Promoting continuity of care for homeless adults with unmet health needs: The role of brief interventions

Denise Lamanna, Vicky Stergiopoulos, Janet Durbin, Patricia O'Campo, Daniel Poremski, and Joshua Tepper

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Abstract

Promoting timely and continuous care for people experiencing homelessness has been a challenge in many jurisdictions, plagued by access barriers and service fragmentation. As part of a larger programme evaluation, this study used qualitative methods to examine the role of a brief interdisciplinary intervention in supporting continuity of care for this population in a large Canadian urban centre. The intervention provides time-limited case management, primary and psychiatric care, and peer accompaniment to homeless adults with unmet health needs discharged from hospital. Data were collected from 52 study participants between July 2013 and December 2014. Three focus groups were conducted with service providers and people with lived experience of homelessness, and 29 individual, semi-structured interviews were conducted with service users and other key informants. Transcripts were analysed using thematic analysis. Analysis was informed by existing frameworks for continuity of care, while remaining open to additional or unexpected findings. Findings suggest that brief interdisciplinary interventions can promote continuity of care by offering low-barrier access, timely and responsive service provision, including timely connection to long-term services and supports, appropriate individualised services and effective co-ordination of services. Although brief interdisciplinary interventions were perceived to promote access, timeliness and co-ordination of care for this population with complex health and social needs, gaps in the local service delivery context can present persisting barriers to care comprehensiveness and continuity.

Key words: brief interventions, continuity of care, homelessness, qualitative research, service co-ordination

What is known about this topic:

- Brief case management for people experiencing homelessness can increase perceived access to community based care, decrease use of acute care and reduce symptom severity.
- Service providers perceive that working alliance can be developed in the context of brief case management interventions for people experiencing homelessness.

What this paper adds:

- Diverse stakeholder groups perceive that brief interdisciplinary interventions can support continuity of care for people experiencing homelessness and unmet health needs.
- Continuity of care can be promoted through low-barrier service design relevant to the realities of homelessness, a focus on service user engagement, responsive service provision and timely navigation of the service system.
- Service users and providers perceive that interdisciplinary interventions can promote co-ordination, timeliness and comprehensiveness of services.

Introduction

Continuity of care is a complex construct referring to individual patients' experiences of health services as integrated and co-ordinated across settings and over time (Haggerty et al., 2003). Although some variability in definitions persist, it is generally established that continuity of care involves service provision that is longitudinal, timely, accessible, individualised and comprehensive, involving co-ordination and communication between service providers, organisational linkages and lasting interpersonal relationships (Bachrach, 1993; Fortney et al., 2003; Haggerty et al., 2003; Joyce et al., 2004; Vandyk, Graham, Vandenkerkhof, Ross-White, & Harrison, 2013). In mental health services, it has been associated with improved social functioning, decreased symptom severity and extended periods without readmission to hospital (Puntis, Rugkåsa, Forrest, Mitchell, & Burns, 2015). However, as continuity of care occurs when separate and discrete elements of care are connected, it is challenging to achieve within the fragmented health and social service systems found in many jurisdictions.

Continuity of care is markedly more challenging for individuals with complex support needs (Dixon, Holoshitz, & Nossel, 2016). Among them, people experiencing homelessness and chronic health conditions warrant particular attention (Fazel, Geddes, & Kushel, 2014; Gozdzik, Salehi, O'Campo, Stergiopoulos, & Hwang, 2015; Wagner et al., 2014). In most settings, health service experiences of this population are fragmented and often interrupted, involving extensive barriers to appropriate community-based services (Corrigan, Pickett, Kraus, Burks, & Schmidt, 2015; Gelberg, Browner, Lejano, & Arangua, 2004; Khandor & Mason, 2007; Skosireva et al., 2014). Within Canada's publicly funded, single-payer system of universal healthcare coverage, access barriers for people who are homeless include the cost of prescription medications (Hwang, Wilkins et al., 2011; Khandor & Mason, 2007), service fragmentation, lack of

identifying documents (Campbell, O'Neill, Gibson, & Thurston, 2015; Krausz et al., 2013), as well as stigma and discrimination (Khandor & Mason, 2007; Skosireva et al., 2014). Burra, Hwang, Rourke, and Stergiopoulos (2012) found that homeless adults discharged from psychiatric inpatient care in a large Canadian urban centre were less likely to be referred to services than their housed counterparts. Furthermore, the At Home/Chez Soi study found that homeless adults' health service use in five Canadian cities varied by ethno-racial identity, suggesting pervasive disparities (Stergiopoulos et al., 2016). Not surprisingly, homeless adults in Canada utilise costly acute services at disproportionate rates (Hwang, Weaver, Aubry, & Hoch, 2011; Saab, Nisenbaum, Dhalla, & Hwang, 2016), a trend reported internationally (Buck, Brown, Mortensen, Riggs, & Franzini, 2012; Department of Health 2010, O'Carroll & O'Reilly, 2008).

