Perspectives on Homelessness: A qualitative study with Clinical Psychologists in secondary care mental health services

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ABSTRACT

Aims: People who are homeless are among the most vulnerable and socially excluded populations. While they have several mental health and physical health needs it has been suggested that many barriers prevent them from accessing the support they need. Healthcare professionals' attitudes have been identified to have a significant influence in accessing care. Clinical psychologists have a significant role to play in working with homelessness, but their views towards homelessness are yet to be explored. This study evaluated clinical psychologists' perspectives towards homelessness, what influences them and how they influence their practice.

Method: Semi-structured interviews were conducted with twelve clinical psychologists working in secondary care mental health services. Thematic analysis was performed to identify their views towards homelessness.

Results: The analysis identified three themes: (1) 'Homelessness is a complex, social phenomenon' describing the multi-layered nature of homelessness, whilst identifying non-blaming attitudes with the recognition that homelessness can happen to anyone, (2) 'Homelessness is not for psychology' describing that people affected by homelessness are not suitable for psychological therapy unless their basic needs are firstly met and (3) 'Our role as Clinical Psychologists' describing that clinical psychologists are not just therapists and acknowledging the influence clinical training, experience working with the population, and values have on professionals' perspectives towards homelessness.

Conclusion: Concluding this study identified that clinical psychologists have a significant role in ending psychological distress rooted in health and social inequalities. Services and organisations will need to nurture and support clinical psychologist to work with homelessness while they address service barriers to develop accessible services for all. Clinical training will need to prepare future psychologists to work more systemically to address the social determinants of health and help clinical psychologists to develop skills in consultations, working at a wider systemic level and at a policy level to address social issues such as homelessness, which contribute to psychological distress.

ABBREVIATIONS

CP	Clinical Psychologist
UK	United Kingdom
BPS	British Psychological Society
FEANTSA	European Federation of National Organisations Working with Homelessness
ETHOS	European Typology on Homelessness and Housing Exclusion
NHS	National Health System
GP	General Practitioners
ATHI	Attitudes Towards Homelessness Inventory
ATHQ	Attitudes Towards Homelessness Questionnaire
HPATHI	Health Professional Attitudes Toward the Homeless Inventory
PIE	Psychologically Informed Environment
CMHT	Community Mental Health Team
EIS	Early Intervention Service
MDT	Multi-Disciplinary Team

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CHAPTER ONE: INTRODUCTION

Little is known about clinical psychologists' (CPs) views towards homelessness, how they are developed, or how they influence practice. This chapter provides a background on homelessness and the links between homelessness and mental health. Health inequalities experienced by people who are homeless and the barriers that prevent them from accessing care will be considered. Healthcare professionals' views towards homelessness and their role in health disparities amongst people who are homeless will be presented, with the role of CPs being considered. Finally, the research questions will be outlined.

1.1. Literature Search Strategy

The literature search was conducted using the EBSCO, SCOPUS and Google Scholar databases. For the database search, a combination of research terms relating to attitudes, homelessness and CPs were used. Research terms included were 'clinical psycholog*', 'psycholog*', 'prof*', 'mental health prof*', 'attitudes', 'perceptions', 'opinions', 'thoughts', 'beliefs', 'homel*', 'housel*', 'roofl*'. From the results generated, the titles and abstracts were reviewed, and articles were selected based on their relevance to the topic. Furthermore, through a reference list trawling more articles were identified. Finally, government websites from the United Kingdom (UK), the British Psychological Society (BPS) website, websites from third-sector organisations, and non-governmental organisations working with homelessness were searched for relevant policies and strategies.

1.2. Defining Homelessness

1.2.1. International Context

For years there was a lack of consensus in defining homelessness (Amore, Baker, & Howden-Chapman, 2011), which contributed to difficulties in researching and enumerating it. The European Observatory on Homelessness and European Federation of National Organisations Working with Homeless (FEANTSA) developed the European Typology on Homelessness and Housing Exclusion (ETHOS). ETHOS was developed in 2004 as a conceptual definition and a classification system that captures the broad spectrum of homelessness and housing exclusion. This aimed to improve research and enumerate homelessness more accurately, which would influence policy provision (Edgar, 2012). ETHOS was accepted by most countries in Europe (Busch-Geertsema, 2010) and has been adopted as the global definition of homelessness (Busch-Geertsema, Culhane, & Fitzpatrick, 2015).

