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### **An Exploration of Homelessness and Mental Health**

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## **An Exploration of Homelessness and Mental Health**

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A thesis submitted in partial fulfilment for the degree of Doctorate in Clinical Psychology

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## Table of Contents

<b>Declaration</b>	4
<b>Acknowledgements</b>	5
<b>Thesis Abstract</b>	6
<b>Chapter One: The Mental Health of Families Experiencing Homelessness in the UK:</b>	8
A Scoping Review	
<b>Abstract</b>	10
<b>Introduction</b>	10
<b>Objectives</b>	14
<b>Methods</b>	15
<b>Results</b>	18
<b>Discussion</b>	31
<b>References</b>	37
<b>Appendices</b>	
<b>Appendix A: Data Extraction Form</b>	48
<b>Chapter Two: Professional Perspectives on Barriers and Facilitators to Mental Health</b>	49
Care for People Experiencing Homelessness	
<b>Abstract</b>	51
<b>Introduction</b>	51
<b>Methods</b>	55
<b>Results</b>	58
<b>Discussion</b>	68
<b>References</b>	75
<b>Appendices</b>	
<b>Appendix A: Proof of Ethical Approval</b>	85

<b>Appendix B:</b> Participant Information Sheet	86
<b>Appendix C:</b> Participant Consent Form	88
<b>Appendix D:</b> Semi-structured Interview Schedule	89
<b>Appendix E:</b> Initial Coding Transcript Example	91
<b>Appendix F:</b> Example of Transcript Codes, Themes, & Subthemes	92
<b>Appendix G:</b> Example Theme Generation	93
<b>Chapter Three: Contributions to Theory and Clinical Practice</b>	94
References	108
<b>Word Count</b>	116

### **Declaration**

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

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Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy

***Jessamine Rayner***

***28.05.2023***

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## **Thesis Abstract**

This thesis broadly aimed to expand current understanding of mental health amongst people experiencing homelessness (PEH) to inform policy, practice, and research.

The first paper consisted of a scoping review which explored literature regarding the mental health of families experiencing homelessness in the UK. The key aims were to map the characteristics of extant research, offer an initial synthesis of findings, and identify gaps in knowledge. Fifteen studies were reviewed, including both qualitative and quantitative designs. The findings suggested significant and unique mental health needs for both caregivers and children in this vulnerable situation. However, substantial limitations to the small body of literature were identified. Most literature was cross-sectional and significantly outdated. Measures of mental health were variable. Samples were limited in representativeness, particularly gender, family composition, and ethnicity. The results highlighted a pressing need to update the evidence base and recommendations for research were provided.

The second paper comprised a qualitative study which sought to understand what may help or hinder mental health care for PEH through an in-depth analysis of the perspectives of frontline professionals in homelessness services. Thematic analysis revealed three main themes, (i) structural factors, (ii) attitudes and understanding, (iii) frontline professionals' experiences navigating the system. A complex interplay between structural and individual factors impacting care were identified. The findings concluded the need to develop services better able to respond to the multiple complex needs of PEH and respond more effectively to those who have experienced trauma and adversity. The necessity to improve inter-agency working and support the well-being of frontline professionals in homelessness settings was also identified. Clinical and research implications were discussed.

The final paper considered the findings of the studies in the context of current theory, expanded on implications for clinical practice, and offered a reflective commentary.



## **Chapter 1**

### **Scoping Review**

# **The Mental Health of Families Experiencing Homelessness in the United Kingdom: A Scoping Review**

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# **The Mental Health of Families Experiencing Homelessness in the United Kingdom: A Scoping Review**

## **Abstract**

Homelessness is related to poor mental health, however, much of the extant literature explores single adult populations. Despite an increase in the number of families experiencing homelessness in the UK, little research has examined their health and social needs. The objective of this scoping review was to map and synthesise research on the mental health of these families in order to examine the characteristics and findings of current literature and identify gaps in knowledge. The 15 studies reviewed indicated there are unique mental health needs related to homelessness for this population, particularly in the context of historic trauma and child development. However, most literature was dated and cross-sectional in approach, offering limited understanding of long-term effects, or directionality. Measures used were variable and included limited assessment of more severe mental health conditions. Most studies were conducted in urban areas of England and samples were limited in terms of gender, ethnicity, and family composition. The topic remains strikingly under researched. Recommendations for future directions are discussed.

**Keywords:** *homeless, families, temporary accommodation, mental health*

## **Introduction**

In the United Kingdom (UK), the number of families with dependent children threatened with, or already experiencing, homelessness has increased (Department for Levelling Up, Housing & Communities [DLHC], 2022). Families experiencing homelessness are those deemed to lack suitable, stable, and safe housing, and are amongst

one of the most vulnerable and marginalised populations in society (Public Health England, 2019; Shelter, 2023). Most are provided access to ‘temporary accommodation’ offered by local authorities, such as bed and breakfasts, hotels, or hostels. The conditions of these are reported to be poor and overcrowded, in some cases offering no access to basic laundry or cooking facilities and lacking in bed space (Shelter, 2023). Concerningly, the time spent living in such conditions appears to be increasing, with most families remaining for over a year (Shelter, 2023).

Current evidence indicates family homelessness is the end point of an accumulation of multiple individual and structural stressors, underpinned by socioeconomic inequalities (Centre for Social Justice, 2019; Shinn, 2010). Over the past two decades, UK Government policies have seen a reduction in the provision of affordable housing, cuts to disability and housing benefits, and an unregulated rental market, resulting in spiralling renting costs (Fitzpatrick et al., 2019; Shinn, 2010). Records indicate that the loss of rented accommodation is the most reported reason for family homelessness, although many interrelated factors are at play (DLHC, 2022).

Lone mothers with school-age children make up over half of families experiencing homelessness in the UK; many have fled intimate partner violence, community violence, or experienced a relationship breakdown, thus entering homelessness in a vulnerable position (Shelter, 2023; Cumella et al., 1998). A study conducted in the United States (US) showed women who had experienced interpersonal abuse during childhood were more likely to experience repeated episodes of homelessness (Bassuk et al., 2001). There is substantial evidence showing that adverse childhood experiences (ACEs), such as abuse, neglect, parental substance misuse, and criminal activity, are key predictors of homelessness in later life (Liu et al., 2021). The trauma of these experiences is well-known to precipitate an array of psychological and physical health problems and increase vulnerability to future

victimisation and traumatisation (Bellis et al., 2014). In turn, children of these families are more likely to have been exposed to parental mental health difficulties and other ACEs, finding themselves at risk of poorer outcomes (Turney, 2020).

Family homelessness is characterised by multiple disadvantages at the intersection of class, gender, race, and disability (Shinn, 2010). The risk of homelessness is higher for racially minoritised people (Anderson & Christian, 2003; Finney, 2022). A recent survey found half of those living in temporary accommodation across England identified as Black, Asian, Mixed, or another ethnicity (Shelter, 2023). This figure is striking, considering only 15% of the population identify as from these ethnic groups, illustrating structural and racial inequalities (Finney, 2022). Additionally, certain immigration status can lead to ‘no recourse to public funds’, meaning that some families are not provided access to most benefits including house assistance (Home Office, 2019). This includes the increasing number of refugees seeking asylum (Home Office, 2023).

### ***Homelessness and Mental Health***

A lack of stable and safe housing has a detrimental effect on numerous health and social outcomes, with elevated levels of morbidity and reduced life expectancy (Aldridge et al., 2019). The prevalence of mental health difficulties is estimated to be two to three times higher for people experiencing homelessness than the general population (Gutwinski et al., 2021; Ayano et al., 2020). Severe difficulties, such as psychosis and Post-Traumatic Stress Disorder (PTSD) are particularly common. Pre-existing mental health difficulties are a risk factor for becoming homeless, but equally the adversity of homelessness can precipitate or exacerbate such difficulties (Pattison & McCarthy, 2022). Homelessness is inescapably stressful and has been shown to be psychologically traumatising itself, increasing the likelihood of victimisation and poorer mental health (American Psychological Association

[APA], 2010; Deck & Platt, 2015). The consequences are substantial; those with mental health difficulties are at an increased risk of suicide and substance abuse, poorer physical health, and increased challenges in exiting homelessness (Fazel et al., 2014; Lachaud et al., 2021).

### ***The Mental Health of Families Experiencing Homelessness***

Despite growing literature in homelessness and health, most focusses on ‘single’ homeless populations. Little is understood about the mental health of families, particularly in the UK. US studies have shown that mothers experiencing homelessness have poorer mental health than those who are housed (Weinrub et al., 2006; Gilroy et al., 2016), the same is true in children (Gultekin et al., 2020; Bassuk et al., 2015). Cause and effect are difficult to establish due to the limited research and the bi-directional relationship between mental health and homelessness.

For mothers experiencing homelessness, increased psychological distress has been associated with poorer emotional and behavioural well-being for their children (Zima et al., 1996). Infancy and childhood are a crucial time for the development of emotional, social, and cognitive functioning; if disrupted there can be profound negative consequences, both in the short and long-term (Van der Kolk, 1997; Perry et al., 1995). An adequately responsive, emotionally attuned, relationship with a caregiver is important to support physiological, neurological, and psychosocial development (Van der Kolk, 1997; Ranson & Urichuk, 2008). A recent synthesis of qualitative studies found the stressors of temporary accommodation had a significant negative impact on the experience of parenting (Bradley et al., 2018). Practical challenges included a lack of autonomy and privacy, unrealistic expectations of the mother and child from agencies, and a lack of access to enriching activities. Additional to their own distress, parents described feelings of shame, stigma, and challenges in responding to their

child's behavioural and emotional needs. Infants raised under the stressors of homelessness have been shown to have an increased risk of poor attachment and delayed development (Horn, 2017).

Beyond the parent-child relationship, children's development occurs through constant reciprocal transactions with the multiple social and environmental systems they exist within (Bronfenbrenner, 1979). This spans from immediate relations and the home environment, to school, the wider community, and larger sociocultural and economic structures and values. The nature of these systems can help or hinder a child's development. The experience of homelessness can disrupt the interplay between child and environment at multiple levels. Recent evidence reported that families are often moved to different placements multiple times whilst homeless, sometimes a substantial distance from a child's school and the family's extant social network (Shelter, 2023). Other studies have indicated that overall academic attainment is poorer for these children than those who are housed (Shelter, 2023; Murran & Brady, 2022). These speak to the challenges of engaging in education whilst residing in the poor conditions of temporary accommodation and, moreover, managing the stressors of housing instability. Furthermore, there are indications that homelessness also effects other areas of growth that depend on the systems surrounding a child including social relationships and identity formation (Murran & Brady, 2022). In terms of wider systems, sociocultural attitudes in the UK tend to stigmatise and marginalise people experiencing homelessness, which can have a deleterious impact on health outcomes (Reilly et al., 2022). Preliminary research indicates that families are no exception to this, although at present this phenomenon is not well understood (Benbow et al., 2019).

## **Objectives**

The adversity of homelessness presents many challenges which may significantly impact the mental health of thousands of families across the UK. To the author's knowledge, there are currently no comprehensive reviews of this topic. Building a better understanding of this provides the opportunity to identify health and social care needs and inform prevention, policy, and intervention approaches. The purpose of this scoping review was to synthesise the disparate existing literature on this topic. The research questions guiding this review were:

1. *What are the characteristics of the extant research (design, population, location and setting, conceptualisation of mental health, measures) exploring the mental health of families experiencing homelessness in the UK?*
2. *What does this research reveal about this phenomenon and what are the gaps in current knowledge?*

## **Methods**

A scoping review was chosen as it is useful for identifying and mapping a diverse range of evidence on complex, under-researched, and not yet well-defined topics (Munn et al., 2018). The research process followed the Joanna Briggs Institute (JBI) (Peters et al., 2015) framework for conducting systematic scoping reviews and adhered to the Preferred Reporting Items Guidelines for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018).

### ***Eligibility Criteria***

Given the limited research on families experiencing homelessness, a broad range of methodologies were included; these were qualitative, quantitative, and mixed-methods peer-reviewed empirical papers alongside grey literature, including empirical studies in doctoral dissertations and third-sector reports and briefings. Studies not written in English language



and previous review articles, letters, commentaries, editorials, and opinion pieces were excluded. As this area of research is in its infancy, no date parameters were set, thus maximising data gathering opportunities. Further inclusion criteria were described using the population, concept, and context (PCC) framework as detailed in the JBI manual (Peters et al., 2015).

### ***Population***

The population of interest were families that were currently experiencing, or had previously experienced, homelessness. Papers were only included if they specified the homelessness status of the sample. To be eligible for inclusion the sample needed to include a parent or caregiver with a dependent child. As per the widely recognised UK definition, a dependent child was any person aged under 15 years, or between 16 and 18 years if still in full-time education and living with parents or caregivers (Office for National Statistics [ONS], 2022). Papers sampling only children or adolescents who were living independently from their parent or caregiver were excluded. Papers could include non-families, but the sample needed to be composed of upwards 50% families.

### ***Context***

Papers were only included if there was a clear definition of homelessness, this encompassed; (i) temporary accommodation; (ii) domestic abuse refuge; (iii) bed and breakfast; (iv) rough sleeping on the streets. Papers were required to clearly state that the data was collected in the UK. The choice was made to limit this review to the UK as it was deemed that the sociocultural context, including factors such as housing legislation and support, government policy, and health and social care systems, may have specific qualities that uniquely affect experiences of homelessness and health.

### ***Concept***

To be included, studies were required to directly explore mental health. Informed by an initial search of literature and this review's exploratory nature, the definition of mental health remained broad and was not limited to measurements of diagnosis or prevalence, but included explorations of emotional, behavioural, and psychosocial experiences.

### ***Search Strategy and Study Selection***

A comprehensive search strategy was designed. Four databases (PsycINFO, ASSIA, PubMed and PQDT) were systematically searched. Subsequently a thorough search of other sources, including grey literature, using Google Scholar and citation chaining took place. The final literature search was conducted in March 2023. Search terms were selected based on a broad range of terminology in accordance with common terms identified in extant literature (Table 1.)