Despite the success of Housing First interventions in improving housing stability for homeless adults, the model has not been widely implemented across jurisdictions (Aubry et al., 2016; Stergiopoulos, Hwang et al., 2015). Furthermore, although effective health interventions are available in major urban centres, long wait lists for services and strict eligibility criteria create persisting barriers to care continuity, prompting some advocates to call for targeted, low-barrier bridging services to engage and support this disadvantaged population (Hwang & Burns, 2014; Stergiopoulos, Hwang et al., 2015). Indeed, brief interventions, such as the Critical Time Intervention model (CTI), have been designed to facilitate continuity of care for adults experiencing homelessness, offering timely care while facilitating long-term connections to existing long-term services. Early findings have been promising, suggesting that short-term case management in CTI may improve participants' perceived access to community-based services (Tomita & Herman, 2015) and reduce rates of psychiatric re-hospitalisation (Shaffer, Hutchison,

Ayers, Goldberg, & Herman, 2015; Tomita & Herman, 2012). A qualitative study of CTI found that case managers perceived that the time-limited model did not hinder development of a positive working alliance (Chen & Ogden, 2012), widely considered to be crucial in supporting homeless service users (Dixon et al., 2016; Padgett, Henwood, Abrams, & Davis, 2008). Similarly, O'Toole, Johnson, Borgia, and Rose (2015) found that recipients of a brief health assessment and clinic orientation were 2.5 times more likely to access the clinic within the month. Despite evidence that brief interventions can improve service accessibility and utilisation, their role in promoting other aspects of continuity of care, including comprehensiveness, co-ordination and appropriateness, has not been sufficiently investigated. Furthermore, service user perspectives have been largely overlooked in previous research.

For both human and economic reasons, improving continuity of care and health outcomes among people who are homeless is a priority in many jurisdictions. Drawing from existing conceptualisations of continuity of care (Bachrach, 1993; Fortney et al., 2003; Haggerty et al., 2003; Joyce et al., 2004; Vandyk et al., 2013), this study aims to explore diverse stakeholder perspectives on the role of brief interventions in supporting continuity of care for this vulnerable population. We engaged service users of a brief interdisciplinary intervention, service providers, service managers and people with lived experience of homelessness to develop a deeper understanding of how brief interventions can support care transitions into long-term services and service users' ongoing connectedness to care.

Description of the Intervention

Informed by earlier research into brief interventions for adults experiencing homelessness, Co-ordinated Access to Care for Homeless People (CATCH) provides brief (up to 6 months) case management and access to interdisciplinary care for homeless adults discharged from hospital

and lacking appropriate health and social supports (Stergiopoulos et al., 2017). “Homeless” is here defined as living on the street, in a crisis/emergency shelter or couch surfing. The brief intervention operates in Toronto, Canada, and is a partnership of three local hospitals, a large community mental health agency, a homeless shelter, a physician practice plan and a peer-run service organisation.

The intervention aims to provide time-limited services while establishing continuity of care through timely referral to and co-ordination of appropriate and comprehensive long-term health and social services. Three CATCH case managers (CMs), each with a caseload of approximately 20 service users, serve homeless adults discharged from one of three urban hospitals. CMs assess needs, introduce service users to providers within the interdisciplinary team, offer assertive outreach and home visits, and facilitate connections to income supports, housing, and community-based health and social services as needed. Furthermore, CATCH offers service users a dedicated weekly shelter-based clinic staffed by a nurse, a primary care physician and two psychiatrists, helping address immediate health needs while seeking long-term services. Peers accompany service users to clinic and other appointments in the community as needed. Monthly team meetings serve to review comprehensive care and crisis plans. Additional programme partnerships facilitate timely access to income supports, long-term case management and comprehensive primary healthcare.