Edgar and colleagues (2004), when developing ETHOS, identified three domains which were necessary to constitute a home. These were identified as the presence of an adequate residence which people could exclusively occupy (physical domain) where they can enjoy social relations in privacy (social domain) whilst having the legal right to occupy the residence (legal domain). These domains were used to evaluate the adequacy of housing (Edgar, Meert, & Doherty, 2004). Homelessness was conceptualised as the absence of all three domains; housing exclusion was considered as the absence of at least one of the domains (Edgar et al., 2004).

ETHOS developed a typology of homelessness which consisted of four categories - rooflessness, houselessness, insecure housing and inadequate housing (FEANTSA, 2017b). Rooflessness was identified as the lack of residence, such as street homelessness or living in emergency accommodation. Houselessness was identified as people residing in temporary accommodation, people who were due to leave institutions such as hospitals or prisons, or young people leaving care with no residence to go to. Insecure housing was identified as accommodation that is insecure of unstable, either due to risk of violence, risk of eviction or people living temporarily with friends, family. Finally, inadequate housing was characterised as living in temporary structures of unfit housing (FEANTSA, 2017b).

Despite the wide acceptance of ETHOS, Amore and colleagues (2011), critiqued the definition on the ‘arbitrary threshold between homelessness and housing exclusion’

(pp.25). They questioned why the exclusion from two of the three domains (physical, social, legal) is not also considered homelessness. Moreover, they critiqued ETHOS for not acknowledging people's circumstances and only acknowledging their place of habitation when evaluating their housing situation 'Inconsistencies' between the definition and the typology were also acknowledged and Amore and colleagues (2011) argued that this could also result in inconsistencies in applying the definition. Furthermore, they critiqued that the typology is not exhaustive, with Amore and colleagues (2011) outlining cultural differences regarding housing, using examples from New Zealand. They argued the need for adaptations to be made, relevant and specific for each nation in which it is used. As a result of their critique, they recommended that homelessness definitions should include standards about the adequacy of housing and or the inability to access adequate housing (Amore et al., 2011).

Amore and colleague's c (2011) critique was subsequently addressed by Edgar (2012) who argued that ETHOS was developed within an EU context in which a common social inclusion strategy was agreed upon by the European Council of Lisbon in 2000. EU members set out to make coordinated attempts to address homelessness and ensure the availability of adequate housing. Thus, Edgar (2012) argued that defining homelessness based on housing provision would not be relevant to the EU context. Furthermore, Edgar recognised the critique on the threshold of homelessness and housing exclusion as arbitrary as this was recognised to be an area which was widely discussed when developing ETHOS. Edgar (2012) argued that ETHOS was developed to be a policy tool, not a statistical tool to enumerate homelessness although the need for enumeration in assessing whether strategies for prevention and alleviation are effective was acknowledged.

1.2.2. Context in England

In England, there is a clear legal framework defining homelessness. The Housing Act of 1996 identifies three levels of homelessness. The first level is characterised by 'rooflessness', the absence of a residence. The second refers to the availability of a residence but an insufficient legal status to occupy it, and the third is characterised by the presence of a residence but this is characterised by difficulties in occupying

the residence despite having the legal status to do so. The Act also identified and set a time frame for the period in which people would be accepted as being threatened by homelessness. Finally, the Act refers to the availability of reasonable residence for individuals and their families, while it also recognises victims of domestic violence and their rights.

1.2.3. Definitional Issues and Critique

In England, despite the presence of a legal definition of homelessness, it fails to adequately capture homelessness. Even though it attempts to define homelessness, beyond the visible rooflessness, it fails to capture its multi-faceted nature and does not offer a clear understanding of the different types of homelessness. Compared to the ETHOS typology, the Housing Act 1996 only identifies homelessness as ‘rooflessness’ and ‘houselessness’, while what consists of an adequate home is not addressed by the Act. Consequently, the legal framework in England does not determine what characterises an adequate home, like the ETHOS definition does, which can lead to people living in substandard housing conditions without that being acknowledged.