### ***Data Extraction and Charting***

A standardised data extraction form was created based on the recommendations in the JBI manual for evidence synthesis (Peters et al., 2020) and edited in line with the research topic (Appendix A). Due to limited detail provided in the third-sector report, further information pertaining to the design and methods was successfully gathered from the authors via email (Shelter, 2023). Key characteristics and information from each paper were extracted and charted into the data extraction forms. The data was then summarised and reported through examining and analysing the charted information to identify themes, differences, and commonalities throughout the papers.

**Table 1.**

Search script used for database search

Category	Search terms
Population	famili* OR family* OR parent* OR mother* OR father* OR child*  OR caregiver* [limited to abstract and title]  AND
Context	homeless* OR temporary accommodation OR hostel OR temporary housing OR non-housed OR 'bed and breakfast' OR shelter [limited to abstract and title]  AND  UK OR United Kingdom OR Great Britain OR Britain OR England  OR Wales OR Scotland OR Northern Ireland OR London OR  Edinburgh OR Belfast OR Cardiff [no limit set]  AND
Concept	mental health OR mental illness* OR well-being OR well being OR psychiatric OR mental disorder* OR mental health OR mental condition* OR psycho* [limited to abstract and title]

## Results

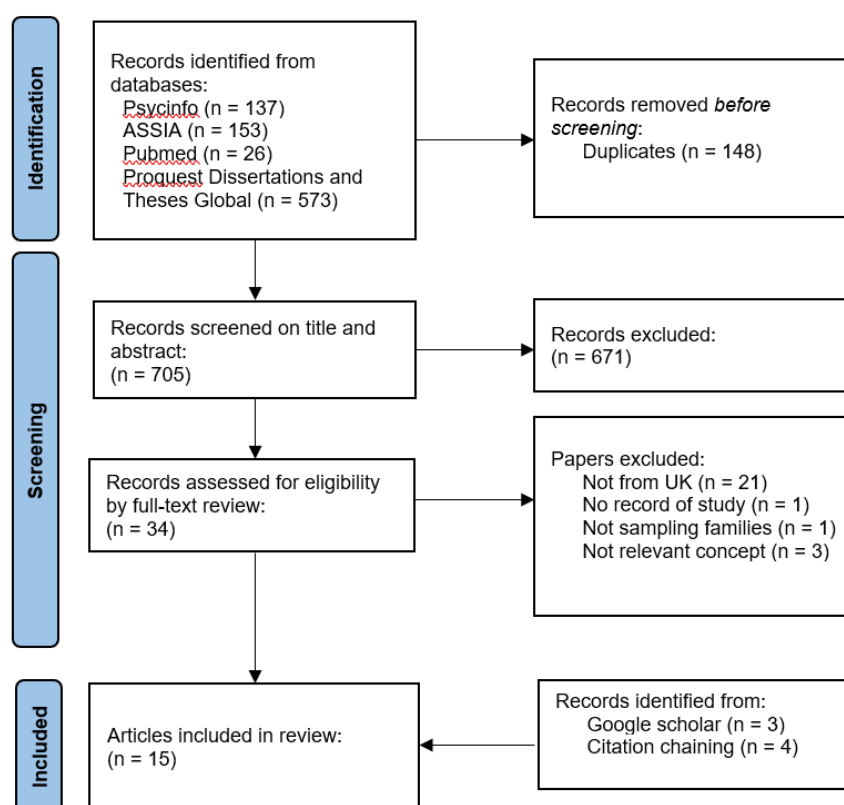
### Study Selection

As detailed in the PRISMA diagram (Figure 1.) 853 papers were identified in the initial database search and uploaded to a digital reference manager programme. After removing duplicates 705 papers remained. The first author screened these articles based on

title and abstract in accordance with the eligibility criteria, leaving 34 papers. These papers were reviewed in full by the first author and reliability checks were undertaken by the second author by reviewing a random sample; any conflicts pertaining to inclusion were resolved. Twenty-six papers were excluded on the basis that; the sample was not from the UK (n=21); no study record was found (n=1); did not sample families (n=1); did not explicitly explore mental health or psychological well-being (n=3). The search of grey literature and citation chaining resulted in the inclusion of a further seven papers. A total of 15 papers were included in the final review.

**Figure 1.**

PRISMA Flowchart



## Study characteristics

Table 2. provides an overview of the characteristics of the 15 papers identified for review. The publication dates ranged from 1997 to 2023. Thirteen papers were published, peer-reviewed, journal articles, one was a third-sector organisation report (Shelter, 2023) and one was an unpublished dissertation (McHale., 2021).

### *Design*

Five of the papers were qualitative (Carey et al., 2023; McHale 2021; Tischler., 2008; Tischler et al., 2007; Walters & East, 2001). Ten papers adopted a mixed methods approach; five of these were cross-sectional (Shelter, 2023; Tischler et al., 2004; Vostanis et al., 2001; Vostanis et al., 1997; Cumella et al., 1998), three were longitudinal (Tischler & Vostanis., 2007; Karim et al., 2006; Vostanis et al., 1998) and two quasi-experimental (Sleed et al., 2011; Tischler et al., 2002).

### *Location and Setting*

All data was collected in England. Nearly all the populations studied were from dense urban areas. Over half of the papers sampled from the Midlands (Cumella et al., 1998; Vostanis et al., 1997, 1998, 2001; Tischler et al., 2002, 2004, 2007; Karim et al., 2006) Tischler & Vostanis., 2007; Tischler., 2008; Walters & East, 2001 ), two from London (Sleed et al., 2011; Carey et al., 2023), one from North West England (McHale, 2021), and one nationally (Shelter, 2023). The samples were drawn from temporary accommodation, primarily provided by local authorities, the only exclusion was a paper by McHale (2021) which stated participants had previous or current experiences of homelessness but offered no further details.

**Table 2.**

Summary of core characteristics of papers

Author(s) & Year of Publication	Publication Type	Design	Location and Setting	Population	Sample Size	Key Focus
Carey et al., 2023	Peer-reviewed journal article	Qualitative	Temporary Accommodation London	Single mothers	n = 12	To understand the impact of homelessness on the mental health for single mothers
Cumella et al., 1998	Peer-reviewed article	Mixed-method cross-sectional	Local authority hostel Birmingham	Families with children aged between 2-16 years	Homeless (n = 113) Housed comparison (n = 29)	To establish the prevalence of mental health difficulties in homeless families as compared to low-income housed families
Karim et al., 2006	Peer-reviewed article	Mixed-method short-term longitudinal	Local authority hostel Leicester	Families with children aged 2-17 years	Families (n = 35)	To establish mental health and parenting difficulties at 4-month follow-up compared with baseline assessments (see Tischler et al., 2004)
McHale, 2021	Unpublished Dissertation	Qualitative	Homelessness setting unspecified North-West England	Families with children and educators of children experiencing homelessness	Parent-child dyads (n = 3) Educators (n = 8)	To understand the impact of homelessness on the emotional well-being of school-aged children through the lens of ecological systems theory
Shelter., 2023	Published third-sector report	Cross-sectional Methodology not stated	Temporary accommodation England	Families and individuals residing in temporary accommodation	1112 of which 69% were families (n = 767)	Assessment of the conditions of temporary accommodation and its impact on health and social outcomes
Sleed et al., 2011	Peer-reviewed journal article	Quasi-experimental	Hostels London	Mothers with infants residing in hostels	Experimental (n = 30) Control (n = 29)	Pilot of a psychotherapeutic baby clinic in a hostel for homeless families
Tischler & Vostanis., 2007	Peer-reviewed journal article	Mixed-methods Short-term longitudinal	Local authority hostels Birmingham	Mothers with children over 3 years	n = 72	To explore the relationship between coping strategies, mental health, and goal achievement
Tischler et al., 2002	Peer-reviewed journal article	Quasi-experimental	Local authority hostels Birmingham	Families with children under 3 years identified as lead need mental health	Experimental (n = 23) Control (n = 31)	To describe the characteristics of homeless families in mental health outreach service (MHOS) and the impact of service on psychosocial outcomes at 6-month follow-up compared to families without specialist service

**Table 2. cont.**

Summary of core characteristics of papers continued

Author(s) & Year of Publication	Publication Type	Design	Location and Setting	Population	Sample Size	Key Focus
Tischler et al., 2004	Peer reviewed journal article	Mixed-methods Cross-sectional	Local authority hostels Leicester	Families with children between 2-17 years	n = 49	To establish the psychosocial characteristics and perspectives of families referred to specialist family support worker
Tischler., et al., 2007	Peer-reviewed journal article	Qualitative	Local authority hostels Birmingham	Mothers with children over 3 years	n = 28	To describe the experience of homelessness in relation to the mental health, care and support needs of mothers
Tischler., 2008	Peer-reviewed journal article	Qualitative	Local authority hostels Birmingham	Mothers with children over 3 years	n = 21	To explore psychosocial issues related to the resettlement following becoming housed after a period of homelessness
Vostanis et al., 2001	Peer-reviewed journal article	Mixed method Cross-sectional	Local authority hostels Birmingham	Families with children 3-16 years	Domestic Violence (n = 48) Neighbourhood Violence (n = 14) Other reasons (n = 31)	To explore and compare mental health difficulties of homeless families who have experienced domestic and neighbourhood violence, and no recorded violence
Vostanis et al., 1997	Peer-reviewed journal article	Mixed-methods cross-sectional	Local authority hostels Birmingham	Families with children 2-16 years	Homeless (n = 113) Housed (n = 29)	To explore psychosocial characteristics of homeless families as compared with housed families matched for socioeconomic status
Vostanis et al., 1998	Peer-reviewed Journal article	Mixed method Longitudinal	Local authority hostels Birmingham	Families with children 2-16 years	Resettled (n=58) Housed (n=21)	To explore the longitudinal psychosocial characteristics of homeless families at one-year follow up (see Vostanis et al., 1997)
Walters & East., 2001	Peer-reviewed journal article	Qualitative Action participatory research	Various temporary accommodation	Mothers under 21 years with children from 9 months to 5 years	n = 3	Explore the experiences of repeated homelessness in young mothers

### *Population Characteristics*

Although many studies did not exclude other demographics, all samples consisted of upwards of 67% single mother families. Nine studies included other family compositions (Cumella et al., 1998; Vostanis et al., 2001, 1997, 1998; Tischler et al., 2002, 2004, 2007; Karim et al., 2006; Tischler & Vostanis, 1997), of which parents in partnerships were the next most frequent family type, ranging between 12% to 36% of the samples, and single fathers the least represented, ranging from around 0% to 6%. Most studies using in-depth qualitative approaches focused exclusively on mothers' experiences (Tischler et al., 2007; Tischler 2008; McHale, 2021; Carey et al., 2023) with one also including the perspectives of children and educators (McHale, 2021). Of those that specified, the children were most commonly aged between two and 17 years. Only one study specifically explored the relationship between homelessness and infants' mental health and development (Sleed et al., 2011). Most studies reported on the participants' ethnicity and/or race. Although these included participants from racially minoritised backgrounds and were derived from multicultural areas, most samples were comprised of over 50% white individuals. One of the several studies conducted in temporary accommodation in the midlands (Vostanis et al., 1998) stated that persons from racialised minorities tended to be supported within different accommodation from that which they sampled. Thus, it is unclear how representative the findings are and likely the other studies drawing their sample from this setting are also limited in this manner (Cumella et al., 1998; Vostanis et al., 2001, 1997; Tischler et al., 2002, 2007; Tischler & Vostanis., 2007). Carey and colleagues (2023) interviewed a racially diverse sample of mothers from London, however, as with another qualitative study (McHale., 2021), those who could not speak English were excluded. Four studies, two of which followed the same sample over time, stated the refugee status of participants; this



ranged from 0% to 6% (Tischler, 2002; Tischler et al., 2004; Karim et al., 2006; Tischler & Vostanis, 2007).

### **Conceptualisation and Measurement of Mental health**

Over half of the studies utilised self-report psychometric tools to define and measure mental health (Table 3.). Two measures for adult mental health were used, the General Health Questionnaire (GHQ-28) (Goldberg et al., 1976) and the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983). Both are primarily validated for use to screen for and identify clinically significant anxiety and depression, and related symptoms, in community settings. A variety of validated, standardised, tools were used to assess children's mental health, offering estimates of clinically significant behavioural, emotional, and social-communication difficulties. These were completed by parents on behalf of the child, despite some being appropriate for completion by the child. Measures of social support, parenting, and coping strategies were also included. Most studies also utilised interview data to provide contextual information, such as pathways into homelessness and service use and experience. Shelter (2023) reported data from a bespoke survey of closed-ended, multiple-choice questions, developed through scoping interviews with people with lived experience of temporary accommodation. A pilot study of a psychotherapeutic parent-infant intervention used observation and scales of child mental and motor development, and parent-infant interactions (Sleed et al., 2011). The remaining studies explored mental health exclusively through the lens of participants' lived experience using a range of approaches. Semi-structured interviews were used to gather data on the experiences of participants, including one study which adopted an ecological systems approach, exploring children's emotional well-being through the system around them (McHale., 2021). One study presented the first phase of a participatory action research project, utilising focus groups (Walters & East, 2001). Theoretically, this seeks to understand social phenomena and problems through the

development of solutions to enact positive change by means of researcher-participant collaboration.

