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A systematic review of the effect of stigma on the health of people experiencing homelessness.

What is known on this subject

- Stigma is commonly reported by people experiencing homelessness
- Stigma is known to have a negative effect on health

What this paper adds

- People experiencing homelessness commonly report stigmatising experiences when they access healthcare
- Perceiving stigma in healthcare settings is associated with poorer access to care and may affect all aspects of healthcare delivery

Keywords

Stigma, discrimination, homelessness, rough sleeping, roofless, mental health, physical health, wellbeing, service access

Abstract

Experiencing homelessness is associated with poor health, high levels of chronic disease and high premature mortality. Experiencing homelessness is known to be socially stigmatised and stigma has been suggested as a cause of health inequalities. No previous review has synthesized the evidence about stigma related to homelessness and the impact on the health of people experiencing homelessness. The present mixed methods review systematically searched four databases and retrieved 21 original articles with relevant data around stigma, homelessness and health. Across all studies there was broad agreement that some people experiencing homelessness experience significant stigma from providers when accessing healthcare and this impacts on general health and service access. There is also evidence that perceived stigma related to homelessness correlates with poorer mental and physical health.

Introduction

Experiencing homelessness is a risk marker for extreme social exclusion and associated with poor physical and mental health. (Bramley et al, 2015; Fazel et al, 2014). People experiencing homelessness (PEH) therefore have high needs for health and social care. Recent systematic reviews of their experiences and barriers to accessing these services by Magwood et al (2019) and Omerov et al (2020) have concluded they have multiple unmet health needs and value trusting relationships within care. PEH are also acknowledged to face stigma in society generally and to be highly aware of the stigma of homelessness themselves. (Phelan et al, 1997; Rayburn et al, 2014) Stigma is defined by Link and Phelan (2001) as “the co- occurrence of labelling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised”. There has been research on the effects of stigma and health with regards to several different statuses such as HIV and sexual orientation and it has been suggested by Hatzenbeuler (2013) the effect of stigma on health is so detrimental it could be considered a fundamental cause of health inequalities. Although many research papers focusing on experiences of PEH mention stigma as a theme, no synthesis aimed at understanding the evidence for the effect of stigma on the health of PEH has been published.

In this review the literature both qualitative and quantitative around stigma and health for people experiencing homelessness is synthesized and recommendations for further research and policy developments outlined.

Health of people experiencing homelessness

Premature mortality in PEH is known to be high with estimated standardised mortality ratios between 3-10 times greater than in the general population (Aldridge et al, 2018; Cheung et al, 2004). The rates of physical conditions, mental conditions and drug and alcohol misuse are high, even compared with the most socioeconomically deprived housed populations (Fazel et al, 2014).

Stigma

Link and Phelan define stigma as “a multi-step process involving firstly labelling and separation of the stigmatised individual or group which causes status loss and discrimination in a context of power differentials” (Link and Phelan, 2001).

Internalised stigma

This refers to “the negative cognitions and beliefs a person may hold about themselves as a result of having a stigmatised status” (Ritsher et al, 2003).

External Perceived Stigma

Stigma acting at the interpersonal level therefore shaping an interaction between two people or groups of people is often referred to as perceived stigmatisation or perceived discrimination. Measuring whether stigmatisation occurs between two people is highly subjective, so researchers often use the perception of stigmatisation to measure its impact. Two forms of perceived stigma are discussed in this paper – **external perceived stigma** which is stigma experienced in society in general and **healthcare provider (HCP) perceived stigma** which is stigma or discrimination occurring within the healthcare system. The terms perceived discrimination and perceived stigmatisation are used interchangeably. In this paper perceived discrimination is used when this is the term used in the primary paper however for the purposes of the analysis they are viewed as the same concept. This is in line with published papers in mental health and learning disabilities that have treated perceived stigma and perceived discrimination as interchangeable concepts (Latalova and Karamandova 2014, Ali et al, 2008).

Stigma as a determinant of health

Both internalised stigma and external perceived stigma/discrimination related to a variety of characteristics have been found to predict multiple outcomes in physical and mental health (Pascoe and Richman, 2009).