Moreover, it has been argued that understanding homelessness either as a housing problem or a socio-psychological problem would influence how homelessness is defined (Edgar et al., 2004) and consequently how it will be addressed. The legal definition of homelessness does not outline how homelessness is conceptualised and what the causes are, which can lead to difficulties in developing targeted strategies to prevent or alleviate homelessness by identifying the root causes. Furthermore, the lack of a clear typology in the English legal system leaves the Act open to interpretations, with people falling through the gaps and struggling to access the support they need. This could be mitigated by the use of the existing ETHOS typology which can be incorporated into the legal framework of homelessness in England.

ETHOS attempted to develop a broad definition and typology of homelessness and housing exclusion which was acknowledged and adopted worldwide (Busch-Geertsema et al., 2015). Despite the attempts of ETHOS to develop a widely

accepted definition, it has been met with critiques (Amore et al., 2011), which gave rise to debates about the definitional problems of homelessness. This can only raise questions about the usefulness and purpose of the definitions developed. Definitions on homelessness will need to help enumerate it, but it will also need to help develop policies and strategies to prevent or alleviate it. Clear definitions reflected in statutory Acts can help identify the causes of homelessness which will promote the development of appropriate strategies and services to help support people who are affected by homelessness. Having adequate definitions is the first step in developing a better understanding of homelessness and developing interventions to address it. Furthermore, as argued by Amore and colleagues (2011), better definitions can help distinguish between the different forms of homelessness which can help develop targeted policies with responses which are relevant to its different presentations .

Not only is it important to develop adequate definitions of homelessness, but it is also important to continue evaluating the usefulness and purpose of those definitions, considering socio-political changes that influence homelessness. For example, changes to the current housing market in England (i.e. increased rents and decreased availability of affordable housing) should be considered when identifying any changes in how homelessness might present. This could also be enhanced through continual research on the determinants of homelessness. Furthermore, continued considerations and discussions on the definitional issues of homelessness could help develop definitions and typologies, which would be widely accepted despite the recognised limitations that they might present with.

The function of working definitions of homelessness will need to involve acknowledging the relevance and representativeness of the definitions in conjunction with the wider context as well as clearly identifying their nature and function. Definitions should be capturing the changing nature of homelessness while recognising the impact of socio-economic structures on the development, maintenance and presentation of homelessness. The definitions should aim to adequately describe the causes, nature and characteristics of homelessness, with their main function to develop policies and targeted strategies aiming to eliminate, prevent and ultimately end homelessness. Definitions being developed will need to be culturally relevant and adaptations will need to be considered on how

homelessness presents in different contexts such as collectivistic as opposed to individualistic societies or between developed or developing countries. The purpose and function of definitions will need to be considered when definitions are developed and when they are reviewed whilst definitions should aim to build on the understanding of the phenomenon and help to drive and inform policies and strategies, with enumeration being of secondary importance.

1.2.4. Terminology Used in This Paper

This paper will refer to homelessness as a broad term, including all forms of homelessness. Clear distinctions will be made when a specific form of homelessness, such as street homelessness or rough sleeping, is referred to. The two terms will be referred to interchangeably.

1.3. Prevalence of Homelessness: Context in England

Defining homelessness has been a challenging task, which results in difficulties enumerating it, with reported numbers differing depending on the source of the figures. There is an increase of homelessness with some reports indicating that as many as 170,000 people across Britain are experiencing homelessness in all its forms (Hewett, 2019). Due to the definitional difficulties, with non-governmental services and the charity sector defining and enumerating homelessness differently from the official government reports, it is difficult to accurately compare them. There is an agreement though, between all parties, that homelessness numbers are increasing.

The Ministry of Housing Communities and Local Government (MHCLG) (2019), reported that between January to March 2019, approximately 70,430 households were initially assessed as threatened by homelessness or considered homeless, which was an increase of 10.7% from the previous quarter. For the April to June 2019 quarter, 68,170 households were assessed as homeless or threatened with homelessness, again an increase of 11.4% from the same quarter the year before.

Around 45% of these households were identified with additional support needs, the most common of which was a history of mental health problems, which amounted to 21.9% of the households (MHCLG, 2019b). Regarding, the third quarter of 2019 (July to September) a total number of 75,520 cases were assessed, with 71,570 identified as being homeless or at threat of becoming homeless within 56 days. This was an increase of 5.6% compared to the same quarter in 2018 (MHCLG, 2019c).