**Table 3.**  
Approaches to conceptualising and measuring mental health

Author(s) & Year of Publication	Measure
Carey et al., 2023	Lived experience obtained through semi-structured interview
Cumella et al., 1998	Semi-structured interview GHQ-28 CBCL VABS; Communication Domain ISSI
Karim et al., 2006	HADS ECBI HoNOSCA PDH Service satisfaction questionnaire
McHale, 2021	Lived experience obtained through semi-structured interview
Shelter., 2023	Survey comprised of closed ended and multiple choice questions
Sleed et al., 2011	BSDI Coding interactive behaviour of parent-infant video recording
Tischler & Vostanis., 2007	F-COPES GHQ-28 (Goldberg et al., 1976) Interview to establish goals
Tischler et al., 2002	GHQ-28 (Goldberg et al., 1976) SDQ (Goodman, 1997) Semi-structured interview
Tischler et al., 2004	HADS ECBI HoNOSCA PDH Service satisfaction interview
Tischler., et al., 2007	Lived experience obtained through semi-structured interview
Tischler., 2008	Lived experience obtained through semi-structured interview
Vostanis et al., 2001	SDQ GHQ-28 FSS SF-36 Semi-structured interview
Vostanis et al., 1997	GHQ-28 CBCL ISSI VABS; Communication Domain Semi-structured interview
Vostanis et al., 1998	GHQ-28 CBCL ISSI VABS; Communication Domain Semi-structured interview
Walters & East., 2001	Focus groups

*Note.* GHQ = General Health Questionnaire (Goldberg et al., 1976); CBCL = Child Behaviour Checklist (Achenbach, 1991); VABS = Vineland Adaptive Behaviour Subscale (Sparrow et al., 1984); ISSI = The Interview Schedule for Social Interaction (Henderson et al., 1980); HADS = Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983); ECBI = Eyberg Child Behaviour Inventory Scale (Eyberg & Ross, 1978); HoNOSCA = Health of the Nation Outcome Scales for Children and Adolescents (Gowers et al., 1999); PDH = Parenting Daily Hassles Scale (Crnic & Greenberg, 1990); BSID = Bayley Scales of Infant Development (Bayley, 1993); F-COPES = Family Crisis Oriented Personal Evaluation Scales (McCubbin et al., 1987); SDQ = Strengths and Difficulties Questionnaire (Goodman, 1997); FSS = Family Support Scale (Dunst et al., 1984); SF-36 = Short Form Health Status Questionnaire (Ware & Sherbourne, 1992)

## Key Findings

### *Parent and Caregiver Mental health*

Studies using self-report psychometric measures concluded high rates of clinically significant psychological difficulties amongst parents and caregivers experiencing homelessness, although results varied. Across the studies and a total sample of 449 participants, estimates ranged from 21.9% to 80% scoring above the clinical threshold on measures, which was found to be significantly higher than income-matched, housed, comparisons (Cumella et al., 1998; Vostanis et al., 1997, 2001; Tischler et al., 2002; Tischler et al., 2004; Tischler & Vostanis, 2007). Karim and colleagues (2006) followed up 35 families four months after admission to a homelessness setting and found no change in rates of anxiety and depression scores over time, despite most being re-settled in permanent accommodation. Tishler and Vostanis (2007) concluded poor mental health may endure following re-settlement. Conversely, Vostanis and colleagues (1998) found a reduction in mental health difficulties at one-year follow-up, when most participants were housed. Although the results must be interpreted with caution as follow-up data was only successfully gathered from 51% of the initial sample (n=58). It was also concluded repeated episodes of homelessness were associated with poorer mental health (Tischler & Vostanis, 2007). Overall, there was little research into the long-term mental health of this population. The response rate in both cross-sectional and longitudinal studies was low. No studies measured, or reported, validated measures of more severe mental health difficulties, and none had been conducted within the past 15 years.

In qualitative studies, mothers described anxiety and depression, often related to relational conflict, as playing key role in becoming and remaining homeless (Walter & East., 2001; Carey et al., 2003). Poor mental health, related to pre-existing trauma, was reported to

be exacerbated by temporary accommodation related stressors (Carey et al., 2023). This study also noted mother's well-being was affected by an awareness of their child's distress, although conversely, parenting could be seen as a source of strength and motivation. McHale (2021) concluded the loss of safety and stability of homelessness as trauma, impacting the whole family system. Two studies following mothers upon entering and exiting homelessness, showed that hostels exacerbated pre-existing psychological difficulties, although some later reflected on the opportunities for growth and escape from relational conflict (Tischler et al., 2007; Tischler., 2008). These studies did not offer a statement of reflexivity, or author positionality. Another found parents reported qualitative improvements in mental health when resettled, however this contradicted psychometric measures which showed enduring levels of clinically significant anxiety and depression (Karim et al., 2006).

Some studies explored factors that were protective for caregiver mental health, most commonly social support. Tischler and Vostanis (2007) found that increased use of social support as a coping strategy was associated with better mental health. Interestingly, refugee caregivers were found to be more likely than other demographics to utilise social support and spirituality to cope but did not significantly differ on measures of mental health. Families experiencing homelessness were documented to have significantly lower levels of perceived social support than an income-matched, housed, comparison group (Vostanis et al., 1997). Increased self-reported social support from other family members or professionals was shown to predict better maternal and child mental health (Vostanis et al., 2001). In three of the qualitative studies, despite adversity, mothers spoke to the power of community and social connection including the support of other women experiencing homelessness (Tischler et al., 2007), resistance against social inequality and community-based initiatives (Carey et al., 2023), and upon re-settlement, a sense that their experiences had provided an opportunity for growth and enacting positive change (Tischler., 2008). Tischler and colleagues (2004)

identified that, for some hostel environments provided social connection, but others experienced intimidation.

### *Child Mental Health*

When implementing psychometric measures, children's emotional, social, and behavioural health was reported to be significantly poorer for those experiencing homelessness than income-matched, housed, comparisons (Vostanis et al., 1997; Tischler, 2002; Karim et al., 2006). This was true in a one-year follow-up study, although attrition rates were high (Vostanis et al., 1998). Two studies explored children's communication skills and found that children in homeless families scored below age-adjusted norms and performed more poorly than income-matched housed comparisons (Vostanis et al., 1997; Cumella et al., 1998). A short-term longitudinal investigation found higher levels of parental depression, but not anxiety, were associated with poorer, parent-reported, emotional, and behavioural difficulties in children (Tischler & Vostanis., 2002; Karim et al., 2006). Slead and colleagues (2011) concluded that homelessness impacts infant development. Using a standardised measure, infants in hostel settings scored to below norms across cognitive, behavioural, and motor development, with around half showing indications of developmental delay.

In a large-scale survey, a majority of parents and caregivers of families in temporary accommodation believed that their housing situation had negatively impacted their child's stress, anxiety, and mood (Shelter, 2023). Over a third of parents with children with neurodevelopmental or neurodivergent conditions such as autism, attention-deficit hyperactivity disorder (ADHD) and learning difficulties, reported a negative impact on the emotional and behavioural well-being of their child. Expanding on this, in qualitative studies, mothers emphasised that the poor conditions of temporary accommodation, such as infestations, noise, and cramped conditions impacted upon the emotional well-being of their

children (McHale., 2021; Carey et al., 2023). McHale (2021) interviewed educators who observed the emotional impact of homelessness to have a deleterious impact on a child's ability to engage in education. In a large-scale survey, just under half of children were found to have had to move school, with one in five moving multiple times (Shelter, 2023).

### *Victimisation, Relational Trauma, and Mental health*

The research documented striking levels of emotional, physical, and sexual abuse, and community violence. For example, Camilla and colleagues (1998) showed lifetime rates of sexual or physical abuse was 45% in a sample of mothers experiencing homelessness, compared to 10% of income-matched housed mothers. This study indicated that children were also more likely to have been directly victimised in this way, reporting 7% having experienced sexual or physical abuse. Notably, parents reported this figure, so it may be an underestimation due to bias, or children not having disclosed their traumatic experiences. As well as being one of the primary risk factors for entering homelessness, neighbourhood or domestic violence appeared to increase vulnerability to repeated homelessness (Tischler & Vostanis, 2007; Karim et al., 2006; Vostanis et al., 1997;1998; Cumella et al., 1998).

Investigation into the interaction between abuse and mental health was relatively minimal. One mixed-methods study found that mothers with a history of abuse were more likely to have poorer mental health, and in semi-structured interviews, children spoke to the lasting impacts of witnessing domestic abuse (Cumella et al., 1998). Karim and colleagues (2006) reported that children from families who had experienced domestic abuse had poorer behavioural outcomes than those who did not, although the sample size was small (n=35). A three-way analysis, with a small sample size (n=98), comparing mothers who had entered homelessness due to neighbourhood violence, domestic abuse, or for other reasons, found

that although all had poorer mental health than would be expected in the general population, neighbourhood violence placed families at the highest risk (Vostanis et al., 2001).

Qualitative studies highlighted the negative impact of relational trauma on mental health. Narratives of powerlessness and a loss of autonomy were present across themes (Walters & East., 2001; Tischler, 2008; McHale, 2021; Carey et al., 2023). One account directly highlighted the connections between the distress and powerless caused by domestic abuse and the experience of an unjust, coercive, and controlling housing and social care system (Carey et al., 2023).

### *Service Use and Experience*

Five of the studies using mixed methods approaches gathered qualitative data on experiences of health and social care service (Cumella et al., 1998; Vostanis et al., 2001; Tischler et al., 2002; Tischler et al., 2004; Karim et al., 2006). Many did not offer a thorough account of data analysis methodologies. Although some studies reported families to find health and social care professionals helpful (Karim et al., 2006; Tischler et al., 2004) many felt poorly supported, with several highlighting the lack of privacy and respect afforded in temporary accommodation (Cumella et al., 1998; Karim et al., 2006; Tischler et al., 2002; Tischler et al., 2004). Cumella and colleagues (1998) reported the rate of contact with specialist child mental health services was low, recorded as 1%, despite high rates of emotional and behavioural difficulties. However, this was based on uncorroborated self-report data and appeared limited in its definition of mental health support. Further to this, all five qualitative studies identified that families experiencing homelessness often felt under-supported and many reported negative stereotyping, judgement and stigma from professionals and the broader system (Walters & East., 2001; Tischler et al., 2007; Tischler., 2008; McHale., 2021; Carey et al., 2023). Suggestions from participants to improve services

included increased access to counselling and support with psychological trauma (Tischler et al., 2007; Tischler 2008), improved communication from hostel staff (Tischler et al., 2007) and the benefits of including service-users in designing and facilitating services (Walters & East., 2001).

### *Interventions*

A quasi-experimental pilot study looked at the implementation of an in-reach psychotherapeutic parent-infant baby clinic at a hostel, which focused on developing attunement and attachment (Sleed et al., 2011). At three months, infant cognitive, motor, and behavioural development had improved significantly relative to controls. However, no differences were found in the quality of parent-child interactions. Tischler and colleagues (2002) examined an out-reach mental health service for families experiencing homelessness and found mixed results; although children in the experimental group showed improvements on measures of mental health relative to controls, parents did not. The sample size of this study was small (n=54) and it is unclear what support the control group were in receipt of, limiting meaningful comparisons. However, qualitative evaluation indicated that the specialist service was well received. It also included a component of hostel staff training, which was reported to increase staff confidence in working with mental health.

## **Discussion**

This scoping review aimed to map current literature pertaining to the mental health of families experiencing homelessness in the UK and identify gaps in knowledge and research. The findings of the 15 reviewed studies indicated that families experiencing homelessness are vulnerable to a range of mental health difficulties and enter homelessness with significant health and social needs. The adversity of homelessness was shown to present unique practical and emotional challenges to both caregivers and children. High rates of domestic abuse were



reported across studies, with some estimating the risk to be ten times greater than the general population (Cumella et al., 1998; ONS, 2021). Domestic abuse comprised the most common precursor to homelessness. Conclusions must be drawn tentatively due to the paucity and heterogeneity of the literature; several gaps in the knowledge were identified.

Strikingly, only three of the studies had been conducted within the past 15 years, limiting the generalisability of the findings. Socioeconomic and political changes inevitably impact housing and healthcare over time; thus, it is essential that the evidence-base is updated. Furthermore, research should explore beyond England; other areas of the UK have devolved legislation, differing health and social care policy, and geographies, which may impact the experience of homelessness (Wilcox et al., 2010). Families from racially minoritised communities were poorly represented, despite being more likely to experience homelessness, further limiting the generalisability of findings and representing a crucial area for future investigation.

Although mental health was explored across the life span, most of the literature focused on adult caregivers. High rates of mental health difficulties have been well-evidenced in single adult homeless population and the findings herein indicate those in families are no exception (Gutwinski et al., 2021). However, due to the lack of high quality, current, epidemiological studies it is difficult to draw conclusions or meaningful comparisons. Furthermore, most studies favoured brief, self-reported, psychometric measures. In addition to being prone to bias, these captured a limited range of difficulties and excluded severe mental health difficulties such as PTSD or psychosis. This is surprising, considering the prevalence of domestic abuse and ACEs, which are known to precipitate such difficulties (Hughes et al., 2019). Future research employing more comprehensive assessment and measurement is essential. Research in other homeless populations has utilised full psychiatric diagnostic interviews for this purpose (Prinsloo et al., 2012). Although an advancement on

the current measures, such approaches have been criticised for being reductionist, failing to capture the systemic, historic, and cultural factors influencing mental health (Johnstone, 2018). Other facets of mental health and well-being could also be explored, such as quality of life or social functioning. The utility of qualitative approaches in providing rich, contextual, information was illustrated, showing how relational trauma and poverty precipitated and interacted with experiences of homelessness (Walters & East, 2001; McHale., 2021; Carey et al., 2023). However, there was a notable lack of literature including those other than single-mother families. Globally, research has suggested fathers may have qualitatively different experiences of family homelessness, influenced by gendered societal expectations of masculinity and fatherhood (Schindler & Coley, 2007; Diebacker et al., 2015).

Reports of children's emotional and behavioural health was also limited by psychometric assessments, often being parent reported. Discrepancies between child and parent reports on such measures are well-evidenced, and future research should consider gathering information from multiple sources to resolve this (Van Roy et al., 2010). Furthermore, childhood and adolescence are characterised by many distinct stages of socioemotional development (Whitebread et al., 2019); the impact of homelessness at these different stages should be further explored.

Current understanding of family and child mental health emphasises the need to view a family as a whole system, where each member's behaviour and emotional well-being is influenced by the others (Davies & Cicchetti, 2004). There was limited exploration of this interconnection, although parental depression was shown to be associated with increased child mental health difficulties as reported by parents (Karim et al., 2006) and qualitative studies indicated parenting as a source of both distress and strength for parents (Carey et al., 2023). Beyond the family, the findings indicated that homelessness disrupts the ecological systems (Bronfenbrenner, 1979) which are essential to support child development at multiple

levels (Shelter., 2023; McCabe, 2021). Social ecological models have been adopted to understand homelessness and health and may be applied to the family context (Nooe & Patterson, 2010).