Methods

This work is a sub-study within a larger mixed methods evaluation of the CATCH programme investigating health and service use outcomes among 225 programme participants over 6 months of follow-up (Stergiopoulos et al., 2017). We chose mixed methods and a realist stance, particularly useful for its strength in linking quantitative measures of programme effectiveness

with qualitative inquiry to expose complex social and structural factors (Pawson, Greenhalgh, Harvey, & Walshe, 2005). Critical realism can be particularly useful in examining the role of health interventions for socially marginalised populations, where the outcome of an intervention must be specified through both mechanisms and contexts (Frauley & Pearce, 2007). In this sub-study, drawing from existing conceptualisations of continuity of care (Bachrach, 1993; Haggerty et al., 2003; Vandyk et al., 2013), we examine diverse stakeholder perspectives on the role of a brief intervention in supporting continuity of care, using qualitative methods for their strength in studying phenomena that have not been well documented (Miles, Huberman, & Saldaña, 2014; Palinkas et al., 2015). We conducted qualitative interviews and focus groups, and analysed data using thematic analysis (Braun & Clarke, 2006). Our study received research ethics board approval from St. Michael's Hospital in Toronto, Canada.

Participant sample and recruitment

We sampled 52 participants, including programme service users ($N = 22$), programme staff ($N = 8$), managers of partnered organisations ($N = 7$), people with prior lived experience (PWLE) of homelessness and mental health conditions ($N = 8$), and external service providers who work in the area of homelessness and mental health or substance misuse and are not connected to the programme under study ($N = 7$). We purposefully selected stakeholders especially knowledgeable about the subject area, forming a sample that encompassed a range of perspectives on both the brief intervention itself and the broader context of homeless service provision. The triangulation of data sources, including programme service users, programme staff and managers, and individuals external to the programme, expanded the range of perspectives in which we looked for patterns and supported the trustworthiness of our findings (Miles et al., 2014).

We recruited service user participants at the 6-month follow-up interview of a study evaluating programme outcomes. Thirty-three service users among 225 service users participating in the programme's outcome evaluation were randomly selected and invited to complete a qualitative interview at the 6-month follow-up visit. Twenty-two of the 33 service user participants approached (66%) agreed to participate. Table 1 presents the characteristics of service users completing qualitative interviews. All partner organisations' managers were invited to participate in individual interviews, and all organisations were represented. All CATCH programme staff were invited to participate, and only one staff member was unable to attend. PWLE were recruited through an affiliated hospital's consumer advisory panel, and external providers were recruited through organisations known to work in this sector. Written informed consent was obtained from all study participants by trained research staff. Service users and PWLE received \$25 honoraria and public transportation fares for their participation.

Data collection and analysis

Data collection took place between July 2013 and December 2014 in Toronto, Canada. Programme staff, external service providers and PWLE participated in three semi-structured focus groups. Programme service users and managers of partnered organisations participated in 29 semi-structured individual interviews. All interview and focus group guides solicited "thick" descriptions of the topic, including information on health and social service needs of this population, service availability and accessibility, processes that enable timely access to appropriate, comprehensive services and co-ordination of services across different service sectors. Guides for service user participants also explored experiences with the brief intervention, including direct service provision and transfers to long-term providers. Guides for programme staff and managers solicited additional information on the intervention, contextualized within the

larger service system; those for external providers and PWLE focused on their perspectives of the service system's capacity to serve people experiencing homelessness. The service user interview guide was piloted with three programme service users prior to data collection. The interviewers and lead researcher met regularly throughout data collection to refine the interview guides and prompts in an iterative process to better understand participant perspectives (Miles et al., 2014). Two interviewers experienced with disadvantaged populations were responsible for all data collection; both facilitated each focus group, and one or both conducted each individual interview. Both interviewers had previously met and established rapport with service user participants. Consistency of interviews was promoted by interviewer training and review of early transcripts. The focus groups and interviews were audio-recorded and transcribed verbatim. The focus groups had a mean length of 86 min, and interviews had a mean length of 59 min. The sample size provided access to rich data and in-depth descriptions of care experiences.

Data were analysed using thematic analysis, informed by conceptual work outlined earlier, including the accessibility, timeliness, lasting therapeutic relationships, co-ordination and comprehensiveness of services, while remaining open to additional or unexpected findings (Bachrach, 1993; Braun & Clarke, 2006; Haggerty et al., 2003; Vandyk et al., 2013).