Stigma in healthcare

The effect of either internalised stigma or perceived HCP stigma on health behaviours and help seeking has also been studied. People with chronic illness who had internalised stigma or had experienced HCP stigma were less likely to access care and had a decreased quality of life (Earnshaw et al, 2012). Internalised stigma related to mental illness has also been shown to reduce help seeking (Clement et al, 2015) and perceived HCP stigma related to mental illness is associated with poorer non-verbal communication in subsequent encounters, healthcare usage and slower recovery (Wang et al, 2018; Hausman et al, 2011). In US based research by Blanchard et al (2011) perceived stigma or discrimination in healthcare settings appears to be relatively common for minority ethnic groups and to relate to poorer care access.

Research Question

It is hypothesized that stigma is a causal factor in the poor health of PEH. The overall aim of this review was to investigate the impact of stigma on health and healthcare for PEH. The decision was taken to frame the review by asking the following question.

To what extent do PEH experience any form of stigma when using healthcare and how does this affect their relationships within healthcare and all aspects of healthcare delivery?

Justification for research method

Two systematic reviews by Omerov (2020) and Magwood (2019) have analysed PEH experiences of services and both found stigma to be a significant theme, however the focus of these reviews was on acceptability of services and experiences of health and social care, as opposed to stigma and the effect on health, and neither focused on evidence of the effect stigma might have on outcomes related to health. Given that both found stigma to be significant in the experience of PEH when accessing healthcare it was decided that a review with a focus on how stigma is within healthcare is affecting PEH was justified.

Scoping searches found two types of relevant research papers. Qualitative papers describing experiences or attitudes of PEH or healthcare professionals and quantitative survey type papers looking at prevalence of stigma or discrimination and associated factors. Since there is a relatively sparse literature related to this it was decided a mixed methods review looking at both prevalence and detailed experiences would be a valuable addition.

Methods

Introduction to Methodology

The review methodology for this Mixed Methods Systematic Review (MMSR) was based on that described by Gough et al (2007) for the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-centre) and the Joanna Briggs Institute (JBI) model for evidence synthesis (Aromatis and Munn, 2020).

In this current review a convergent segregated approach to combining the evidence types is used, as described by the JBI (Lizarondo et al, 2020).

Search Strategy

Terms chosen were related to homelessness, stigma or discrimination and health or health services and HCP. These were combined using Boolean operators to focus on articles dealing with all 3 concepts.

Box 1

Sample search string

(homeless* or rough sleeping or unhoused or roofless) AND (Stigma or prejudice or discrimination or attitudes or bias or stereotyp*) AND ((physician OR doctor OR therapist OR health service OR nurse OR allied health professional OR midwife OR dentist OR physiotherapist OR paramedic OR occupational therapist OR clinician OR primary care OR secondary care) OR (health or mental health or psychological health or quality of life or healthcare access OR wellbeing OR quality life))

References of all papers that were included after the final screen were also checked to find additional relevant studies. The database's used were Medline, Web of Science, Embase and PsychInfo. Initial searches were undertaken in April 2020 with a final updated search in August 2020.

See Appendix 2 for full search strategy

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were generated using the Spider tool (Cooke et al, 2012) which is designed for qualitative or MMSR.

Screening was undertaken independently by two reviewers (JR and IH or JR and AEW) and disagreements resolved by discussion.

(Table 1)

Data extraction and evaluation

The lead author initially read all the final papers included several times, to gain familiarity with the material. Data was then extracted using a standardised template regarding type of study; location; theoretical framework; number of participants. (see table 2)

Qualitative synthesis

A thematic synthesis was performed as described by Thomas and Harden (2008) using a stigma lens to find information relevant to the study questions. Research papers were imported into NVIVO 12 and line by line coding undertaken of the included papers. Initial

codes were generated by inductive reasoning from the material and these were then grouped to form themes.

Quantitative synthesis

Quantitative papers were heterogenous in nature and meta-analysis was not possible. A narrative synthesis of quantitative papers was therefore performed as described by Lisy and Porrit (2016).

Quality and risk of bias assessment

Quality assessment was independently performed by two reviewers for all papers using the JBI standardised checklists (2020) for qualitative and cross-sectional studies.

Figure 1 here

See Appendix 1 for full quality assessment

Results

Overview of research papers

21 original articles were found to fit the inclusion criteria; 5 quantitative or mixed methods papers and 16 using qualitative methods.

