part of the system without intervention in another—for example, the impact on rates of homelessness from increasing healthcare or case management services without a concomitant change in the availability of suitable housing or income security. The participatory processes required for such systems approaches may also be useful in catalysing action across sectors. Realist evaluation can be a particularly useful systems methodology in understanding how the social contexts of norms, values and interrelationships interact to affect programme outcomes.

**CONCLUSION**

Poor health does not inevitably lead to homelessness but does require health, social and housing services to work together effectively to support people when they require assistance to find or stay in appropriate housing. In this article, we point to a number of issues worth focusing on to achieve this, as well as suggest some principles to support the development of an inclusive, rights-based and systems-oriented research agenda. Addressing the structural drivers of homelessness requires advocacy from healthcare services for health equity through better social policy. Healthcare services need to overcome a number of challenges in order to offer meaningful and timely access to quality care for people experiencing homelessness. Effective inclusion of lived experience is necessary to produce evidence of relevance. Researching ways to successfully integrate healthcare services with each other and with other sectors is key to realising both the right to housing and the right to the highest attainable standard of health for people experiencing homelessness.

**Author affiliations**

1. Menzies Centre for Health Policy, The University of Sydney, Sydney, New South Wales, Australia
2. School of Population and Global Health, The University of Western Australia, Perth, Western Australia, Australia
3. Population and Community Health, South Eastern Sydney Local Health District, Darlinghurst, New South Wales, Australia
4. School of Nursing, Queensland University of Technology, Brisbane, Queensland, Australia
5. Health Equity Research Development Unit, University of New South Wales, Sydney, New South Wales, Australia
6. Population Health, Sydney Local Health District, Camperdown, New South Wales, Australia
7. Consumer Led Research Network, The University of Sydney, Sydney, New South Wales, Australia
8. Centre for Health Equity Research, Training & Evaluation, University of New South Wales, Sydney, New South Wales, Australia
9. Population Health, South Western Sydney Local Health District, Liverpool, New South Wales, Australia

**Contributors** BC: conceptualisation, preparation of first draft and manuscript review. SV, LW, SM, JC, FH, KG, AW and PH: conceptualisation and manuscript preparation. The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors. None declared.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Patient consent for publication** Not applicable.
REFERENCES