During data analysis, we looked for and highlighted consistencies and divergences between diverse participant groups' perspectives. To further enhance methodological rigour, we pursued analyst triangulation (Miles et al., 2014). The first interviewer coded a subset of transcripts, which were reviewed by the second interviewer, and discussion informed minor revisions to the emerging coding framework. The first interviewer coded the remaining transcripts. Upon completion of coding, the full code list and a sample of relevant quotes were reviewed by the first interviewer, lead researcher and an additional research team member in an iterative process

that included review of emerging themes and generation of a thematic map of the analysis (Braun & Clarke, 2006), refinement of themes, and grouping into themes and sub-themes. Data analysis was facilitated by qualitative data management software QSR NVivo vers.9.2.

Findings

Study participants across stakeholder groups identified several key elements promoting continuity of care within the brief intervention, including elements promoting low-barrier access to services, timeliness, individualised and engaging care, service navigation and co-ordination. Systemic issues of service availability were also exposed. These themes are elaborated below with illustrative quotes.

Facilitating access to services

Participants identified that service location and appointment escorts were key components promoting continuity of care. Service users valued that CMs were “willing to go out in the community” (service user 6), and that the weekly clinic was easily accessed by public transit. As one service user commented, “one streetcar, [and] I’m there” (service user 12). Another service user valued that the weekly clinic was located “close to my other appointments ... I’m down here a lot” (service user 19).

Programme staff and service users perceived that accompaniments to appointments with new service providers were effective in reducing barriers to accessing services. Cognitive impairments or active mental health symptoms made it difficult for some participants to remember or make it to appointments, while others were nervous about meeting new service providers. PWLE similarly reported that their mental health sometimes made it challenging to meet their scheduled meetings, with one saying that a one-hour appointment consumes “half the

day ... it's just dealing with my disorder to get there". Accompaniments by peer support workers or CMs offered practical and emotional support, and improved appointment attendance: "I needed somebody just to start me off going to appointments, and I was feeling weak and worried and anxious, so [CM] hooked me up a couple of times with that" (service user 22).

Offering timely services

Within the brief intervention, service users were offered immediate access to the interdisciplinary team's range of skills and expertise. Such timely service connections were a new experience for most service users, as this quote highlights: "I was not expecting it to be so quick ... that was amazing" (service user 3). Service users described timeliness, through both scheduled appointments and drop-in clinic times, as highly valued.

Both service users and providers perceived that some health and social needs could not be met by the brief intervention's own clinicians. Promptly scheduled appointments with additional services were therefore deemed necessary to effectively address service user needs. Timely connections to needed supports alleviated service users' stress, as this service user, quickly approved for income support, reported: "I didn't expect it that quickly ... I was relieved" (service user 9). Another service user, referred to a specialist, described: "I can't believe how quickly I got in to see the rheumatologist ... it's best to get it done really quickly, so I don't have to worry about it" (service user 21).

The importance of timeliness extended beyond the value of simply receiving treatment promptly. Quick connections to appropriate services signified rapid results, and some service users needed to see results to sustain the hopefulness and motivation to remain engaged with the help-seeking process. As shown above, many service users described the speed of service connections to

programme and community-based service providers with enthusiasm and surprise. Some service users explicitly contrasted these experiences with past ones in which long wait times eroded hopefulness, as this individual did in describing his past searches for services:

Interviewer: In the past, when you couldn't access a service fast enough, something that you really needed, what would you do instead?

Well, what I did was I ended up getting depressed, frustrated and started using. It's almost like a brick wall's in front of you and you can't knock it down ... it was just hard to get through to get people (service user 3).

Supporting early and sustained engagement

Efforts to support early and sustained engagement by attending to individual service user needs, maintaining frequent contact, and offering knowledgeable and welcoming services emerged as critical to supporting continuity of care. Identifying service users' individual needs, essential to planning appropriate and lasting long-term service connections, was not always a straightforward process. Although some service users easily shared information with their CMs, others considered the relationship-building process challenging. One service user feared stigmatisation and "didn't want to dump everything at once" (service user 2). Another service user reported feeling uncomfortable with her CM "at first, because she was a stranger" and took "four or five visits ... just getting to know her" before a comfortable rapport developed (service user 1). Nearly all service users described that once confidence and trust developed, communicating their needs became easier. In fact, a number of service users felt responsible for "honesty [about] what your issues are" in order to promote their own successful service connections (service user 14). Service users described that when they were seen as individuals with personal needs and goals, they were more likely to engage with the brief intervention and were more satisfied with the referrals made to long-term services, as highlighted below:

287 [CM] really listened to my needs. At detox, they just always have the same solution,
288 which is, put the person in a recovery home for a year or two ... that's what they do,
289 right? It's not about, "what does this person as an individual need?" ... She was open to
290 what my needs were in the moment (service user 6).