Broadly the qualitative and quantitative results confirmed perceived stigma was a relatively common occurrence when accessing healthcare for PEH, that PEH experienced perceived stigma as extremely negative and upsetting and that perceived stigma was strongly linked to healthcare access, with PEH being less likely to access healthcare if they had previously been stigmatised by a HCP.

Qualitative studies

The qualitative studies were largely focused on PEH although six also interviewed HCP. PEH were largely recruited through hospitals or day care centres and data gathered through interviews or focus groups with 320 PEH in total and 64 HCPs. The majority of PEH in the studies were adult males but one study focused on young people (18-25) (Hudson et al, 2010) and Gordon et al (2019) and Biederman (2014) focus exclusively on women. No studies included sought the experiences of homeless children and families. Most studies used semi structured interviews or focus groups to elicit data although one included a focused ethnography of PEH (O'Carroll and Wainwright, 2019).

The aims of the studies were generally heterogenous focusing on either barriers to care or experiences/perceptions of PEH within the healthcare system. None had a stated aim of exploring stigma within healthcare.

Quantitative or mixed methods studies

Five quantitative or mixed methods studies were identified. Three cross sectional studies containing 1232 participants in total measured the impact of perceived stigma related to homelessness as well as other attributes (race, HIV status) and related this to psychological distress, physical health and service avoidance (Skosireva et al, 2014; Weisz and Quinn, 2018; Davila et al, 2010). Only Skosireva et al focus specifically on stigma within the health system. The other studies focused on internalised stigma related to homelessness but not specifically or solely experienced within healthcare.

A further two studies used a cross sectional survey design but did not specifically study stigma.

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Quality assessment

Most of the included studies were judged to be fair to good quality with minor concerns highlighted on quality assessment in some papers. Concerns for the qualitative papers were around use of an appropriate ethical framework and for the cross sectional studies around statistical methods and use of appropriate outcomes.

Table 2

Qualitative Synthesis

A striking finding from the studies was how much importance people experiencing homelessness put on healthcare professional's attitudes towards them, and how deeply experiences of perceived stigma were felt. Language used was highly emotive.

After coding the data, generating inductive themes then grouping and merging relevant themes together, sixteen sub-themes relevant to stigma were found. These were then grouped into four overarching categories which are described:

Dehumanisation

“it makes me subhuman almost, like that I don't really belong in society” (Wen et al, 2007)

Dehumanisation is the process by which a person is seen as not fully human but like an animal or a thing. Although no study used the term dehumanisation or specifically looked for this as an outcome, this was a strong theme that emerged; dehumanising statements or feelings were reported in several studies (Wen et al, 2007; O'Carroll and Wainwright, 2019;

Rae and Rees, 2015; Gilmer and Buccieri, 2020). There were statements from people experiencing homelessness stating that they felt they were treated as less than human, or like animals. They felt humiliated by this treatment. There were also statements from healthcare professionals which although superficially caring were in fact subtly dehumanising. Attitudes from HCP towards PEH were described as “*demeaning*” (Ramsay and Hossien, 2019) and PEH felt when their homeless status was discovered their individual identity was lost, “*succumbed to negative group association*” (Beiderman and Nichols, 2014). HCP also noted this tendency so see PEH as a group and not as individualised human beings. Campbell and O’Neill (2019) noted a darker side to the medical community - “*the other half is a definite, darker side of the medical community that turns around and goes ‘oh, is that what you are?’*” and when discussing training for HCP in dealing with PEH the necessity of “*stepping out of? the medical model*” was noted by Varley et al (2019), referencing the need for HCP to understand the life circumstances of a person and offer holistic care rather than simply aim to diagnose and treat single conditions.

Power differentials and stereotyping

“Participants also referred to a generic fear of health professionals and the power they can wield. Participant12: “Yeah. And I’m very intimidated by ... big Doctors ... I get very intimidated around them. I start to get panicky” (O’Carrol and Wainwright, 2019)

Power is a key part of the stigma concept and PEH referred to the power that HCP had on multiple occasions. Instances of stereotyping also came into this; so judgemental; rude or dismissive behaviour that was perceived to be due to the persons homelessness status. HCP had the power to stereotype and belittle PEH. It was clear that PEH were cognisant of the power HCP hold (to prescribe a medicine for example or intercede with other agencies on their behalf) but this was not mentioned by HCP. PEH who were addicted to drugs or suffered from chronic pain felt powerless to get treatment they needed as they felt doctors thought they were just after a “*fix*” however they felt they needed urgent treatment (Gilmer and Buccieri, 2020). This was experienced as a sense of utter powerlessness and despair for example - “*half the time the GP’s not going to believe you ... they’re just gonna think you*

want another script early because you're using it recreationally' (M, aged 24 years, SA)" (Gunner et al, 2019).