Rough sleeping is estimated to have increased by 98–132% since 2010 (Barrow & Medcalf, 2019; Fitzpatrick, Pawson, Bramley, Wilcox, & Watts, 2017). Statistics gathered by the Ministry of Housing, Communities and Local Government in 2019 indicate that rough sleeping increased from 1,768 in 2010 to 4,751 in 2017, which was the highest numbers recorded in the past decade. The report outlined that the numbers appeared to have declined to 4,677 in 2018 and 4,266 in 2019, which was attributed to the introduction of the Rough Sleeping Strategy in 2018.

There is a documented increase of statutory homelessness as shown by the numbers above. This could be due to the changes implemented by the Homelessness Reduction Act 2017 which resulted in changes in the way homelessness is enumerated. The Act set out new duties on local authorities for supporting people who are homeless or at risk of becoming homeless. One such change was the duty to provide advice on homelessness to everyone in their district. This could have resulted in increased numbers of previously hidden groups from the statistics, to be partially represented by the numbers. However, this does not accurately reflect the number of people affected by homelessness, as it only includes people who are in contact or have been referred to their local housing authorities for advice. The numbers of hidden homelessness are likely to be much higher, given the difficulties in enumerating it and the lack of a clear typology and definition of all forms of homelessness, such as people living in overcrowded conditions, squatters, sofa-surfing, involuntarily sharing with other households, and people sleeping rough in hidden locations (Fitzpatrick et al., 2017; Rose, Maciver, & Davies, 2016).

1.4. Relevant Policies and Frameworks

The Five Year Forward View was introduced in 2014 and aimed at improving NHS services and to support people experiencing mental health difficulties, to improve their wellbeing and to reduce premature mortality (NHS, 2014). It set out plans for early intervention, evidence-based care, and greater integration of physical and mental health services. The need for all services, the National Health System (NHS), local government, housing, education, employment and voluntary sectors, to work together for effective change to be implemented was also outlined.

The Homelessness Reduction Act was introduced in 2017 and outlined the obligations of the public sector in supporting people who are homeless or at risk of homelessness. Everyone employed by public authorities including certain NHS settings, such as inpatient physical and mental health services, are now expected to identify peoples' housing situation and, with their consent, refer those who are homeless or at risk of homelessness to their local housing authorities for support. In line with the new Act, the NHS will need to adapt its practices to ensure that service users' housing circumstances are identified and officially documented.

The rough sleeping strategy (MHCLG, 2018) aims at specifically targeting rough sleeping – hoping to halve it by 2020 and end it by 2027. This will require all relevant services and bodies to work together. The strategy aims at housing everyone sleeping rough and recognises that targeting homelessness starts with the availability of affordable and secure housing. It has also recognised the increasing mental health needs of the population, with 50% of people sleeping rough in 2018-19 in London reporting having mental health needs (Chain, 2019). Thus, the strategy identifies the need to support people with their mental health difficulties and outlines that mental health services will need to use integrated care models, in which mental health professionals will need to cooperate with outreach teams and hostels to assess the needs and identify the support needed for people sleeping rough. Finally, the strategy recommends for support to be offered for people sleeping rough to access community health services (MHCLG, 2018).

The NHS long-term plan (NHS, 2019) was introduced in 2019 and follows from the work of the Five Year Review Plan. The NHS long-term plan identifies that to reduce homelessness attempts will need to be made to reduce health inequalities by supporting outreach programmes which are helping people affected by homelessness. The plan acknowledges that a large proportion of people affected by homelessness have complex needs – financial, interpersonal and emotional – which contributes to difficulties engaging with mainstream services. Several parts of the UK with large numbers of street homelessness do not have specialist mental health support, while access to mainstream services remains challenging and difficult. Acknowledging these difficulties, it was proposed for financial support to be increased for services supporting rough sleepers, including social enterprises and charities supporting hard-to-reach groups.

Ending and preventing homelessness has been identified of primary importance for the government, with the NHS having a critical role in identifying and supporting those affected by homelessness to exit homelessness. The importance of meeting the mental health needs of people affected by homelessness has been widely recognised through NHS initiatives and governmental strategies. This is despite only having limited specialist mental health services to do so. As a result, mainstream mental health services will need to revise their practices to ensure better access to their services; and better cooperation between services to promote integrated practice, to help meet the needs of people affected by homelessness.