291 Additionally, CMs kept service users engaged through regular progress updates on the status of
292 referrals to long-term services and by responding to service user questions promptly. As this
293 service user described: "[CM] checked in with me through text: 'Everything's okay, this is an
294 update' [or] 'nothing has changed', you know. That was cool, like I didn't go days on end
295 wondering... 'is he just screwing me around?'" (service user 11).

296 Programme staff perceived that their deep understanding of individual and systemic factors
297 associated with homelessness facilitated service users' early and sustained engagement and care
298 continuity:

299 Everyone here has a good knowledge of homeless issues. Like, the short-term and long-term
300 issues that affect our service users. So, it's very specialised and that's an important piece ... we
301 create a comfortable environment, so service users feel comfortable, at ease. They develop quick,
302 easy rapport with us (programme staff).

303 Relatedly, nearly all PWLE, service users and frontline service providers perceived that service
304 providers' welcoming and respectful approach can support service engagement and continuity of
305 care. Exposing the prevalence of interpersonal barriers in the mental healthcare system, one
306 PWLE shared, "I have a difficulty with psychiatrists. I really find they're not very down-to-
307 earth". This struck a chord with other PWLE focus group participants, who added, "not really
308 easy to talk to them". Within the brief intervention, many service users found that staff's sincere
309 and welcoming interpersonal approach strengthened engagement and the working alliance, as
310 this service user highlighted: "[the CM had a] wonderful personality ... that makes you want to
311 establish a bond with her. So certainly, it's easy to have a working relationship with her" (service
312 user 7).

313 **Co-ordinating a multitude of services**

314 Co-ordination of diverse services can facilitate access, reduce unnecessary duplication, and
315 improve the effectiveness and efficiency of health and social services (Bodenheimer, 2008).
316 Service co-ordination in the CATCH programme involved managing new and existing service
317 connections to ensure congruence in service goals, and clear, complementary roles for service
318 providers. Within the interdisciplinary brief intervention, service co-ordination was facilitated by
319 frequent communication between providers and shared emphasis on flexible service provision.
320 Intervention staff and physicians felt they “work very individually, but well as a team”. At the
321 same time, some service users entered the brief intervention with one or more pre-existing
322 service connections, requiring additional co-ordination efforts to support continuity of care. This
323 process entailed identifying all pre-existing service providers, streamlining redundant services,
324 and organizing care from multiple specialties and sectors. For example, one staff person reported
325 that “part of our job [is] to get an idea of how many different doctors they’re seeing, and—yeah,
326 it’s a little bit like investigation work sometimes”.

327 Service users highly valued the navigation of the service system and co-ordination of services
328 provided by their CMs. Reflecting on the time of their enrolment to the programme, many
329 service user participants described feeling overwhelmed by the large number of their own unmet
330 needs and ill-equipped to independently manage co-ordinating needed services. Service users felt
331 that CMs’ advocacy and support were instrumental in their progress. This was highlighted by
332 one service user who was able to access medication following information transfer by his CM:

333 It was nice to have that backup support, where she could call and [tell the agency],
334 “Look, you’re supposed to be doing this”. However if it’s a client, it’s you versus them
335 ... if you actually have someone intervening on your behalf—it was very helpful (service
336 user 14).

Staff of the brief intervention similarly perceived that their position and knowledge of the service system made them, at times, more effective than service users themselves in co-ordinating long-term services:

Programme staff 1: We have more of a voice than if a client calls themselves...
Programme staff 2: And because we've done it a hundred times and they haven't.
Programme staff 1: We know the system.

The service landscape

For brief interventions to promote continuity of care, appropriate services must be available within the service system. Services for some conditions were readily available; however, all participants employed in the service system, as well as a smaller number of service user and PWLE participants, identified that other supports were scarce. These constraints in the service system limited the comprehensiveness of immediate as well as long-term services attainable. Constraints extended to health services that were essential for this population, including traumatic brain injury services and mental healthcare. Echoing many participants in this study, an external service provider perceived it was becoming “harder and harder to secure psychiatrists to work with people”. Similarly, the limited availability of affordable housing presented a significant challenge, as one programme manager highlighted:

When the housing stock is not there, when rent is going through the roof every year, it is just almost impossible ... the societal difficulties are really very tough. So, we try to do our best, but the problems are still there (manager).