PEH recalled even minor incidents of dismissive treatment that others might not. They found dismissive treatment to be humiliating (Whitley, 2013; Rae and Rees, 2015) . Trust was also a frequent mention in this category and a feeling that healthcare professionals did not trust them as they stereotyped them as drug addicts or criminals (Wen et al, 2007; Gilmer and Buccieri, 2020). People experiencing homelessness felt they received poorer care because they were stereotyped due to their housing status (Gilmer and Buccieri, 2020).

Healthcare professionals also mentioned stereotyping of PEH for example in Campbell et al (2015) *"The other half is a definite, darker side of the medical community that turns around and goes 'oh, is that what you are?'"* and were aware of the possibility of this in themselves or others but were less likely to mention power differentials as a concern. **Error! Bookmark not defined.**

Internalised/Anticipated Stigma and care avoidance

"According to our respondents, stigma manifested in health care providers not taking into account patients' lived realities when considering recommended courses of action; in overt discrimination, rude or thoughtless behavior toward their clients; and finally resulted in care avoidance due to negative past experiences on the part of service users" (MacKenzie and Purkey, 2019)

Campbell and O'Neill, O'Carrol and Wainwright and Rae and Rees all document an association between perceived or anticipated stigma, discrimination or poor treatment and reluctance to seek care. It was also reported in several instances by O'Carrol and Wainwright that poor care and discrimination reported by other PEH stopped people seeking treatment. Internalised stigma was not explicitly discussed in reference to reluctance to seek care but was clearly present in some of the quotations. In Gordon et al the authors state PEH *"anticipated negative stigma, making them hypersensitive."* in the same paper a woman describes herself as *"disgusting"* in relation to her homeless status and her shame at attending for medical care, showing clearly how deeply internalised stigma can be felt. Internalised stigma was also evident in the way PEH would try and conceal their homeless status at times as they were ashamed of it but they found having to lie embarrassing. A PEH states

“Sometimes I lie about being in a shelter. It’s degrading but I do it so they [hospital staff] aren’t inconvenienced” (Greyson et al, 2013)

Several papers referenced that regardless of actual poor treatment and discrimination in many instances this was a significant expectation of PEH (Gunner and Chandon, 2019; Sturman and Matheson 2020) making them highly sensitive to any hint of disparaging treatment. There was no objective evidence offered of treatment disparities for PEH but it was notable that many PEH believed they had not received appropriate care or treatment for their health. It seems unlikely that clinicians would actually alter a management plan based on the fact of someone being homeless however negative stereotypes could mean they are less likely to reach a correct diagnosis or take a complete history for example. Even if the correct treatment is given if the patient felt they did not have enough information or reassurance they might believe their treatment to be substandard.

Healthcare professionals also frequently highlighted past poor experiences in healthcare as a reason for care avoidance by patients. HCP who worked with PEH were clearly aware of the difficulties PEH faced accessing appropriate care and treatment and made suggestions for improving this (Varley et al, 2020; Campbell and O’Neill, 2015).

Importance of positive relationships

“The influence of staff attitude on a patient’s health-seeking behaviour was emphasised by several participants and said to be a ‘decider between life and death’ for some patients who are homeless:” (Gunner et al, 2019)

Although all studies mentioned stigma and discrimination as a major problem for PEH in the healthcare system a number also mentioned positive attitudes and relationships. The notable finding here was how much value and importance was placed on these positive relationships with healthcare professionals. Many of the people experiencing homelessness clearly valued a rapport and good understanding with one of their healthcare providers and appreciated when they felt someone took time and trouble with them. It appeared that people experiencing homelessness viewed care in more than purely technically sound terms but wished their healthcare to come with positive and trusting relationships to make a difference.

Positive relationships were described in more than one instance as “*life saving*” (Wen et al, 2007; Gunner et al, 2019).