Social support was shown to buffer mental health and improve the likelihood of exiting homelessness (Vostanis et al., 1997; 2001; Tischer & Vostanis, 2007). Peer support groups have been shown to be helpful for fostering social connection and improving health and social outcomes for single homeless people (Barker & Maguire, 2017). Future studies might seek to better understand social support in a family context. Other research suggests an array of internal and external resources may be harnessed by children and adults experiencing traumatic events and homelessness (Gartland et al., 2019; Karadzhov et al., 2019). An increased understanding of coping, resources, and resiliency in families would inform effective interventions and preventative social policies. Retrospective explorations of those who have exited homelessness may support this.

Most studies employed cross-sectional or qualitative designs, making it difficult to establish directionality or the long-term impact of homelessness. The three longitudinal studies reviewed were short-term, following families for under one-year, and presented conflicting findings in terms of mental health outcomes (Vostanis et al., 1998; Karim et al., 2006; Tischler & Vostanis, 2007). At follow-up most participants had re-settled in stable housing. Recent reports show most families are housed in temporary accommodation for over a year (Shelter, 2023). As such, findings are limited in generalisability and provide little insight into the long-term effects of homelessness on mental health. No studies comprehensively explored mental health status prior to homelessness; future research would benefit from employing longitudinal cohort designs.

Complex systemic issues rooted in the distribution of power were indicated. Stigma and powerlessness presented a theme throughout; this echoes studies in other homeless populations and is shown to have a negative impact on health outcomes (Reilly & Williamson, 2022). As the pathways to homelessness and poor mental health are rooted in pervasive social inequalities, it is essential to develop a deeper knowledge of the structural factors that impact families in vulnerable positions and develop preventative measures. There was minimal evidence exploring interventions to support families experiencing homelessness; the two reviewed herein suggest specialised in-reach or out-reach services may enhance outcomes for children (Tischler et al., 2002; Sled et al., 2011).

### ***Limitations and Conclusions***

This review highlights the need to expand and update evidence to inform how best to meet the health and social care needs of families experiencing homelessness across the UK. As a scoping review, the included papers varied in terms of focus, population, and methodology, so it was not possible to draw further conclusions pertaining to the findings. This review is limited by the search terms utilised; future reviews might explore other aspects of homelessness and mental health, such as quality of life, child development, and education. Future research should consider broader conceptualisations of mental health and associated measures, adopt longitudinal designs, assess social determinants of homelessness, and include more diverse samples which better represent the population. Such research offers the opportunity to inform policy, practice, and provisions. This is crucial to supporting the health and social care needs of families experiencing homelessness, and to develop strategies to prevent homelessness, given the context of social exclusion, poverty, and lifetime trauma.

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## Appendices

### Appendix A

#### Data Extraction Form (worked example)

Data Extraction Form
<b>Author(s) and Year of Publication:</b> Cumella et al., 1988
<b>Publication Type:</b> Published Peer-Reviewed Article
<b>Aim/Purpose:</b> To establish the prevalence of mental health difficulties in homeless families as compared to low-income housed families
<b>Design:</b> Cross-sectional
<b>Location &amp; Setting:</b> Birmingham, England Local Authority Temporary Accommodation
<b>Sample Size:</b> Homeless (n = 113) Housed comparison – matched for income (n = 29)
<b>Sample Characteristics:</b> 1. <i>Composition of family</i> Parent/caregiver with children aged 2-16 <u>years</u> 86% - single mothers 4% - single fathers 12% - both parents 2. <i>Ethnicity</i> 76% - white 13% - south Asian 11% - <u>afro-caribbean</u> or <u>african</u>
<b>How 'psychological health or well-being' has been conceptualised:</b> - As per psychometric measures - Records of experiences of abuse
<b>Measures utilised:</b> Semi-structured interview Child Behaviour Checklist (CBCL) Communication Domain of the Vineland Adaptive Behaviour Scales (VABS) General Health Questionnaire-28 (GHQ) The Interview Schedule for Social Interaction (ISSI)
<b>Analysis methods:</b> Non-parametric statistical analysis Rudimentary inclusion of semi-structured interview data (no analysis methodology reported)
<b>Key findings:</b> - 85% of families homeless due to domestic/neighbourhood violence / 54% due to relationship breakdown - GHQ – parents 49% clin significant mental health difficulties / significantly more than housed. - Lifetime trauma (abuse) 49% for parents / significantly more than <u>housed</u> - VABS – child delayed communication significantly lower than norms (29% clinical range) / significantly lower than comparisons - CBCL – children 48% clin significant / significantly lower than comparisons - ACES children (7%) vs. 1% housed. - Service use – particularly low contact with MH services for children (>1%) - Service user – perception that there had been inadequate health and social support
<b>Comments:</b> - Published over 20 years <u>ago</u> - Primarily single mothers - Poor representation of cultural diversity (particularly in relevance to setting a multicultural city) - Poor reporting of use of semi-structured interview data - Measures of mental health validated but limited in scope

## **Chapter 2**

### **Empirical Paper**

**Professional Perspectives on Barriers and Facilitators to Mental Health Care for People  
Experiencing Homelessness**

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## **Professional Perspectives on Barriers and Facilitators to Mental Health Care for People Experiencing Homelessness**

### **Abstract**

The objective of this study was to examine barriers and facilitators to mental health care for people experiencing homelessness from the perspective of frontline professionals in homelessness settings. Semi-structured interviews were used to collect data and thematic analysis was performed. The results revealed three main themes: (i) structural factors such as resources, practices, and geography; (ii) attitudes and understanding pertaining to stigma and psychological trauma; (iii) frontline professionals experiences including the emotional burden of their role and navigating health and social care systems. The findings highlight the need for tailored services to meet the complex, multiple, needs of those experiencing homelessness, trauma-informed practice, and improved inter-agency working. Additionally, the development of interventions to support frontline professional's emotional health is recommended.

**Keywords:** *homeless, mental health, frontline professionals, barriers and facilitators*

### **Introduction**

Across the United Kingdom (UK), the number of people experiencing homelessness (PEH) is rising (Department for Levelling Up, Housing & Communities [DLUHC], 2022; Welsh Government, 2022). Although the Covid-19 pandemic saw a decline in numbers due to government interventions, that trend has reversed. In Wales, data indicates approximately 10,000 households were threatened with homelessness last year, with thousands more across

the rest of the UK (Shelter, 2023; Welsh Government, 2022). As the nature of homelessness is often transient and episodic, it is thought that true figures are higher than current cross-sectional estimates (Deleu et al., 2021).

Homelessness is defined as the absence of stable, safe, or appropriate shelter (American Psychological Association [APA], 2011). This includes ‘rough sleeping’, living in temporary accommodation such as hostels, or having inadequate or insecure housing (Public Health England, 2019). A complex mixture of individual and societal factors contribute to becoming homeless. Previous life experiences often characterised by trauma, abuse, violence, addiction, and physical and mental health difficulties, intertwine with macro structural factors, such as poverty, lack of affordable housing and unemployment (Maguire, 2017; Mabhala et al., 2021). This exists in the context of pervasive social inequities and the multi-generational marginalisation of certain populations. People from minoritised ethnic communities are significantly over-represented in the homeless population, contributed to by these factors (Bramley et al., 2022).

Homelessness is associated with devastating health inequities. The average life expectancy for PEH is estimated between 47 and 52 years, approximately 30 years less than the general population (Thomas, 2012; Aldridge et al., 2019). Long-term physical health conditions, mental health, substance misuse and suicide contribute to this (Fazel et al., 2014). In high-income countries especially, homelessness and the associated loss of life is thought to be largely preventable, primarily caused by structural injustice and poor provision and practice in health and social care (Fransham & Dorling, 2018; Aldridge, 2019).

### ***Homelessness and Mental Health***

The prevalence of mental health difficulties for PEH is estimated at two to three times higher than the general population and even more for severe conditions, such as psychosis

and Post-traumatic stress disorder (PTSD) (Gutwinski et al., 2021; Ayano et al., 2020). Such difficulties commonly co-exist alongside high rates of substance misuse, often acting as a coping strategy for psychological distress (Brown et al., 2003; Polcin, 2016). Large-scale studies show that adverse childhood experiences such as abuse and neglect, and subsequent traumatic life events are over-represented within this population (Liu et al., 2021). Such experiences are well-known to precipitate poor mental health (Hughes et al., 2019). Over a third of PEH will be admitted to hospital each year, of which approximately 30% are related to mental health (Homeless Link, 2022). Substance misuse and suicide account for half of the deaths in this population (Office for National Statistics [ONS], 2021). Poor mental health is associated with poorer physical health, stigma and social exclusion, and risk of victimisation, such as sexual or physical assault (Fazel et al., 2014; Sanders & Albanese, 2016; Hossain et al., 2020). Poor mental health presents a risk factor to becoming homeless, equally, the chronic stress of homelessness, an often-traumatising experience itself, can precipitate and exacerbate mental health difficulties (Pattison & McCarthy, 2022). In addition, mental health problems can reduce the likelihood of exiting homelessness, suggesting a complex, mutually reinforcing, relationship (Nillson et al., 2019; Lauchaud et al., 2021).

### ***Accessing and Engaging with Health and Social Care***

Despite substantial health and social care needs, there are significant barriers for PEH in accessing and engaging with services. PEH are 40 times less likely to be registered with a general practitioner (GP) than the general population and are less likely to utilise mental health services, even when experiencing acute difficulties (Reid & Klee, 1999; Hodgson et al., 2014; Elwell-Sutton et al., 2017). Findings from a small body of qualitative studies suggest multiple complex barriers to accessing general healthcare services including fragmented and unresponsive services, and difficulties registering with services (Armstrong

et al., 2021; McConolouge et al., 2021; Gunner et al., 2020; Rae & Reese, 2015). There are indications of stigma and discrimination across most studies, characterised by unhelpful interactions with healthcare professionals, perceptions of being judged, and exclusion from services (Bhui et al., 2006; Armstrong et al., 2021). The current evidence presents a paradox; on one hand PEH were seen to be unable to prioritise healthcare due to immediate survival needs, yet also expressed a wish to address their health difficulties. Literature highlights that service provisions may not be equipped to cater for the complex multiple needs of PEH, particularly those with co-existing mental health and substance use difficulties (Armstrong et al., 2021; McConalogue et al., 2021). Although research primarily focusses on general health, some has explored mental health. PEH have described how adverse childhood experiences can foster distrust in social establishments, a sense of betrayal, and a reluctance to seek help in favour of self-sufficiency, indicating a complex interplay between systemic and individual barriers (Collins & Barker, 2009; Bhui et al., 2006).

Although offering some insight, the literature is limited. Most of the studies were conducted in heavily urbanised areas of England. Housing legislation and health and social care practice is devolved across the countries in the UK and rural geography can affect healthcare experiences (Parr et al., 2004; Wilcox et al., 2010). Additionally, it is difficult to ascertain if the samples are representative. PEH who are living a more transient lifestyle, or experiencing poorer health may be less likely to participate where conventional research methodologies can fail to engage marginalised populations.

The responsibility of supporting PEH experiencing severe mental health difficulties increasingly falls upon frontline homelessness services. Research indicates that they too may encounter barriers to accessing care for PEH including disparate service structures and a lack of provisions or response from other healthcare professionals (Canavan et al., 2012; Devine & Bergin, 2020; Armstrong et al., 2021). Frontline professionals in homelessness services

often have to manage high levels of distress and associated risk behaviours, related to the multiple complex needs of PEH (Cornes et al., 2011). Recent studies indicate that the nature of their work may impact their mental health; although not well researched at present there are reports of high rates of vicarious trauma, depression, and burnout (Lemieux-Cumberlege & Taylor, 2019; Waegemakers & Lane, 2019).

### ***The Present Study***

Much of the current evidence has explored access to healthcare for PEH broadly, the present study aims to understand barriers and facilitators specifically for those with mental health difficulties. To do so it will utilise the perspectives of frontline professionals in homelessness settings. This study will be conducted across rural Wales; to the author's knowledge this is the first time this topic has been explored beyond urban environments. Over the past two decades, UK and Welsh governments have released homelessness prevention plans, including increased multi-agency approaches to service provision and strategies to improve equity of care (Homelessness Act, 2002; Welsh Government, 2009). Despite this, homelessness is rising amidst increasing economic hardship and a lack of affordable housing. Additionally, the National Health Service is struggling to meet demands, with extensive wait times and a lack of resources (Care Inspectorate Wales., 2019; Royal College of Psychiatrists, 2020). This study aims to inform current understanding of this topic to develop health and social care practice and policy.

## **Methods**

### **Ethical Approval**



The research was approved by Bangor University School of Psychology Research Ethics Committee (Ref: 17130) (Appendix A).

### **Setting and Design**

This study was conducted in conjunction with a third-sector housing and homelessness organisation serving communities across Wales. They have been supporting many individuals with severe and enduring mental health difficulties whilst reporting challenges in accessing appropriate care. As such, this study formed part of larger campaign, by providing in-depth qualitative analyses to accompany survey data and case studies being conducted by the organisation, with the aim of understanding health and social care provision inequalities. The services offered by the organisation, and participants within this study, included outreach and residential support for PEH.

### **Recruitment**

Recruitment and data collection spanned from September to December 2022. Participants were recruited from three project sites in counties in north and west Wales, through purposive sampling. To be included in the study participants were required to be over the age of 18 and have worked in the frontline homelessness for six months or more. Recruitment was supported by a member of the third-sector organisation and project managers. Initially, a summary of the study and corresponding information sheet (Appendix B) was sent via email to frontline professionals with the assistance of project managers. However, enrolling participants using this method proved challenging. It was noted that the lack of response to this recruitment approach was largely due to demands on staff time and, in one instance, hesitancy in participating without the opportunity to discuss the rationale in person. Consequently, the primary researcher attended the services and approached

participants in person. Upon expressing interest, participants were offered an opportunity to ask questions, provided informed consent, and were then reimbursed following participation (Appendix C).

### **Participant Demographics**

A total of 10 participants from projects across the three counties participated. The length of time they had been working within frontline services ranged from nine months to over ten years.

### **Data collection**

A semi-structured interview schedule was developed and reviewed by a professional from the homelessness organisation (Appendix D). Questions explored the practical barriers and potential facilitators experienced by frontline professionals when seeking mental health care for PEH and their experiences navigating these systems. The interviews encouraged reflection and remained flexible to exploring relevant topics outside of the schedule.