Furthermore, system fragmentation and service silos led programme staff to preferentially refer service users to long-term service agencies offering integrated health and social services for vulnerable populations. Staff perceived that once service users were connected to one service at a multi-service agency, linkages within the agency would facilitate in-house referrals for service users' additional or evolving care needs. The effectiveness of this approach was supported by some service users, as those connected to integrated-service agencies perceived easy access to

multiple services. When asked about these long-term services, service users said “they do everything for me. If a blessing is happening, let’s keep it happening” (service user 22) and pointed to the “one stop shopping. There’s so much available there that I might need that—why go to ten, five different doctors when you [can] go to one office?” (service user 9).

Discussion

Our findings highlight and expose key elements promoting continuity of care for homeless people with unmet health needs, including experiences of access, timeliness, co-ordination, comprehensiveness and relationships in the context of a brief interdisciplinary intervention. Study findings suggest that brief interventions can promote continuity of care through low-barrier design relevant to the realities of homelessness. These design features can include timely service provision, intentional efforts to support service user engagement, including the interpersonal characteristics of service providers, and helping service users navigate the service system. We also found that systemic issues of constrained service availability can limit the comprehensiveness of services, although multi-service agencies with integrated case management, primary and mental healthcare were perceived to mitigate these challenges. Our findings support earlier research on long-term service provision and add a multi-stakeholder perspective.

An ample body of literature has documented the many barriers to services faced by people experiencing homelessness and called for flexible, accessible designs in brief and long-term programmes (O’Toole et al., 2015; Padgett et al., 2008; Stergiopoulos et al., 2016). Consistent with the literature, we found that continuity of care was enhanced by the accessibility of the brief intervention, particularly related to service location. Additionally, our findings suggest that peer accompaniment to appointments may be a useful strategy in supporting continuity of care. As

appointment absenteeism is a significant issue in service provision for homeless people (Hwang, Wilkins et al., 2011; Weiser et al., 2006), peer accompaniment may have an important role to play. The mental health services literature indicates that peers can promote service users' social functioning, sense of empowerment and hope for a better future (Repper & Carter, 2011), and may be well-positioned to support this population.

Timeliness of services was identified as a key element supporting continuity of care, similar to studies of homeless persons' experiences with long-term services. However, whereas participants in long-term services often identify the importance of timeliness through their negative experiences with wait lists (Corrigan et al., 2015; Gelberg et al., 2004), participants in this brief intervention did so through their positive experiences with immediate service provision. Our findings highlight that timely service provision within the brief intervention and through referrals to long-term services led to prompt attention to acute and chronic health conditions, relieved stress, and encouraged hopefulness and motivation to sustain engagement in the help-seeking process. Conceptual models of recovery consistently highlight the importance of hope and goal-setting (Leamy, Bird, Boutillier, Williams, & Slade, 2011; Mead & Copeland, 2000), and evidence indicates that internal motivation is an important predictor of reduced substance use (Collins, Malone, & Larimer, 2012) and mental health service utilisation (Jakupcak et al., 2013). While there is little evidence supporting any specific strategies to increase hopefulness, some qualitative work has suggested that experiences of success are generally helpful (Schrunk, Bird, Rudnick, & Slade, 2012). It is noteworthy that, among homeless people seeking health services, brief interventions may promote hope and motivation by providing more timely service connections.

Service users highly valued providers' responsiveness, service co-ordination and advocacy. Their complex needs required multiple service connections, and co-ordination could be a challenging process, especially when not all pre-existing service connections were disclosed. The finding of perceived effective co-ordination of services by a brief intervention resonates with literature on the CTI model of time-limited case management, which offers up to 9 months of case management to individuals with mental health problems transitioning from institutional to community settings (Herman, Conover, Felix, Nakagawa, & Mills, 2007). Although research on its effectiveness is largely restricted to settings in the US, CTI has been associated with easier access to services (Tomita & Herman, 2015) and more regular outpatient service utilisation (Dixon et al., 2009).