1.5. Understanding Homelessness

Homelessness is a complex phenomenon involving overlapping structural, economic, political, cultural and social factors (Hopper, 2012), as well as individual and interpersonal factors. The interplay of these factors leads to the development and maintenance of homelessness, “with no single trigger that is either ‘necessary’ or ‘sufficient’ for it to occur” (Fitzpatrick et al., 2017, pp.39). In the past decade, the face of homelessness changed with a larger ageing cohort, increasing numbers of

women with children, and a growing proportion of people experiencing mental health difficulties (Tsai, Lee, Byrne, Pietrzak, & Southwick, 2017).

1.5.1. Structural Factors Influencing Homelessness

Structural and societal factors were identified as causal factors for homelessness, with international literature identifying the absence of low-cost housing (Burt, Aron, Lee, & Valente, 2001; Mago et al., 2013) and exclusion from the housing market (Fitzpatrick et al., 2017; Ritchie, 2009; Tsemberis, 2010) as main contributing factors for homelessness. This is also recognised by the 'Statutory Homelessness in England' briefing paper, which identified the impact of the wider economy and the housing market on homelessness (Wilson & Barton, 2019). The lack of affordable housing in the UK and the failure of local authorities to provide adequate social housing were identified to be contributing to the homelessness crisis (Wilson et al., 2019).

Other structural factors identified to be contributing to homelessness are changes in the labour market such as low wages, (Fitzpatrick et al., 2017; Kiesler, 1991; McChesney, 1990), unemployment (Ritchie, 2009; Tsemberis, 2010), as well as the lack of employment opportunities for low-skilled workers (Burt et al., 2001). Furthermore, welfare changes (Burt et al., 2001; Fitzpatrick et al., 2017) have been recognised as contributing factors for homelessness.

Susser and colleagues (1993) argued that the only way to understand the causes of homelessness is to understand poverty first, with homelessness being considered by some as an extreme form of poverty (Kingree & Daves, 1997). Joffe (1988), described poverty as 'the cause of the causes', with Albee (2006) arguing that poverty is the major factor leading to homelessness, and while poverty can affect anyone, it can lead to several underlying problems such as depression or other more severe mental health difficulties. These findings were also corroborated by Murphy and Tobin (2011), who identified the strong link between homelessness and poverty, with homelessness understood as a consequence of the interplay between social inequalities and poverty.

1.5.2. Individual Factors Influencing Homelessness

Research suggested that peoples' individual histories and experiences can increase the risk of homelessness. It has been identified, that homelessness is often precipitated by life adversities such as childhood abuse, poverty or social exclusion (Fitzpatrick, Bramley, & Johnsen, 2013). People experiencing homelessness have reported having had a history of difficulties within the family background, with many reporting having received support from social services (Fitzpatrick, Kemp, & Klinker, 2000). A quarter of people living in the streets were reported to have had experiences of being in care (Equality and Human Rights Commission, 2016).

Childhood trauma is prevalent within the homeless population and has been identified as one of the routes to homelessness, with people reporting experiences of abuse, neglect, domestic violence, parental mental health and parental substance abuse (Fitzpatrick et al., 2013). Cockersell (2012), conducted a study with people affected by homelessness and identified that 47% experienced emotional abuse and/or neglect in their childhood, 31% experienced the early loss of a parent and 27% disclosed early sexual abuse. Participants also reported high levels of parental drug and alcohol use and domestic violence.

Early life adversities have been considered to contribute to varying future difficulties, including involvement with substance use; interpersonal difficulties; problems with employment; institutionalisation (Mcdonagh, 2011) such as contact with criminal justice system and social work interventions (Anderson, 2007; Fitzpatrick et al., 2000); and physical or mental health difficulties (Fitzpatrick et al., 2000). Substance use has been increasingly researched and identified as a cause, a contributing factor and a consequence of homelessness (Lawless & Corr, 2005). Despite the recognition of the link between homelessness and substance abuse, there is no clear direction of the relationship (Kemp, Neale & Robertson, 2006; Neale, 2001).