### **Data Analysis**

Reflexive thematic analysis (TA) was utilised, applying Braun & Clarke's methodology (2022), chosen as it offered the flexibility of inductive analyses with the capacity to capture semantic and latent content, thus providing both descriptive and interpretative accounts of the participants experiences. The data was transcribed and then checked for accuracy, making any necessary corrections, after which, initial impressions were noted. Subsequently, the transcripts were re-visited in detail multiple times and initial codes generated, whilst considering potential themes. An iterative process followed whereby the transcripts were re-visited multiple times and codes refined. Resultant themes were identified

and built upon. Sections of the data pertinent to the themes were highlighted, grouped, and adjusted where necessary (Appendix E-G). The tenets of quality in qualitative research, as defined by Yardley (2000; 2017) were considered throughout. These include (i) sensitivity to context; (ii) commitment and rigour; (iii) transparency and coherence; (iv) impact and importance. To support this, the first author kept a reflective log, received regular supervision, and the other authors reviewed a sample of transcripts and theme generation.

### **Reflexive Statement**

The first author identifies as a white, British, female. She is training to become a Clinical Psychologist and has previously worked as a frontline professional in homelessness services. Throughout her life, she has traversed the socioeconomic spectrum, from personally experiencing housing instability and unemployment, to being a homeowner and in stable employment. She also has lived experience of mental health difficulties. Reflexively, these experiences allow her to hold a non-judgemental approach to understanding homelessness and mental health, with an awareness of the multiple factors that contribute to such experiences, as well as the experiences of frontline professionals. First-hand experience of the challenges of working in homelessness and witnessing systemic failings, required her to be particularly mindful where emotive past experiences may influence the research. As a mental health professional, the author considered she could also have been perceived as ‘part of the problem’ by participants. A critical realist epistemology was held, recognising the researcher’s prior experiences and knowledge inevitably impacted her observations, but ultimately aiming to identify an objective, shared, reality relating to participants experiences, whilst holding preconceptions in mind.

### **Results**

The thematic analysis results revealed three themes from which several subthemes emerged (Table 1). Two themes encapsulated participants' perceived barriers to mental health support and included facilitators offered to counter these; these were *structural factors* and *attitudes and understanding*. A third theme, *frontline professionals navigating the system*, provided insight into how barriers and facilitators were experienced on the frontline.

**Table 1.**

Themes and Subthemes

Themes	Subthemes
<b>Structural Factors</b>	Approaches to communication and engagement
	The need for services willing and able to meet complex needs
	Response during mental health crises
	Inter-agency cohesiveness and communication
	The housing crisis
	Rurality
<b>Attitudes and Understanding</b>	Stigma
	Understanding and working with trauma
<b>Frontline Professionals Navigating the System</b>	The impact of continuous stressors and related coping
	Navigating power in the system

## Structural Factors

### *Approaches to communication and engagement*

All participants described that mental health care was inhibited due to limited and rigid methods of communication, such as telehealth, written letters, and inflexible rules regarding engagement, such as strict non-attendance policies. These were perceived to be exclusionary for PEH. Practical factors, such as lack of access to phones and no fixed address were cited. In addition, many participants observed that navigating services was untenable in

the context of the often-chaotic lifestyle and routines that accompany the hardships of homelessness, mental health difficulties, and addiction.

*“...their priorities are gonna be survival and basic survival and what that translates to in the real world is non-engagement, that's what it's seen as, that they're not attending appointments they're not answering the phone. How can they answer their phone if they haven't got a phone and they can't charge it? How do they know to go to an appointment if a letter has been sent to them and they're no longer at that address and they can't receive mail?” (Participant 8)*

Extended wait-times and delays in responding to referrals or other requests for care were also noted by all participants, exacerbated by the Covid-19 pandemic; one participant described *“They've just been left in limbo, waiting, anxious...” (Participant 9)*. Such barriers were seen to result in service-users losing faith and disengaging, particularly where it may have taken courage for a person to request support, sometimes disclosing past traumatic experiences. Flexibility and individualised approaches to engagement and communication based on transparency and responsiveness were offered as solutions to facilitate care.

### ***The need for services willing and able to meet complex needs***

All participants emphasised a lack of support for co-occurring mental health and substance use difficulties; they appeared bewildered and frustrated at this, where they conceptualised substances as a coping strategy for psychological distress.

*“... he self-harms and he’s swallowed razor blades and he’s made attempts on his own life, but he has mental health difficulties, they’re just dismissed all the time as being related to his substance misuse, but then they’re not, he’s using substances to cope with his mental health” (Participant 5)*

More broadly, most participants explained difficulty obtaining any support for individuals deemed to have more complex difficulties, often characterised by multiple mental health diagnoses, high levels of distress, and risk behaviours. These individuals were *“passed from pillar to post” (Participant 2)*, with no services willing to take responsibility for care. This was seen to have profound negative consequences, perpetuating a cycle of mental health crises and substance use, often leading to crime and loss of temporary accommodation. Many participants spoke of carrying an additional burden of managing service-user’s expectations and distress, in the absence of support from mental health teams; one described *“It is soul destroying, you can see a car crash coming... but there’s nothing you can do but sit there and watch it happen” (Participant 3)*.

There was a sense that one way in which participants coped with this burden was to apportion responsibility, traversing between assigning failures to individual services and wider governmental and systemic factors. The former often resulted in an ‘us-against-them’ mindset, with several participants seeing it as a battleground; one stated *“I felt like every day when I was getting ready for work, I was getting ready for war.” (Participant 5)*. The latter appeared to result in increased solidarity with other agencies, although was often accompanied with hopelessness and frustration. Participants emphasised the necessity of increasing services equipped and willing to meet the multiple needs of PEH in the context of mental health and substance use. The charity provided a unique in-house counselling service for service-users, which many felt was helpful, but insufficient.

### ***Response during mental health crises***

Nearly all participants described a lack of response from mental health professionals during mental health crises. This was illustrated by numerous stories of service-users in psychological distress, often suicidal or self-harming, whom, despite participant's attempts to access support from 'crisis teams' at local community mental health services, received little response. Participants frequently resorted to calling emergency services, by which time the situation had often escalated; one person stated, *"they're essentially being the taxi service to ferry someone..."* (Participant 9). Although the police were generally reported to respond well, their presence risked escalating situations further, where service-users felt threatened. Many also felt that service-users were discharged from hospital following a crisis whilst still at risk. One described *"...they'd discharge her, because they were like, 'it's not crisis point anymore', and I'd then just be dealing with her self-harm and suicide attempts..."* (Participant 1). It appeared that participants shared a belief that it was the remit and duty of local mental health services to respond to crises by attendance in person and many referred to the inaction of a 'crisis team'. However, it appeared there was no clear, shared, definition of the role of such a service, leaving the expectations of frontline professionals unmet. One participant explained, *"I don't know what their job is... The only time I've seen the crisis team come out is when they're delivering medication to preexisting people on their caseload, not somebody in crisis. (Participant 9), another stated, "they'll say 'we can come out in the morning' and I know full well that the morning is not going to be quick enough...and you're thinking, where is the preventative here?"* (Participant, 4).

Repeatedly witnessing the lack of support for service-users in such distress was seen to violate participants own moral beliefs with some describing a lasting impact on their emotional well-being. Many participants suggested one of the key changes that would

facilitate engagement for PEH and reduce crises was to be “*proactive rather than reactive*” (Participant 9). Suggestions included a prompt crisis response team, where mental health professionals attend to those in psychological distress with the intention of preventing the need for emergency services to intervene where possible, improved support following a crisis, and assertive in-reach and out-reach in homelessness settings.

### ***Inter-agency cohesiveness and communication***

All participants inferred that a lack of partnership working and poor communication between services comprised one of the most substantial barriers. This appeared to be related to little understanding of each agency’s role and a fragmented service structure. Addressing this was proffered as one of the simplest and most effective ways to improve care in the absence of additional resources.

*“I think what it what it boils down to is a [pause] a lack of understanding about what each agency does a lack of cooperative working and obviously what happens then is that has a detrimental effect on the service user...it feels like there’s a big wall between services...” (Participant 6)*

Additionally, poor information sharing was cited to lead to increased risk, such as prescribing errors in addition to service-users with traumatic histories having to repeat their stories to multiple professionals, leading to further trauma or disengagement. One participant explained, “*they need to know his background, or her background, their background, you know, rather than try and bring that up all the time and make that client then repeat themselves...*” (Participant 2). Misunderstanding and miscommunication from agencies



appeared to exacerbate already strenuous relations between services, at the expense of frontline professionals and service-users well-being.

### ***The housing crisis***

Many participants referred to “*the housing crisis*” (Participant 4) and indicated the need for increased specialised, staffed, and supported accommodation to meet complex needs. One person recounted “*...in the end he ended up burning his bungalow down, he should have been in supported living, but nowhere would take him, because his risks were so high because of his mental health*” (Participant 1). Others stated a lack of appropriate move-on accommodation leads to poor mental health and hopelessness. It appeared many participants felt Covid-19 had “*missed a massive window of opportunity to end the homelessness problem*” (Participant 3), where they had ended the duty of care to end homelessness.

### ***Rurality***

The geographical and social impact of living in rural settings were discussed by many. This included disparate services, poor public transport, and a lack of availability of third sector and community opportunities compared with urban settings.

“*...if you do have complex mental health you do tend to be placed in temporary accommodation and a lot of it isn't on bus routes...so people can't get out and about. They are out in the middle of nowhere... if you're sat in temporary accommodation with mental health, no money, nowhere to go, you're out in the sticks, it's enough to send anybody into crisis*” (Participant 10)

It appeared that geography might interact with the presence of stigma and inhibit help-seeking behaviours. Participants described that rural villages “*are so close-knit and everybody knows everybody*” (Participant 8), which was perceived to increase service-user concerns about judgement from the wider community and healthcare professionals.

## **Attitudes and Understanding**

### ***Stigma***

Most participants referred to encountering multiple negative stereotypes held by health and social care agencies toward service-users at the intersection of mental health, homelessness, and addiction. This was perceived to impact the quality of mental health care and access to move-on accommodation.

*“if say one person in that chain out of say eighty people label somebody with something negative that normally gets seen by the entire eighty and that then effects how the other seventy nine view that person, does that make sense?” (Participant 4)*

Service-users who frequently attended services or had received a diagnosis of borderline personality disorder appeared to be particularly marginalised.

*“I think that she got a reputation as being a kind of “frequent flyer” and they’d be like “Oh it’s just this person ringing up again...okay” and then eventually, you know, later in the week they’d be like ringing us up like “could you just sort of sort this person out” .... a month ago now she killed herself” (Participant 6).*

Additionally, participants spoke to service-user's fear of judgement inhibiting their engagement in group or community activities, indicative of internalised stigma.

### ***Understanding and working with trauma***

Participants alluded that poor care and stigma was related to a lack of understanding and consideration of the role of traumatic experiences in precipitating and maintaining poor mental health and homelessness.

*“I think the main barrier is with people who have experienced a lot of trauma, and I find that mental health tend to say it's personality disorder, which then, they say, means they are not entitled to any support from CMHT [Community Mental Health Team].” (Participant 10)*

Many inferred that service-users past experiences of interpersonal trauma made it more challenging for them to build trust and relations with professionals, with increased empathy, patience and sensitivity required to facilitate this.

*“We have a lot of clients... whose behaviour might be perceived as challenging, but they don't mean to be challenging, it's as result of their mental health or their experiences...but it's really difficult to express that to other agencies and get them to take on the same viewpoint” (Participant 5)*

This theme seemed to speak to participants feeling of separation from other services on a deeper level. One participant explained a sense of fundamental 'otherness' where they had generalised attitudes to whole services “...the mental health team don't share our same

*values our insight or opinion or views... ” (Participant 9).* However, another made sense of this in the context of the of resources and systemic challenges faced by health services, explaining *“I just work on the basis that I do believe that everybody wants positive outcomes” (Participant 6).*

## **Frontline Professionals Navigating the System**

### ***The impact of stress and related coping***

One participant explained *“90% of my job is dealing with clients in crisis” (Participant 3).* Many referred to continuously attending to complex mental health needs and crises; stories of these distressing incidents framed many discussions throughout the data. One described *“I’ve gone on the train tracks, to get someone off when their mental health’s been bad. I have another client, who self-harms every day...” (Participant 1).* Many referred to stress, anxiety, exhaustion, frustration, and a consistent pervasive fear of a catastrophe, suggesting the presence of burnout and vicarious trauma; one reported *“You’re living on your nerves sometimes..., we don’t sleep very much we we’re hyper hyper vigilant to things which causes even more stress” (Participant 9)*

For some, a sense of lasting personal responsibility for tragedies was evident. One spoke to this, stating *“I ended up thinking ‘was there more I could have done? I know it’s not my fault, because it’s not in my power to stop her killing herself, but like, could I have helped her more?’” (Participant 5).* This was indicative of moral injury; where emotional distress is caused by witnessing violations to one’s own morals, particularly where there is an inability to prevent such violations.

Despite these challenges, it seemed participants were deeply motivated by empathy and understanding; one explained *“I don’t accept and can never accept that there can never*

*be a path of recovery for anybody no matter how bad things have got” (Participant 3).* For some, they framed their role as fighting for justice, one participant passionately described *“we care and we don't like the injustice...” (Participant 9).*

Support from colleagues was cited as a key coping strategy for most participants, underpinned by a strong sense of group cohesion, seemingly reinforced by shared experiences of adversity *“... it's a really strong team...they can see what's happening and, and, how difficult it is and we're always there for each other” (Participant 8).* Interestingly, most participants spontaneously referred to their lived-experience of mental health difficulties as a factor in either helping them understand service-users or in managing the emotive aspects of their work. However, in some cases it seemed that this insight could make witnessing service failures more distressing.

### ***Navigating power in the system***

Participants referred to feeling powerless or de-valued by registered professionals in other health and social care agencies. One explained *“We don't have the power and authority and people don't listen to us because we're 'just' support workers” (Participant 5).* It was often felt that this was detrimental to the service-users quality of care as it negated the insight that they held, based on the intensive relationships they had built working closely with service-users. One described *“cause technically we are support workers, we are sort of dismissed and our opinion doesn't really, doesn't really, count...” (Participant 10)*

Participants regularly referred to calling on management, or other allied professionals, to accumulate power to engage community mental health services. Once again, this appeared to be conceptualised with a strong narrative of war. The perception of a power imbalance appeared inflamed by poor understanding and transparency between agencies.