Nowhere in the studies described was good care described by PEH in technical terms – getting the correct medication or referral for example. Good care was always about a caring relationship, empathy, and a feeling of being seen as human. Good care was associated with extra effort to get to know the circumstances PEH were in for example through outreach work (Hudson et al, 2010) which was seen as positive as it involved professionals reaching out to PEH and meeting them on their own terms. It also was described as professionals being interested in PEH and seeing them as individuals (Varley et al, 2019).

Quantitative Synthesis

In total five studies had relevant quantitative data however only 3 directly measured stigma or perceived discrimination related to homelessness and related this to health in PEH. The two other association studies were all were cross sectional surveys performed in the US or Canada and are described below.

Skosireva et al (2014) measured perceived HCP stigma in 550 ethnically diverse homeless mentally ill adults. They found a prevalence of perceived HCP stigma within healthcare related to homeless status of 30% and that discrimination due to homeless status was reported more frequently than due to race or ethnicity in non-white participants. In this sample perceived discrimination in healthcare settings was associated with higher emergency department use, greater duration of homelessness and severity of mental health problems.

Davila et al (2018) focused on stigma experiences of people with HIV who were homeless. They found external stigma related to homelessness to be reported by 30.8% of participants. Perceiving stigma for one condition increased the likelihood of perceiving stigma related to other conditions eg HIV or mental health problems. The findings did not report on any correlation between homeless stigma and health related quality of life although this was also measured. The study had one question about perceived health care provider stigma due to homelessness and prevalence reported was lower than in the previous study at 9.6%. Perceived stigma related to homelessness by HCP was more prevalent than HCP stigma related to mental health (5.6%) or substance misuse (7.2%) in this sample. It was noted that

the low prevalence of HCP stigma in this sample could be because participants were linked to having previously been enrolled on a specialist HIV treatment program that prioritised sensitive culturally competent care.

Wiez et al (2018) directly measured stigma by interviewing 138 PEH in the US and tested the associations between perceived external and internalised stigma related to homelessness, racial stigma and physical and psychological health and service avoidance. They found moderate correlations between perceived external and internalised homelessness stigma and all three outcome measures even after controlling for race; mental illness and time spent homeless. This study did not measure perceived HCP stigma related to homelessness.

Two further studies that used quantitative or mixed methodology were included in the review. These studies did not set out directly to measure stigma but were included as the results are pertinent to the research question.

Irestig et al (2010) performed a cross sectional survey in Sweden of PEH trust and experiences in the healthcare system and other social institutions. They asked about levels of trust and experiences of being well treated or badly treated by the healthcare system. 21% of the sample reported being rather badly or very badly treated by the healthcare system. They did not link levels of trust or mistreatment in the healthcare system with physical or mental illness, but their sample had a high level of mental and physical morbidity. Levels of trust in the healthcare system were high (76%) but the authors included a free text question in their survey asking about improvements to the healthcare system. 88 PEH in the sample responded to the question. The authors state that responses fall into two categories – administrative issues and attitudes towards patients. They give examples but do not state numbers of PEH who cited attitudes as a concern. Some examples of stigma experienced by PEH in the paper are *“Not being classified as trash” “Not being discriminated if no address” “Human beings are not machines” “Talk nicely and so I can understand”*

Greyson et al (2013) conducted a mixed methods study based in the US. They aimed to evaluate quality of discharge care for PEH which involved a survey of PEH experience including both closed and two open ended questions relating to hospital discharge; and reviewing medical records. They found that 56% of patients chose not to disclose their housing status and when asked the reason why cited fear of receiving suboptimal care or being discriminated against. They found assessment of housing status while an inpatient was

associated with better discharge care assessed by performance on several indicators such as follow up arrangement.

Taken together the quantitative studies provide evidence that perceived stigma in healthcare is at the least not an unusual experience for PEH, with frequencies of between 9.6 - 32%. In Sweden a country generally considered to have excellent health outcomes; a significant minority report being treated very badly by the health service. There is also evidence of a direct link to poorer care specifically discharge care in Greyson et al and evidence that perceived external stigma, perceived HCP stigma and internalised stigma were linked to poorer health.

Integrating the Qualitative and Quantitative findings

Five of the sixteen sub-themes found in the qualitative studies are also supported by the quantitative findings. Care avoidance related to stigma was found in two of the quantitative studies (Skosireva et al, 2014; Weisz et al, 2018). Evidence for poor care was also found in two studies as was stereotyping **Error! Bookmark not defined.** mistrust of HCP and internalised stigma (Wood et al, 1997; Irestig et al, 2010; Weisz et al, 2018).