1.6. Mental Health Difficulties and Homelessness

Entrenched homelessness has been strongly correlated with severe mental health difficulties (Seager, 2011) while mental health difficulties have been conceptualised both as a cause and a consequence for homelessness (Perry & Craig, 2015). Fazel and colleagues (2008) in their a systematic review on the prevalence of serious mental health difficulties in people who are homeless identified that alcohol and substance abuse was the most prevalent 'diagnosis' of mental health difficulties between major depression, psychosis and personality disorders. Moreover, both depression and psychosis were significantly more prevalent with people who were homeless compared to the general population and other high-risk groups such as prisoners (Fazel & Danesh, 2002) and refugees (Fazel, Wheeler, & Danesh, 2005).

A large proportion of people who are street homeless or sleep in hostels experience serious and severe mental health difficulties such as psychosis and mood difficulties (Maguire, 2015; Perry et al., 2015). Street homelessness is associated with higher rates of personality disorder (Maguire, 2015; Rees, 2009), self-harm and suicidality (Rees, 2009). These difficulties are complicated further by a history of abuse and trauma (Kim, Ford, Howard, & Bradford, 2010) and attachment difficulties (Seager, 2011).

Mental health difficulties and homelessness are interlinked and can be difficult to distinguish between the two. As Seager (2011) argued, the same factors which cause mental health difficulties also lead to homelessness, some of which have been identified as early childhood trauma, neglect, abuse, insecure attachments and difficult family dynamics. Thus, trauma has been reported to be prevalent with people who are homeless as a result of their childhood experiences of adversities and trauma (Sundin & Baguley, 2015). Moreover, people who are homeless experience traumatic experiences while being homeless, particularly people sleeping rough report high incidences of victimisation (Mcdonagh, 2011). Lastly, the role that services have has been recognised in re-traumatising people through practices that leave people feeling powerless and controlled (FEANTSA, 2017a).

1.7. Homelessness in Mental Health Services

1.7.1. The Role of Secondary Care Mental Health Services

The needs of people who are homelessness can be understood through a tri-morbidity lens, where a combination of physical, mental health difficulties and addictions interplay (Stringfellow, Kim, Pollio, & Kertesz, 2015; Homeless Link, 2014). Due to the complexity of the needs of people experiencing homelessness, services aiming to address specific parts of the presentation tend to be ineffective, thus an integrated holistic approach aiming at addressing the complex health and social needs of the population is more suitable (Bauer, Baggett, Stern, O' Connell, & Shtasel, 2013; Bramley et al., 2015; Cornes et al., 2018; Stergiopoulos et al., 2017).

Specialist services for homeless people are not common in the UK (Cornes, Joly, Halloran, Manthorpe, & Carter, 2007), despite being recognised as more suitable to address the needs of people who are homeless (Fazel, Geddes, & Kushel, 2014). Some specialist services do exist and mainly work with people sleeping rough following initiatives from the NHS Long Term Plan and Rough sleeping strategies. These initiatives though, mainly address the needs of specific groups in the population, such as people sleeping rough. People affected by homelessness which do not fit into these categories are often left with few opportunities for support, despite clear guidelines for services to ensure accessibility and support for all (NHS, 2019). It must be acknowledged though that the charity sector working with homelessness tend to offer a lot of support. Charities offer support with peoples' housing and social needs as well as offering support with mental health needs.

St Mungo's *Stop the scandal* study investigated whether people living in supported accommodation can access NHS mental health services (St Mungo's, 2016). Their research identified that recent budget cuts enforced on mental health services led to increased thresholds for inclusion to services, longer waiting times and less provision for interventions. The report argued that these changes increase barriers for people accessing early support with support being provided only when peoples' mental health has deteriorated significantly. The study outlined that staff supporting people who are homeless report that 64% of their service users are unable to access NHS mental health services, while people with multimorbidity of substance misuse and

mental health needs experience even more difficulties to access necessary help. Finally, only 28% of the staff interviewed reported that service users were able to access talking therapies with only 16% of them identifying that their local NHS mental health services were able to meet their service users' needs.