## Discussion

This study harnessed the insight and experiences of frontline professionals to explore barriers and facilitators to mental health care for PEH. Multiple, interrelated, levels of this phenomenon emerged across three themes. Structural barriers revealed a lack of appropriate approaches to engaging and supporting PEH, poor provisions and inadequate crisis response, alongside the geographic impact of rural, fragmented services. Attitudinal factors held by services included stigma and a lack of trauma awareness, which were perceived as inhibiting care, and appeared to amplify rifts between homelessness and mental health services. Additionally, for frontline workers, the emotional burden of supporting PEH in acute psychological distress whilst lacking support was substantial and appeared magnified by a lack of power within a system perceived as broken.

The findings of this study align with, and build upon, previous literature, highlighting the need for developing tailored approaches to care (Gunner et al., 2019; Armstrong et al., 2021). This study indicates rural geography presents unique challenges relative to urban areas, from poor transportation to social isolation. Although no benefits of rural living were discussed within the data it would be beneficial to explore this further in a more targeted exploration; previous studies suggest that urban environments may have increased social and environmental stressors that present a greater risk for mental health difficulties (Lederbogen et al., 2011). Barriers to rural healthcare have been recognised elsewhere (Parr et al., 2004; Coleman, 2023), although there may be some protective factors of rural environments. Future research would benefit from exploring this further in the context of homelessness and health. Experiences of historic trauma, common in this population, often precipitate mental health difficulties, these were perceived by professionals to adversely impact the ability of PEH to trust and build relations with healthcare professionals. These echo previous findings showing

distrust and perceptions of services as authoritarian for PEH with experiences of relational trauma (Bhui et al., 2006; Collins & Barker, 2009).

Stigma and exclusion were reported as common and are well-known to create barriers to healthcare for marginalised populations (Reilley et al., 2022; Armstrong et al., 2021). PEH regularly attending services in distress, were often labelled as ‘frequent flyers’. Such language has been identified as rooted in implicit bias, perpetuating harmful stereotypes, and impacting care (Raney et al., 2021). Co-occurring substance misuse appeared to preclude PEH from accessing mental health support, despite being inextricably related (Smith et al., 2017). This is an issue well-recognised within policy and is counter to current guidelines (National Institute of Health & Care Excellence [NICE], 2016). Stigma, perceived or external, results in poorer mental and physical health outcomes for PEH (Reilly & Williamson, 2022). Other research applying the lens of intersectionality to understand homelessness, emphasises the interrelatedness of social categories that result in cumulative discrimination and exclusion (Verissimo et al., 2021). Although not directly exploring this concept, this study suggests multiple exclusion at the intersection of addiction, mental health, and homelessness. A more detailed investigation of other factors, such as gender, race, and refugee status, is merited.

Exacerbating stigma and exclusion, professionals reported the attitudes and practices of services failed to recognise and respond to trauma and suggested increased sensitivity, empathy, and time to build relations was required. Such psychologically informed approaches have been shown to facilitate care, although can be challenging to implement in resource depleted settings (Schneider et al., 2022; Huo et al., 2023). Frontline professional’s perceptions of the attitudes and approaches of mental health services were undoubtedly coloured by the complex and fraught structural and communication issues between services. Future studies would benefit from gathering data on this topic from mental health

professionals themselves. The narrative of ‘us against them’ toward mental health services illustrated a strong sense of social identity, which, although bonding frontline professionals together under adversity, may have exacerbated friction between groups (Tajfel & Turner, 1979). The potential pitfalls of social identity in the context of effective interprofessional teamworking, particularly where there are differences in status and group norms, has been identified in other healthcare settings (Lloyd et al., 2011). Future research should explore this further and may consider utilising focus groups comprised of professionals from multiple agencies to build a collective understanding of this issue and its impact.

Frontline professionals were managing acute psychological distress and traumatic situations, often related to a lack of response from mental health services both during and following, a crisis. A lack of congruence between frontline professionals’ expectations and the reality of mental health services’ ability to respond was evident. In part, it is possible that this was exacerbated by the lack of inter-agency communication and understanding. There are ‘crisis resolution and home treatment teams’ which exist across mental health services, which aim to offer intensive treatment in the community for those in crisis. NICE guidelines (2011) state that such services should be available to respond promptly, in the early stages of crisis, 24 hours a day, 7 days a week, with the intention of supporting a person to stay within the community, rather than hospital. The findings of this study, coupled with previous literature, suggest that, in practice, their implementation is highly variable, and they may struggle to provide the recommended level of intervention, particularly where they are falling under increasing demand (Wheeler et al., 2015; RCP, 2020; Healthcare Inspectorate Wales, 2022).

Despite evidence of adaptive coping strategies, managing mental health crises in isolation from other services was indicated to have an adverse impact on frontline professionals’ well-being. This may be explained by vicarious trauma, a phenomena whereby similar symptoms to PTSD are experienced by professionals working with trauma survivors



(Newell & MacNeil, 2010). This corresponds with quantitative studies measuring high levels of vicarious trauma amongst homelessness professionals and would benefit from deeper qualitative exploration (Waegemakers & Lane, 2019; Lemieux-Cumberlege & Taylor, 2019). A narrative of powerlessness whilst witnessing systemic failures in care often underpinned distress. This may be indicative of moral injury, where high levels of lasting distress are experienced upon witnessing situations which violate ones ethical or moral values (Kerman et al., 2022). To the author's knowledge, this phenomenon has not yet been explored in homelessness settings, meriting further research. Prolonged exposure to stressors in the workplace, particularly those experienced in health and social care settings characterised by high demands and low resources, alongside fast paced and emotionally intensive work, can result in burnout in professionals (Maslach et al., 1997; Salyers et al., 2017). This is a chronic response to stress characterised by exhaustion, depersonalisation, and a reduced sense of accomplishment and effectiveness; not only is this burdensome for the health of professionals but may also impact the quality of care for service-users (Salyers et al., 2017).

### ***Limitations***

Although the participant numbers were small, the qualitative methodology gathered rich and in-depth data, capturing a dynamic perspective on this phenomenon, appreciative of the context. However, the findings are limited by the lens from which they were drawn; the complex relationships between frontline professionals and other services may have introduced bias to the data. Additionally, this sample may not represent other frontline professionals in organisations with different working practices or cultures. Nonetheless, many findings corresponded with and expanded on previous research. A substantial limitation of this study is that it did not include interviews with PEH; future explorations would benefit from taking a multi-perspective approach.

### ***Implications***

This topic remains under-researched and future study is crucially required, recommendations for this have been detailed throughout the discussion. PEH have a wide range of needs, including substance use, trauma, and mental health, which need to be addressed together, rather than compartmentalised. Flexible appointments, out-reach and in-reach approaches, and the use of multiple modes of communication have been found to improve accessibility (Davies & Wood, 2018; Kopanitsa et al., 2022). There is an urgent need to develop more responsive mental health crisis services. As a large proportion of deaths amongst PEH are related to overdose and suicide, such interventions could save lives and reduce demands on emergency services and hospital beds (ONS, 2021; Aldridge et al., 2019). Furthermore, challenges to the design and delivery of services in rural areas is well recognised and requires further consideration in the context of homelessness and mental health (Carey, 2023). This study supports movements toward ‘psychologically informed environments’ which aim to increase healthcare provider’s awareness and responsiveness to trauma and reduce stigma (Shneider et al., 2022). The use of anti-bias training, particularly in terms of the language used to refer to service-users, may also improve care across services (Raney et al., 2021)

Services should seek to enhance relations and partnership working. Although there is no single answer, this may be achieved through a clear definition of roles, increased shared learning opportunities, improved channels of communication and clear care pathways (Gardiner et al., 2012; Glasby & Lester, 2004). The findings also emphasise the need for interventions to support the emotional well-being of frontline professionals; to be effective this will likely require organisational and individual level approaches (West et al., 2016). Health and social care services exist in the larger socioeconomic and political context which is characterised by a lack of resources or funding to match demands (Cummins, 2018). This was evident within this study and requires addressing at a structural level to facilitate

meaningful change. Whilst it is important that appropriate interventions are available to address the mental health needs of PEH, ultimately a policy level approach is required which not only addresses the social determinants of homelessness, such as childhood adversity and poverty, but also aim to eradicate homelessness.

### ***Conclusion***

Using qualitative methodologies, this study revealed barriers and potential facilitators to mental health care for PEH by capturing the knowledge and experiences of frontline professionals. PEH are often termed ‘hard-to-reach’; although a seemingly convenient label, it fails to capture the complex histories and structural factors beyond the individual’s control, that both determine homelessness and health inequities (Flook et al., 2020). A paradigm shift toward ‘need-to-reach’ or services as ‘hard-to-access’ may be more helpful when considering advancements in healthcare practice and provision in the future.

**Declaration of Interest:** There are no financial interests or personal relationships that may have influenced this study to declare. As stated in the methodology, the project sits alongside a pre-existing and ongoing project into mental health care and homelessness by the participating third-sector organisation. However, although supported by the organisation, this study was completed independently, in line with processes and requirements for independent primary research in partial fulfilment of the Doctorate of Clinical Psychology.

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## Appendices

### Appendix A

#### Proof of Ethical Approval



E-bost/E-mail: c.saville@bangor.ac.uk  
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To whom it may concern,

I can confirm that Jessamine Rayner's research project *Professional perspectives on barriers and facilitators to mental health care for people experiencing homelessness* has been reviewed by the ethics committee of the School of Human and Behavioural Sciences at Bangor University, and received a favourable opinion.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Chris Saville'.

Dr Chris Saville  
13<sup>th</sup> June 2022

Cadeirydd Pwyllgor Moeseg Ysgol Gwyddorau Dynol ac Ymddygiadol  
Chair, School of Human and Behavioural Sciences Ethics Committee

**Rhaglen Seicoleg Clinigol Gogledd Cymru**  
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## Appendix B

### INFORMATION SHEET

#### **A study into the experiences and perspectives of frontline professionals supporting those who have mental health difficulties and are homeless: an exploration of barriers and facilitators to care**

I would like to invite you to take part in a research study exploring the experiences of frontline professionals working with adults who are experiencing mental health difficulties alongside homelessness / housing instability. The information on this sheet provides details about the study, please read it carefully before deciding to take part.

If you have any questions about the information here, you can contact the researcher whose details are at the bottom of this sheet. They will be happy to answer any questions.

#### **Who is carrying out the research?**

Jess Rayner is a Trainee Clinical Psychologist on the North Wales Clinical Psychology Programme at Bangor University. This study is being undertaken as part of her training and is supervised by Dr Robin Owen and Dr Mike Jackson. The project has been approved by the Psychology Research Ethics Committee.

#### **What is the purpose of this study?**

The aim of this study is to better understand the barriers and facilitators to care for adults who are managing significant mental health difficulties and are experiencing homelessness or housing instability by exploring staff experiences and perspectives. The hope is to use this understanding to identify problems and help to improve health and support services.

#### **What will happen if I take part?**

If you decide to take part in this study you will be asked to meet with Jess to discuss your experiences of working with the people you support and offer your perspectives on the barriers and facilitators to health and support services for them. You will also be given the opportunity to explore how this work has been for you at a more personal level. The time the interview will take will depend on how much you would like to talk about. The time and place of the interview will be somewhere convenient for you.

#### **Do I have to take part?**

**No.** It is completely your choice. You do not have to give a reason if you decide you do not want to take part and your decision to participate, or not, will not be shared with anyone.

#### **What are the possible benefits of taking part?**

In taking part in the study, you will be helping to develop a better understanding of mental health and homelessness and frontline staff experiences. This may be useful for services to develop how they support people in the future. You will also receive a £20 voucher for amazon, or high street shops, dependent on your preference, after the study to reimburse you for the time you have given.

#### **What are the possible disadvantages to taking part?**

Taking part in the study does not involve any direct risks, but it is understood that talking about this topic might raise some difficult feelings. During the interview you do not have to answer any questions and you are able to take a break or end the interview at any time. You do not have to give a reason if you do.

#### **What will happen to the information I give if I participate?**

All information will be kept confidential. The interview will be recorded on an audio device and then immediately transferred to a password protected computer, before being permanently deleted from the audio recording device.

The things we have talked about in the interview will be typed up into a document with any information that identifies you removed. The audio recording will be permanently destroyed once the interview has been typed up and no later than the completion and assessment of the research report for the researcher's training qualification. The typed-up document will be destroyed after the study has been completed and the final research report has been assessed as part of the researcher's training qualification.

The things you discuss as part of this research will be confidential. They will not be shared with anyone else beyond the research team, including [REDACTED], until the information that identifies you has been removed and summarised in the form of a research report.

#### **What will happen to the results of the study?**

The information you give might be used for published research papers and things like presentations at conferences. All information that identifies you will be removed before it is used in this way. The information also forms part of a wider campaign by [REDACTED] to improve services.

It is important that you understand that by participating in the interview that you are consenting to anonymised quotes from your interview being published in the study. If you want to know more at the end of the study, you can speak to the researcher, who will explain the results to you and answer any questions.

#### **What if I decide that I want to withdraw from the study?**

You can withdraw from the study at any time. You do not need to give an explanation. You also do not have to answer any questions during the study that you do not want to answer and do not have to give a reason for this either. If you want to withdraw your data, you can do so at any time up until it has been anonymised and summarised into a research report.

#### **What if something goes wrong?**

Talking about these topics can sometimes bring up difficult thoughts or emotions. If you experience any distress, the researcher will support you, signpost you to relevant support, and offer to talk with your line manager to make them aware. Your line manager will be available to discuss anything that participating in this study brings up for you. Although they will not be told you are personally participating, they will aware the research is taking place and the nature of the topics being discussed. If you would like to speak to someone independent of [REDACTED] confidentially, including trained counsellors, you can access the Employee Assistance Programme. The details for this will be provided to you upon participation.