Although some service users found it challenging to communicate their needs and preferences, it was a necessary step towards individualized service plans and appropriate service connections. The value of relationships, interpersonal characteristics of friendliness and respectfulness, and knowledge of the issues associated with the "realities of homelessness" emerged as key supporting elements. These qualities facilitated service user engagement and participation in the planning process (Dixon et al., 2016). As a result, care plans aligned with service user goals, a recognised feature in the promotion of continuity of care in many long-term services (Corrigan et al., 2012, Mental Health Commission of Canada 2009). Service provider training to enable care that is accessible, engaging and appropriate for people experiencing homelessness is an important consideration across the service system.

In the context of a brief intervention, longitudinality, the long-term connection of service users to care, was facilitated by rapid service connections to long-term services. To that end, we found that both within the brief intervention and long-term community services, the value of

interdisciplinary models including some combination of primary, psychiatric and social services emerged strongly. Programme partnerships within the brief interdisciplinary intervention improved capacity to meet several service user care needs quickly; this “one stop shopping” promoted continuity of care through more comprehensive and co-ordinated service provision. This finding is consistent with work by O’Toole, Johnson, Aiello, Kane, and Pape (2016), which found clinics serving homeless populations may be more effective when appropriate social services are co-located. There is an international push for service hubs and integrated primary and mental health services, often referred to as “integrated” or “collaborative care” models (Kaliebe, 2016; Woltmann et al., 2012). For people with mental health conditions that are currently or recently homeless, integrated services have been associated with improvements in community functioning, utilisation of community health services (Stergiopoulos, Schuler et al., 2015) and treatment adherence (Ho et al., 2015; Parashar et al., 2011). When combined with housing, integrated services are generally preferred by people experiencing homelessness and mental health challenges (Corrigan et al., 2015; Lee, Crowther, Keating, & Kulkarni, 2013). However, comprehensive health and social services must be available across the system for continuity of care to be achieved (Bachrach, 1993), and this study draws attention to a systemic lack of affordable housing and specialised health services frequently required by the homeless population, including Housing First programmes. Another Canadian study of homeless and precariously housed older adults similarly found that limited availability of housing and accessible community services created a context of constrained options for service users and those trying to support them (Ploeg, Hayward, Woodward, & Johnston, 2008). There is an urgent need to address existing service gaps, including appropriate affordable housing, health, mental health and rehabilitative services, in many jurisdictions facing similar challenges. As

homelessness is a social phenomenon partially created and perpetuated by systemic inequities (Hwang & Burns, 2014), these issues cannot be overcome by interventions targeting problems at the individual level.

Limitations

The current study has some limitations. As two-thirds of service users approached agreed to participate in this study, we may have missed the perspectives of some service user participants whose experiences differed from those of our sample. While earlier work has found that demographic characteristics including gender and ethno-racial identities impact homeless persons' experiences accessing healthcare (Gelberg et al., 2004; Stergiopoulos et al., 2016), these diverse experiences did not emerge in our data. Additionally, service users within different service delivery settings may differ in their experiences of continuity of care. However, our purpose was to generate knowledge on the local intervention and inform modifications to this and similar models of care delivery. Despite these limitations, few studies have examined elements of brief interventions supporting continuity of care for people experiencing homelessness. Our findings therefore may be helpful to planners and service providers engaged in the design and delivery of appropriate services for this population.

Conclusions

Within fragmented and poorly resourced service delivery systems, our findings suggest that brief targeted interventions have an important role in promoting continuity of care for homeless people with complex health needs. Future efforts to improve continuity of care and health outcomes for this population should consider brief interdisciplinary models and evaluate a range of brief interventions suitable to diverse service delivery contexts.

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Table 1

Demographic and clinical characteristics of qualitative service user sample

Characteristic	Mean $\pm$ SD Or n(%)
Age	42.0 $\pm$ 9.8
Gender	
Woman	6 (27.3)
Man	16 (72.7)
Education	
Less than high school	11 (50.0)
Completed high school or attended post-secondary school	11 (50.0)
Single longest period of homelessness	
< 1 year	12 (54.6)
$\geq$ 1 year to < 3 years	5 (22.7)
$\geq$ 3 years	5 (22.7)
Mental health diagnoses ¹	
Mood disorder	17 (77.3)
Psychotic disorder	6 (27.3)
Anxiety disorder	9 (40.9)
Alcohol or substance misuse	12 (54.6)
Comorbid medical conditions ¹	
$\geq$ 1 conditions	21 (95.5)
$\geq$ 3 conditions	13 (59.1)

¹Participants selected all that applied.