Overall, the findings suggest that stigma has at least a moderate effect on health of PEH. The qualitative findings suggest that perceived HCP stigma is a common experience of many PEH and when experienced is seen as extremely detrimental to ongoing healthcare and relationships. The quantitative findings provide support for the hypothesis that HCP stigma is a relatively common occurrence and confirms its relationship to service avoidance. They also suggest an association between internalised stigma related to homelessness and health although conclusions cannot be drawn about the direction of this relationship.

The qualitative studies suggested a significant positive effect from non-stigmatising or positive relationships. This was not tested or evident in the quantitative studies but could be an avenue for future interventional research.

The intersectional nature of stigma was evident in both the qualitative and quantitative papers with many studying more than one stigmatising status including mental illness, HIV status,

substance misuse, minority race/ethnicity or sexual orientation. It was evident that stigma is a complex interlocking phenomenon and untangling the effects of multiple stigmatised status's on health is difficult, however it was clear from both sets of research that PEH ranked the stigma related to homelessness relatively high mentioning this at least as frequently as other stigmatised status.

Discussion

This is the first review to focus on stigma related to homelessness and its relationship to health. The review provided evidence that experiencing stigma when accessing healthcare is a relatively common occurrence for PEH and that it affects relationships within and future access to healthcare.

Findings in relation to research questions

There was ample qualitative evidence that PEH experienced perceived HCP stigma extremely negatively and that this caused them to avoid services. There was also evidence of anticipated stigma when attending healthcare facilities and that PEH also had internalised stigma which could become evident when attending for healthcare.

There was evidence of negative and stigmatising attitudes from HCP towards PEH, this included qualitative evidence with multiple examples from PEH indicated they expected and had experienced discriminatory attitudes. HCP also reported negative attitudes to PEH – often reporting on the attitudes of other HCP but also describing their own attitudes in some studies. The exact prevalence of perceived HCP stigma due to homelessness was not determined as this was only directly measured by two studies.

The relationship between perceived stigma and service avoidance was widely confirmed. There was quantitative evidence that stigma at all levels related to homelessness was associated with lower physical and mental health but this was fairly limited with only one or two measures in each study and only assessed at one point in time.

Implications for research

Further research using a longitudinal design might be able to elucidate the direction of the association between internalised and perceived stigma and physical and mental health and service avoidance. The relationship between perceived HCP stigma and internalised stigma and poorer mental and physical health could also be further defined. In mental health perceived HCP stigma has been shown to be related to internalised stigma and patient disempowerment (Wang et al, 2018) but whether this would also be the case for PEH is unknown.

There is also an urgent need to research anti stigma interventions related to homelessness. A number of anti-stigma interventions focusing on patients, providers and the general public have been evaluated in relation to mental health stigma by Rao et al (2019) but no research appears to have attempted to reduce stigma related to homelessness.

Implications for services

The review suggests that PEH experience significant stigma and marginalisation in care and strengthens the case that PEH as a highly marginalised group require specialised patient centred services with training in compassionate care. Initiatives involving trauma informed and compassionate care are being promoted in services worldwide and these should be beneficial although there has been shown to be a gap between theory and practice when putting into place these interventions (Tehrani-neshat et al, 2019).

Strengths and Limitations

Only studies published in English were included and there was a focus on high income countries, in particular the US and Canada and the experience of PEH in the global south is

not described. It could be argued that attitudes to homelessness in the US and Canada may be particularly stigmatising as the US especially is known for being a meritocratic society and therefore could be argued to be judgemental on those who are disadvantaged. Although this is possible studies from Europe and Australia including Sweden, traditionally seen as a very progressive country with an excellent social security system, also confirmed that PEH experience significant stigma.

Although a quality assessment was performed no studies were excluded on the grounds of poor quality, but the studies judged of poor quality had only a minimal contribution to the overall findings.

Conclusion

Overall, the findings suggest that stigma related to homelessness contributes to the significant health inequalities experienced by this group. Stigma was noted at multiple levels including internalised stigma, external perceived stigma and external perceived HCP stigma and evidence for an association with poorer health and service avoidance was present.