Although unlikely, if there is serious concern raised about an issue of risk, which include harm to yourself, or another, child protection issues, or money laundering and other crimes protected by the prevention of terrorism legislation, the researcher may have to contact someone outside of the research team. In the unlikely case this occurs, it is possible that the boundaries of confidentiality will have to be broken. The researcher will make every effort to seek your permission before sharing information.

#### **How do I volunteer to take part in the research study?**

If you would like to participate in the study, you can email the researcher directly. The researcher is happy to answer any questions you might have about the study.

The researcher will then work with you to arrange a convenient time and location to meet for the interview. If you decide to take part, you will need to complete and sign a consent form.

**Thank you for reading this information sheet**

#### **Contact details for researcher**

Jessamine (Jess) Rayner, Trainee Clinical Psychologist  
North Wales Clinical Psychology Programme (NWCPP)  
School of Psychology  
Brigantia Building,  
Bangor University,





## Appendix C

### Participant Consent Form

**Study Title:** A study into the experiences and perspectives of frontline professionals supporting those who have mental health difficulties and are homeless: an exploration of barriers and facilitators to care

**Researchers Name:** Jessamine Rayner

**Please initial each box to show that you agree with each statement:**

I have read and understood the information sheet provided to me by the named researcher.

☐

I have had time to consider the information I have had the opportunity to ask any questions, which have been answered satisfactorily.

☐

I understand that taking part in this study is voluntary and I have the right to withdraw from the study, without giving a reason.

☐

I understand that the data collected about me during this study will be recorded on an audio device before being written up into a word document with identifying information removed.

☐

I understand the data I give whilst taking part in this study is confidential. Although if the researcher becomes concerned about mine, or another person's, well-being they may have to inform [REDACTED], or another agency if necessary.

☐

I agree to take part in this study

☐

Participant Name \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Researcher Signature \_\_\_\_\_ Date \_\_\_\_\_

## **Appendix D**

### **Semi-Structured Interview Schedule**

Thank you for taking the time today to take part in this study and be interviewed.

*Disclosure Statement:*

- To protect client/professionals' confidentiality can I ask that you use pseudonyms and when referring to services, use more general terms (e.g. CMHT/police) than refer to specific services.
- Everything we speak about will be kept confidential and I would only need to share anything beyond the research team if I am concerned about harm coming to yourself, or another or where I am legally required to (i.e. child protection / money laundering & terrorism / protection of vulnerable adult)

Do you have any questions? Are you still happy to go ahead with the interview?

#### **Background**

I am interested in hearing about your experiences of working with people who are experiencing homelessness/housing instability and significant mental health difficulties (these might be people who have received a diagnosis such as psychosis, schizophrenia or personality disorder, or perhaps people who have not received a diagnosis and are still experiencing significant distress/difficulties).

In particular, I would like to explore what your perspectives are on barriers and facilitators to accessing care and support for these difficulties (any challenges that you face when supporting this population) and how it has been as a member of staff working with these barriers/facilitators. I am also interested in your recommendations / ideas on what would be good components for ideal services/care provisions for these individuals.

*Demographics:*

- Time working with service
- County of work

#### **Barriers and Facilitators to Services**

- In your experience, do you feel there are any things that have been a barrier or challenge to accessing help, or support, for individuals with severe mental health difficulties who are homeless? (i.e. what challenges have you faced?) What do you perceive the impact has been for the individual?
- ... Including specifically when someone is in acute psychological crisis/critical point.
- How has it been for you navigating these challenges/barriers (practical ways of overcoming barriers and/or emotional experience of this)
- Pertaining to challenges/barriers - do you think there are any things that services could have done differently to support people who are homeless and experience severe mental health difficulties to help them to be able to seek / access / remain with services/support?
- In your experience, do you feel there are any things that have been a facilitator to accessing help, or support, for individuals with severe mental health difficulties who are homeless?
- ....including specifically when someone is in acute psychological crisis.

- How has it been for you when you have experienced these facilitators (practically / emotionally).
- Do you have any further thoughts on what might help or hinder support for those experiencing homelessness/severe mental health difficulties?
- Anything else you would like to add?

## Appendix E

### Initial Coding Transcript Example

Data	Codes
<b>P:</b> Yeah a lot. I've like, gone on the train tracks, to get someone off when their mental health's been bad. I have another client, who self-harms every day. I finally got her into supported living, but the barriers with her have been extreme genuine.	Staff exposed to MH crisis (self-harm daily)  Complex/risk additional barrier
<b>I:</b> That sounds tough	
<b>P:</b> It's almost like nobody knew what to do with her, so nobody wanted to know because she was so complex. Y'know she'd seen a psychiatrist, a psychologist, in London. Y'know, she'd been to like 9 different foster homes, she's been diagnosed with thing's I've never heard of, from a young age. So I go to the GP and it was almost kind of they were just sick of her behaviour, she'd like get a referral to secondary mental health team, she'd attend where that place is and then they'd discharge her, because they were like, "it's not crisis point anymore", and I'd then just be dealing with her self-harm and suicide attempts I was like screaming for help, I put safeguarding referrals in and I got somewhere eventually. But it was months, months and months. Now, the crisis team would just see her and discharge her, she also had a neurological disorder FND.	"passed from pillar to post" (complex)  Frequent attender (stigma?)  Crisis response (early discharge)  Staff exposed to MH crisis  Staff persisting  Extensive wait times
<b>I:</b> Oh umm functional neurological disorder?	
<b>P:</b> Yeah, so while she was in the hospital she was having seizures and stuff, so while she's in there, they just want to get her out as quick as possible and they was like "oh she's only in this position because of her FND, she's depressed" but if we don't fix her mental health, we're never going to fix her FND. Because it's related	Crisis response (early discharge)  Stigma (based on MH)
<b>I:</b> Yeah, absolutely related	
<b>P:</b> Yeah so we were just being chunked from pillar to post like mental health, social services. They would tell me it's not for them, then the disabilities team were telling me it isn't for them and I'm just trying to figure this out.	"passed from pillar to post"  Staff uncertainty
<b>I:</b> and you're stuck in the middle, how was that for her do you know?	
<b>P:</b> oh my god, terrible	
<b>I:</b> did she want the support?	
<b>P:</b> Oh my god yeah and I think that she got to the point with CMHT, for years she'd got some support and just been let down by services, so she just kind of given up. But it hasn't been easy, but I've got her to stick with it, and we've got an amazing psychiatrist, psychologist, what is it, a doctor, in the CMHT, and he just hasn't given up on her, he's just taken her under his wing.	Disengagement (poor service experiences)  Staff persisting  Facilitative "when professionals don't give up"

## Appendix F

### Example of Transcript Codes, Themes and Subthemes

<b>Excerpt from Participant 8</b>			
<b>Transcript</b>	<b>Coding</b>	<b>Theme</b>	<b>Subtheme</b>
<b>P:</b> You've then got services that are hugely stretched and not just in mental health but in in the NHS in in general and	Lack of resources	Structural barriers/facilitators	Services unable to meet needs
you know I've had a couple of occasions this year where I've been with people that are threatening suicide are quite serious about it	Staff exposed to MH crisis (suicide threat)	Professionals navigating the system	Continuous stressors
and I'm being told there's gonna be an 8 hour wait for an ambulance.	Delayed crisis response (ES)	Structural barriers/facilitators	Response in MH crisis
<b>I:</b> that sounds ((overlap)) tough			
<b>P:</b> ((overlap)) You know, and you're expected to wait with that person for 8 hours you can't walk away you can't stay what what do you do? It a horrendous situation to be in and so there's kind of that side of it	Staff managing crisis alone	Professionals navigating the system	Continuous stressors
and then what I'm seeing a lot of people who are extremely mentally distressed umm, I've been told well, they've got capacity to make that decision so if somebody has capacity, then it seems to tick the box of well, that's their choice and	Assumption of capacity	Structural barriers/facilitators	Response in MH crisis
I can understand how it is for the services that they're really limited resources so they've got to prioritise for those most in need you've got you've got you've had covid, you've got the cost of living crisis you've got all sorts of different factors that are gonna impact on people's mental health. And I I just think we're heading for a perfect storm.	Lack of resources  Conceptualising barriers in context systemic/economic diffs	Structural barriers/facilitators	Services unable to meet needs

<b>Excerpt from Participant 9</b>			
<b>Transcript</b>	<b>Coding</b>	<b>Theme</b>	<b>Subtheme</b>
<b>P:</b> and even though the mental health team don't share our same values our insight or opinion or views or recommendations or anything like that they don't value us whatsoever we they don't think that we know what we're talking about	"us and them"  Staff perceived undervalued/heard	Professionals navigating the system	Navigating power and professional relationships
but somebody in that e-mail chain might be you know somebody with a bit of clout and having them in there you know it makes them act, it makes the move a little bit quicker I mean it does	Staff utilising other professionals (power)	Professionals navigating the system	Navigating power and professional relationships
it just reinforces how much they dismiss us and don't hear us but at the end of the day it's for the benefit of the of the of the client but that's the only thing in the past	Staff perceive undervalued/heard	Professionals navigating the system	Navigating power and professional relationships
because we can send endless emails they won't reply we'll send them to every name we know in the mental health team including the generic e-mail so everybody gets this e-mail and we won't get a reply we won't get a response we'll get nothing you know so	Inter-agency communication  Staff/persist	Structural barriers/facilitators	Inter-agency cohesiveness/communication
<b>I:</b> I'm interested what you think is going on there?			
<b>P:</b> I'd even just like to even go there for a day you know and just hang out and see what what, what's going on. So we get a better understanding of like how it works so I mean, obviously we're we're missing something because we don't I don't understand it at all	Need to increase inter-agency understanding	Structural barriers/facilitators	Inter-agency cohesiveness/communication

## Appendix G

### Example of Theme generation



## **Chapter 3**

### **Contributions to Theory and Practice and Reflective Commentary**

## **Contributions to Theory and Clinical Practice**

This chapter will consider the findings of the two papers presented for this thesis and expand on their contributions to theory and clinical practice. Finally, a reflective commentary is provided.

## **Theoretical Context and Future Directions for Research**

### **Collective Findings**

Both papers highlight multiple complex structural and individual factors which may influence the mental health of PEH, pathways into homelessness, and access to and engagement with services. Exorbitantly high rates of mental health difficulties and low service utilisation amongst PEH are already well-recognised (Hodgson et al., 2014; Guwinski et al., 2021). However, the empirical paper built a richer understanding of the factors impacting this relationship, in context, to inform policy and practice. The scoping review provided the first comprehensive appraisal of evidence exploring the mental health of families experiencing homelessness within the UK.

Both poor mental health and the risk of homelessness have been shown to be substantially contributed to by the social and relational environments in which people are born and live (Alegria et al., 2018; Johnstone & Boyle, 2018; Mabhala et al., 2021). This is underpinned by growing research evidencing the impact of social determinants on health, including poverty, poor access to employment, education and healthcare, structural racism, and exposure to adverse childhood experiences (ACEs) (World Health Organisation [WHO], 2014; Algeria et al., 2018). These determinants are often rooted in long-standing structural



inequities; those who are more socioeconomically disadvantaged experience poorer social conditions, leading to poorer health outcomes, than those who more advantaged (World Health Organisation [WHO], 2014; Algeria et al., 2018). The cumulative effects of the chronic stressors and trauma related to these social factors precipitate mental health difficulties and may adversely impact a person's ability to utilise socially normative coping strategies, navigate life challenges, and lead to risk of further traumatisation and social exclusion (WHO, 2014). This has been termed complex, or compound, trauma, and homelessness itself has been posited to represent one extremity of the accumulation of such stressors (Cockersell, 2018; Mabhala et al., 2021). The findings of both papers emphasise the importance of considering the cumulative effects of such adversities in the mental health of PEH and how this continues to interact with the systems and structures surrounding them throughout life.

### **Scoping Review**

To the author's knowledge, the scoping review was the first comprehensive appraisal of literature into the mental health of families experiencing homelessness in the UK, providing a significant contribution to current knowledge on this topic. The use of a scoping review approach presented both strengths and limitations (Pham et al., 2014; Hanneke et al., 2017). On one hand, it achieved its aim of mapping a broad range of literature in this under-explored area and offered extensive recommendations for future research. The mapped results indicated substantial mental health needs within this population and provided an initial understanding of this phenomenon across multiple social-ecological levels, from parent-child relations to community and wider systems. However, by design, it was limited in its ability to draw more robust conclusions of these findings, favouring breadth over an in-depth appraisal pertaining to a specific facet of the mental health experiences or needs of the population.

Additionally, scoping reviews use a more flexible, iterative, process to identify literature (Arksey & O'Malley, 2005). Although efforts were made to conduct a comprehensive literature search it was recognised that the review was conducted in a finite timeframe and explored a broad conceptualisation of mental health. As such, it remains possible that some relevant studies were missed. Nonetheless, measures were taken to reduce bias and ensure a transparent, systematic, approach was taken, concluding in what was hopefully a rigorous and worthwhile contribution to the literature.

### **Empirical Paper**

The findings of the empirical paper rest within a small, but growing, body of literature exploring access to healthcare for PEH more broadly (Armstrong et al., 2021; McConalogue et al., 2021). Many of the barriers and facilitators identified were similar. However, through exploring mental health more specifically, and accessing the insight of frontline professionals, the study provided novel additions to guide future practice, policy, and research.

Complex inter-agency dynamics related to service structures, social identity, power, and values and beliefs, were revealed. Frontline professionals perceived mental health services to lack an appropriate understanding of, or response to, the complex needs of PEH, particularly in relation to historic trauma and certain behaviours such as substance use and self-harm. Policy and practice guidelines increasingly recognise the need for psychologically informed approaches to care (Public Health Wales NHS Trust, 2022; Schneider et al., 2022). These promote working practices which broadly aim to; (i) recognise mental health difficulties as an understandable response to adversity and trauma experienced across the lifespan, (ii) acknowledge institutions can re-traumatise people, (iii) ensure services are designed and delivered in a way that mitigates re-traumatisation or exclusion. Many of the

themes signalled barriers to this including stigma, inflexible working practices, compartmentalised and exclusionary services, and an inadequate response to those experiencing high levels of psychological distress. Future research should integrate the perspectives of mental health professionals themselves on this topic. The use of multi-professional focus groups may be of utility to capitalise on a range of knowledge and experiences, to identify barriers and solutions. This may also increase empathy and relationships between professionals, and create the opportunity for an empowered, collective, approach to campaigning for structural change if necessary. Using multi-professional research approaches has shown utility in informing policy and practice in other areas of healthcare (Rowan et al., 2010; West et al., 2012).