It is important that people who design and work in services for people experiencing homelessness should be aware of the impact of stigma related to homelessness on health. Further research on mechanisms and interventions to combat stigma are needed including in the whole health system and wider society

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Table 1. Spider inclusion and exclusion criteria

<p>Sample</p> <p>Include</p> <ul style="list-style-type: none">• People in homelessness by ETHOS definition (FEANTSA, 2006)Error! Bookmark not defined.• Any age group• Healthcare providers (HCP) describing attitudes or experiences with PEH• Published 2005 – present day <p>Exclude</p> <ul style="list-style-type: none">• Non - healthcare providers or in education i.e., students, social workers,• PEH where homeless stigma is not described i.e., focusing on mental health stigma in PEH only
<p>Phenomenon of Interest</p> <p>Include</p> <p>Qualitative studies</p> <ul style="list-style-type: none">• Stigma of any type either in interactions with healthcare or linked to health is a result or a theme in the study and discussed in the research findings.• Discrimination or perceived poor treatment in healthcare settings if attributed to homelessness status• Include intersectional stigmas if stigma due to homelessness also described within the paper. <p>Exclude</p> <ul style="list-style-type: none">• Papers describing stigma experienced by PEH in general if no clear link to health or healthcare settings <p>Quantitative studies</p> <ul style="list-style-type: none">• Any measures of stigma or perceived stigma on a standard scale if linked to any outcome relevant to health• Any measure of prevalence of perceived HCP stigma towards PEH• Measures of attitudes to PEH in healthcare professionals• Intersectional stigma if homeless stigma also described

Exclude

- Stigma unrelated to homelessness e.g., mental health only
- Prevalence of stigma studies in non-healthcare settings

Design

Include

Qualitative studies

- Focus groups, interview studies, ethnographic research

Quantitative studies

- Questionnaires, cross sectional or longitudinal surveys

Evaluation

N/A

Research type

Include

- Quantitative or quantitative or mixed methods studies.

Exclude

- Case reports, editorials, review articles
- Not published in a peer reviewed journal
- Thesis and dissertations
- Not published in the English language

Table 2 – Overview of included papers and quality assessment

Authors Year	Setting	Participants	Aim of study	Data collection	Theoretical framework (if applicable)	Quality assessment 10 point checklist <small>Error! Bookmark not defined.Error! Bookmark not defined.</small>
Hart Romeo 2005	New York US	1 researcher posing as a person experiencing homelessness in clinics	Attempt to understand the experiences and needs of people experiencing homelessness as well as their interactions with health care providers	Participant observation study	NA	10
Wen et al 2007	Toronto Canada	17 shelter dwelling adults	Define experiences of welcomeness and unwelcomeness in healthcare encounters	Semi structured interviews	Bubers I-it and I- Thou framework to define ways of interacting	8
Hudson et al 2010	Santa Monica US	24 young people experiencing homelessness (18- 25 years) frequenting services of a drop- in site.	What are homeless young adults' perspectives on facilitators and barriers to receiving health care? How can existing homeless youth and young-adult-centered health care programs be improved?	Focus groups	NA	8

Whitely 2013	Rural new Hampshire US	13 participants 11 men 2 women. Recruitment via local homeless service.	Explore attitudes to health care and examine overall health and psychosocial perspectives among a non-random sample of people experiencing current or recent homelessness	Interviews with topic guide	NA	9
Beiderman and Nichols 2014	North Carolina US	15 women experiencing homelessness	What are homeless women's perceptions of interactions with service providers? What behaviours or actions of service providers do homeless women consider supportive? What behaviours or actions of service providers do homeless women consider unsupportive?	Semi structured interview	Interpretive phenomenological	
Campbell et al 2015	Calgary Canada	Adults experiencing homelessness (n = 11) Healthcare service providers for those experiencing homelessness (n = 11)	Enhance knowledge about perceived primary healthcare needs among urban homeless populations in Calgary. Explore what barriers currently exist to meeting these needs.	Semi structured interviews Focus groups	Qualitative Descriptive study	9
Rae and Rees 2015	London UK	14 adults from shelter for homeless people or day service.	Understand the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influence their health-seeking behaviour.	Semi structured interviews	Interpretative phenomenology	9