Crucially, to align with a psychologically informed approach, research and service development should value the expertise of service-users through collaboration and co-production (Public Health Wales NHS Trust, 2022). It was recognised that the voice of PEH was absent from the empirical paper and future research should seek to rectify this. The adoption of less conventional research methodologies which empower participants and draw on strengths may be beneficial for future studies. An example is community-based participatory research (Israel et al., 1998). At the heart of this methodology is the pursuit of an equitable relationship between collaborators, redressing researcher-participant power imbalances, and emphasising community identity, resilience, and resources, to produce positive change. This methodology has been shown to be useful in addressing health disparities in disenfranchised and stigmatised populations (Kiser & Hulton, 2018; McCuistian et al., 2023).

Additionally, the empirical paper provided a rich account of factors that may impact frontline professionals' well-being, in the context of their position in the healthcare system. Expanding on previous findings showing burnout and vicarious trauma in this population, it

was suggested that the distress experienced by participants may be understood using the concept of moral injury (Lemieux-Cumberlege & Taylor, 2019; Waegemakers & Lane, 2019). Although acutely aware of the care that PEH required to support their mental health, they reported feeling powerless as they watched the systems around them fail to respond, sometimes with devastating consequences. As such, the systemic barriers that negatively impacted care for PEH, also played a role in shaping the well-being of professionals. It has been argued that moral injury may be a more helpful means of conceptualising professional's distress than terms such as 'burnout', as it locates "the source of distress in a broken system, not a broken individual" (Dean et al., 2019, p. 400). Subsequently, the most effective solution has been suggested to reside in organisational and policy level change that creates environments which acknowledge the time and resources required to work compassionately and effectively. These are the very same qualities required for effective psychologically informed care. Although it was beyond the scope of this study to report in detail, frontline professionals utilised an array of coping strategies to manage their workplace mental health, support PEH when experiencing distress, and navigate barriers to accessing healthcare. Future research would benefit from exploring this in further detail.

Finally, to the author's knowledge this was the first time that barriers and facilitators to healthcare for PEH have been explored in a rural setting in the UK. The results indicated that rural geography may present several barriers to care, and experiences of stigma may be amplified by community structures and beliefs in rural settings. Higher levels of stigma have been observed in rural settings (Poloha et al., 2015; Stewart et al., 2015), and smaller populations can result in decreased anonymity, further inhibiting help-seeking (Helbok, 2003). Arguably, although close-knit, rural communities may provide a sense of belonging, well-known to be protective of psychosocial and physical health, those excluded from communities, such as those experiencing homelessness, addiction, or mental health

difficulties, may find themselves further ostracised. Practical barriers in availability and accessibility to services in rural settings are well-acknowledged, including transportation, connectivity, staffing issues, and funding (Coleman, 2023; Smalley et al., 2010). It is likely that those who are socioeconomically deprived, with homelessness being an extremity of this, are most affected by such barriers, unable to access transportation and information necessary to access healthcare. Future research should explore the impact of rural settings in healthcare for PEH to inform service design and delivery.

### **Clinical and Policy Implications**

In current practice, guidelines for supporting those with mental health difficulties primarily focuses on individualised interventions. As discussed within the current papers, for PEH, the impact of structural and systemic level factors on mental health and access and engagement with services are profound. The adversity of homelessness itself brings ongoing instability, trauma, and powerlessness, often beyond the individual's control. This can potentially limit usefulness of therapies centred on treating individual problems, particularly in traditional healthcare settings. This highlights the need for the use of a multilevel, flexible, approach including community and systemic working, and collective action.

Adaptations to current healthcare provision and practice are recommended including the use of in-reach and out-reach approaches to bring mental health care to PEH. Such approaches have been adopted successfully and have improved service utilisation and outcomes in areas such as primary and palliative care and caused hospital admissions to be reduced (Armstrong et al., 2021; Kopanista et al., 2023). Many PEH have multiple needs, including mental health, substance use and offending behaviours. Current service structures tend to compartmentalise such difficulties. This is counter to guidelines; for example, the

National Institute of Health and Care Excellence [NICE] (2016) clearly state that those with substance misuse difficulties should not be excluded from mental health services.

Furthermore, recently released guidance places the need for integrative care for PEH front and centre, including holistic assessment, flexible approaches to engagement, and psychologically informed care (NICE, 2022). Such approaches to care were identified as lacking by frontline homelessness professionals; this should be addressed promptly to ensure equitable and quality care for this marginalised population.

It would be hasty to assume that PEH cannot benefit from more traditional modalities of therapy, particularly if adapted in accordance with needs. Such assumptions risk perpetuating stereotypes which fail to appreciate the diversity, abilities, and needs of this population. Although literature is sparse, there are indications that tailored cognitive-behavioural therapy (CBT), acceptance and commitment therapy (ACT) and dialectical behaviour therapy (DBT) may be feasible approaches (Maguire, 2006; Lynk et al., 2015; Murthy et al., 2020). A recent feasibility study in the US showed trauma-focused CBT (TF-CBT) to reduce youths' post-traumatic stress symptoms when delivered to families in a woman's temporary shelter (Spiegel et al., 2022). It is essential that one remains mindful that such intervention approaches run the risk of locating the problem within the individual. Considering the social determinants of homelessness and mental health, individual therapies must acknowledge and explore how psychological distress exists in response to factors such as oppression and poverty over the lifespan. In the context of family homelessness and the implications for child development, prioritising early interventions and accessible health and social support is essential, particularly for those experiencing family conflict. Additionally, given that social support is critical for well-being, the implementation of peer-support groups may also be efficacious. Recent literature speaks to the potential of such approaches (Barker et al., 2018; Miler et al., 2020).

In terms of responding to stigma and discrimination, the language used to define and categorise groups of individuals influences public perception and attitudes and can perpetuate oppression (Palmer, 2018). Psychologists are urged to attend to, and challenge, unhelpful labels and dialogues used by professionals and organisations and engage in advocacy work beyond the therapy room (Palmer, 2018; Reynolds, 2012). It is possible that more formal interventions targeting stigma reduction in healthcare settings may be of utility (Raney et al., 2021; Sreeram et al., 2022). The findings emphasised the importance of the implementation of psychologically informed environments. Psychologists may support this through training and supporting other professionals in formulation and providing reflective practice and supervision. This has been shown to benefit care planning, teamwork, creativity, service-user relationships, and encourage more positive perceptions (Berger & Quiros, 2014; Buckley et al., 2021; Schneider et al., 2022).

Given the preponderance of emotional stressors faced by frontline homelessness professionals, strategies to support their well-being are recommended. There is evidence that person-directed interventions, such as therapeutic groups, psychotherapy, and yoga, may be useful, as well as organisational-level interventions such as resource management, leadership approaches, workload management, and training (Coates & Howe, 2015; Johnson et al., 2018). However, many services across the UK are characterised by threat, finding themselves under-staffed, under-funded and struggling to meet demands (Henshall et al., 2018). These conditions can impact the ability to work effectively, compassionately, and harmoniously both inter-professionally and with service-users (Henshall et al., 2018). This ultimately requires a structural level response to policy and provision.

Despite concluding the need for equitable and accessible mental health care for PEH across the UK, it is essential that this issue is addressed at multiple social-ecological levels (Fitzpatrick et al., 2021). Preventative measures may take the form of national level

initiatives targeting the social determinants of homelessness and health inequities. In terms of interventions for those already experiencing homeless, the ‘housing first’ model has been adopted in the UK, which prioritises the rapid provision of stable housing and co-ordinated and intensive care within the community. This approach can improve outcomes for PEH (Woodhall-Melnik & Dunn, 2016). However, it relies on co-ordinated and responsive health and social care, and available affordable housing, to be successful. Poor mental health and risk of homelessness is often rooted in social exclusion over time, as such, preventative, community-based approaches, which value the unique social and relational health needs of each community, are essential (Public Health England, 2015; Castillo et al., 2019).

### **Reflective Commentary**

This commentary emerges from the content of a reflective journal which I kept throughout the research process. Where I have been intensely entangled with this project for so long and indeed feel rather physically and mentally exhausted from the process, it is a challenging moment to step back and bring together the multitude of experiences coherently. As I read back through my journal its value has become eminently clear. Coupled with reflective supervision, it has supported decision making, quality, and reflexivity, throughout the research process. This ultimately sits at the heart of qualitative research, where one’s own experiences, emotions, and preconceptions inescapably influence the process at each stage (Dodgson, 2019).

Practically, I identified what I hope are worthwhile and applicable areas of research in homelessness. However, the broad topic I chose, has and will always be, close to my heart. I was guided to it by my personal experience of housing instability and subsequent experiences in frontline homelessness working. I came with an assumption that my experiences of



frontline working would be similar to those of the participants. Although it was in part, nothing could prepare me for the emotive and humbling content of the interviews. The magnitude of the continuous stressors they were experiencing were beyond any which I had.

My previous research experiences have utilised quantitative methodologies. I wonder if this was because it felt more contained or ‘certain’, and thus, less anxiety provoking. Having decided on the question I was hoping to explore, I took the plunge and embarked on my first qualitative study and despite bumps along the way, have thoroughly enjoyed the process. Understanding and navigating the different qualitative approaches and their epistemology was challenging. A critical realist epistemological stance was adopted; as such participants’ narratives were assumed to pertain to a reality, partially accessible through exploring their experiences. Thematic analysis was used in accordance with the question explored, offering the flexibility to explore and map practical factors and the experience of participants in context, as it arose.

The construction of a workable research question and design was challenging. My initial proposal was to interview PEH with experiences of mental health difficulties. I was aware of the need to think beyond traditional means of advertising and recruiting, so took an active and assertive approach (Sterhlau et al., 2017). It took many weeks, numerous emails and phone calls, and a lot of sitting with uncertainty, as I tried to find a third-sector organisation willing, or able, to support my research. The relief when I finally did, was palpable. I placed value in building relations with the homelessness professionals and visiting projects, which was undoubtedly the key to the success of the final project. However, my first visit was eye-opening; the severity and complexity of the psychological difficulties faced by PEH and the level of crises staff were coping with daily left me shocked. Although willing to support recruitment, frontline professionals shared concerns which presented ethical and practical dilemmas. It would be difficult to identify individuals able to provide informed

consent and willing and able to participate without undue distress. They suggested it would take an extended period for me to build trust and rapport necessary to facilitate participation. After a significant investment of time as I attempted to achieve this, it became clear that it was not feasible within the resource and time limitations of the project, leaving me deflated.

Informed by my time spent within the projects, further consultation with the organisation, and a return to reviewing literature, it was concluded that the topic could be explored by harnessing the insight of the frontline professionals. I struggled with this shift; I am deeply aware that PEH are often disempowered and unheard, and desperately wanted to make space for their voice. However, it emerged that professionals had unique perspectives to provide, particularly in the context of dynamics between services and systems. I reflected that, in a different way, they also experienced disempowerment.

I considered utilising focus groups to gather data, however, my time at the projects revealed the emotive nature of the topic. Thus, I felt individual interviews would offer a more appropriate space for professionals to explore their experiences openly and safely. Additionally, on a practical level, it would have been challenging for multiple professionals to take time out of their duties simultaneously. The experience of interviewing was rich, but more intense and emotive than I expected. I gathered data in quite a short period, often exhausted from travelling the span of Wales. On reflection, I would have allowed more time for self-care and reflection between interviews. I was struck by the psychologically informed approach participants held, to a degree beyond which I had expected. This has stayed with me, reminding me to hold my own assumptions lightly when working across agencies.

I felt angry about the structural injustices shared, coloured by my own leanings toward social justice and systemic failings I had witnessed in the past. During the earlier interviews, I reflected that my questioning had perhaps given less attention to exploring

facilitators and positives, in favour of the barriers, which had evoked a strong response within me. As such, I made efforts to ensure I was curious and encouraged exploration of both.

Upon transcribing, it was evident that this had increased the richness of data and was more aligned with my initial question. I was aware that I saw myself as positioned alongside participants, however, as an NHS mental health professional, I may be seen as ‘part of the problem’ and as an outsider. This may have influenced the data gathered, for example, I could have been seen as a place to offload the negatives, a ‘face’ of the organisation.

Ultimately though, I left with a felt sense that being connected and engaged with the topic increased my ability to offer a safe and containing space, and an unrelenting curiosity in my questioning during interviews enhanced the depth of the data collected. I felt commonalities between these skills and those I have developed throughout clinical training. One participant reached out after the interview to feedback that they had found it a useful and enjoyable reflective experience.

As my first qualitative study, I found the analysis process tough, but ultimately enjoyed piecing the puzzle together. As I reflected on my own position in the process, I found myself having hesitations as to whether I was competent enough to accurately represent their experiences. I was aware that I had been primed by my own experiences (and strong feelings) regarding the practices and provisions of mental health care, the injustice of homelessness, and my reading of papers on similar topics. Re-visiting the data repeatedly, holding such preconceptions in mind, was essential. I initially questioned whether the sub-theme ‘*understanding and working with trauma*’ was something I wanted to see, rather than true to participants’ own experiences. As I explored the data again, I found this was a salient narrative, although my own formulation driven conceptualisation of mental health likely played a part in identifying this. In writing up, I struggled as I tried to include everything, desperate to do justice to participants’ stories. Initially I ended up leaning heavily toward

describing everything and was encouraged by supervisors to include my interpretations. Once I found the confidence to do so, I fully realised the value of qualitative research in its acknowledgement of the role of the researcher in the process. I will always notice the absence of some quotes, some stories, that I was unable to include in the finished paper, and perhaps this is inevitable in qualitative research.

As I draw to the end of this research journey, I hope that both the empirical paper and the scoping review offer the opportunity to bring much-needed attention to an under-researched topic. Although I hope for publication, I am thankful that the empirical study will be of utility for the supporting homelessness organisation regardless. I have always enjoyed research, and this project has served to connect me with its value. Although aware of the competing demands of clinical duties, oftentimes leaving little room for research and development projects, I hope that I can engage in further research throughout my career.

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