Mago et al. 2018	Vancouver Canada	25 participants. Approached through shelter staff	Reveal and describe from open-ended interviews how homeless people in Vancouver interpret, appraise and cope with dental care.	Semi structured interviews.	Interpretive description Lazarus's theory of emotions.	10
Ramsay and Hossein. 2019	Canada	16 adult participants 13 men, 3 women. Approached through shelter system	Explore how participants living with homelessness experience barriers and facilitators during their interaction with the health system.	Semi structured interviews	NA	10
O'Carrol and Wainwright 2019	Dublin Ireland	142 people experiencing homelessness. 47 interviewed 26 hospital doctors in focus groups	Describe the health service utilisation of homeless people in Dublin and to gain insight into why it differs from the domiciled population.	Ethnographic observation. Semi-structured interviews. Focus groups	Critical realist ethnography	10

McKenzie and Purkey 2019	Canada	10 professionals involved in end of life care for people experiencing homelessness	Explore barriers and solutions to the delivery of palliative care to people experiencing homelessness.	In depth interviews	NA	9
Gunner et al. 2019	West Midlands UK	22 adults recruited via shelters or homeless healthcare centre	Explore the perspectives of the population that is homeless around their access to and use of primary healthcare services, including mainstream general practices and a specialist centre.	Semi structured interviews	NA	10
Gordon et al 2019	South Yorkshire, UK	11 pregnant women experiencing homelessness	Explore how pregnant women experiencing homelessness conceptualise perinatal care.	Semi structured interviews	NA	8
Varley et al. 2020	Birmingham US	36 adult homeless patients receiving care from a VA provider. 24 healthcare professionals	What meanings, aspirations and understandings do homeless-experienced patients and clinicians caring for them assign to general concepts of primary care quality?	Semi structured interviews. Snowball sampling	NA	8

Sturman et al. 2020	Australia	20 men largely residing in one hostel	Explore the experiences and attitudes of homeless men regarding community-based healthcare, and general practice in particular, to identify the potential areas for improvement.	Focus groups	NA	9
Gilmer and Buccieri 2020	Rural and semi-rural Ontario Canada	47 people experiencing homelessness	Where do vulnerably housed or homeless individuals receive health care and what needs do they feel are not adequately addressed in these settings due to clinician bias?	Semi structured interviews and hospital notes review	Fraser's narrative enquiry	8
Studies with Quantitative or Mixed methodology						Quality assessment
Greyson et al 2013	USA	98 hospitalised people experiencing homelessness. 8 people focus group	Characterise the quality of discharge care for this population.	Chart review Survey Focus group	Chart review indicated discharge care poor. Perceived stigma related to disclosure of housing status.	7

Irestig et al 2010 Error! No bookmark name given.	Stockholm Sweden	155 participants	Elucidate people experiencing homelessness perceived treatment and trust in healthcare service	Structured questionnaire (quantitative) and open-ended question (qualitative)	Trust in healthcare system not significantly different from gen public. Qualitative results indicate attitude important. Strong association between trust and perceived treatment.	6
Skosireva et al 2014	Canada	550 homeless adults with mental illness	Examine prevalence of perceived discrimination in healthcare over 1-year period related to homelessness, mental health and addiction or race and ethnicity. Association of PD with psychiatric symptoms, ED usage and substance misuse.	Cross sectional survey	Results Perceived discrimination in healthcare settings common >30%. More commonly reported due to homelessness and poverty than race or ethnicity. Highest prevalence of perceived discrimination was in long term homeless people.	8

Davila et al. 2018	Canada	Cross sectional survey 571 participants. People experiencing homelessness and living with HIV.	Explore stigma related to HIV, homelessness, mental health, and substance use, as well as perceived and experienced provider stigma. Also examined factors contributing to high levels of stigma among PLWHA who are homeless.	Cross sectional survey.	Results Perceived external stigma highly prevalent homelessness most common cause. Provider stigma less prevalent but not questioned in relation to homelessness.	7
Weisz et al. 2018	USA	175 people experiencing homelessness	Test the hypothesis that homelessness stigma would predict worse physical health, higher psychological distress, and more service avoidance after controlling for the effects of age, race, gender, time spent homelessness, and mental illness status	Cross sectional survey.	Results Participants who experienced and anticipated more stigma as a function of being homeless reported more psychological distress, worse physical health, and a greater tendency to avoid using services, even after controlling for gender, race, age, time homeless,	8

Figure 1. Prisma flow diagram