Studies identified that the most frequent support required by people who are homeless is support with their mental health needs and alcohol and substance dependence (Wright & Tompkins, 2006). The Crisis Skylight mental health project primarily worked with people who were homeless and offered mental health services for their service users. The housing situations of the users of their services were: 40% were housed but not in secure or permanent housing, 15% were housed in hostels, 8% were living in supported accommodation and 8% were living rough (Pleace & Bretherton, 2013). The project offered counselling sessions which amounted to 48% of mental health services provided, with 19% accessing mental health workshops, 14% mental health forums and 19% drop-in sessions (Pleace et al., 2013).

Furthermore, the St Mungo's LifeWorks project (St Mungo's, 2011) offered psychotherapy sessions for their service users. They provided individual therapy for people who were homeless or at risk of homelessness, including people sleeping rough. The project was evaluated as being successful with service users attending regular psychotherapy sessions, some of which attended up to twenty-five sessions. Evaluation of the service revealed that 75% of service users reported improvements in service users' wellbeing and a reduction in the use of emergency and crisis services was also evident.

Luchenski and colleagues (2017), conducted a systematic review, identifying effective interventions for people who are socially excluded and presenting with multiple and complex needs such as people who are homeless, who have a history of sex-work, imprisonment and substance misuse. The review identified that case management for people who were homeless demonstrated improvement in mental health and substance use (Hwang, Tolomiczenko, Kouyoumdjian, Garner, 2005). Furthermore, contact with an assertive community treatment team where a Multi-disciplinary Team (MDT) approach was used, with the team managing low caseloads

with 24-hour availability and community services, demonstrate improvements in homelessness. Contact with the teams reduced mental health symptoms for people who were homeless with severe mental health difficulties (Coldwell & Bender, 2007; Hwang et al., 2005). Luchenski and colleagues (2017), identified the adequacy of Housing First interventions for people who are homeless with mental health and substance abuse problems (Woodhall-Melnik & Dunn, 2016). Engagement with Housing First demonstrated longer housing stability and improved quality of life (Woodhall-Melnik et al., 2016). Other approaches such as occupational therapy which focused on the provision of education, employment and life skills have been identified as successful for people who are homeless (Thomas, Gray, & McGinty, 2011). The review identified differences between effective interventions for men and women. For homeless women, it was identified that educational interventions, Cognitive Behavioural Therapy and Motivational Interviewing improved overall psychological outcomes (Speirs, Johnson, & Jirojwong, 2013).

The lack of specialist homelessness services in parts of the UK will result in secondary care mental health services adapting their practice to be able to meet the needs of the population. As demonstrated by Luchenski and colleagues (2017) there are several effective interventions for people who are homeless, with case management providing coordination between services having positive effects on mental health and substance abuse for people who were homeless (Hwang et al., 2005). It has been argued by the charity sector working with people who are homeless that the NHS mental health services have not been enabling access for people who are homeless (St Mugon's, 2016), despite the NHS having the structures and provision to meet the needs of the population. The expertise that the NHS has in MDT approaches that providing holistic understandings of peoples' experiences and difficulties can be detrimental in providing the necessary support needed by people who are homeless. The breadth and knowledge held by secondary care mental health services is vital in supporting people who are homeless with a combination of social and mental health needs. With this knowledge and expertise and the resources of the NHS, adequate support for the homeless and their litany of obstacles could be solved. It will require time and a coordinated effort by all relevant sectors.

1.7.2. What is Currently Offered in England by the NHS

1.7.2.1. *Specialist teams for rough sleeping:* The NHS mental health implementation plan 2019/20 – 2023/24 (NHS, 2019), following up from the Five Year View Plan and the NHS Forward Plan in conjunction with the Rough Sleeping strategy (MHCLG, 2018) outlines that specialist services are necessary to address rough sleeping. These services will be developed to support existing support. This will be achieved by proving extra specialist clinical mental health support in high-need areas where the prevalence of street homelessness is high. The services developed will comprise of psychiatrists, nurses, support to clinical staff/ therapist, social workers and administrative staff.

Despite the funding for specialist services for rough sleeping being increased as a result of the above initiatives, it remains low. Thus, it is outlined that all areas in the country should support mental health services to provide care for people sleeping rough, particularly where specialist services are not available. Plans will need to be developed to improve access to services, while attempts will need to be made to create services that promote trauma-informed approaches that deliver integrated and long-term holistic care (NHS, 2019).

1.7.2.2. *Pathway teams*: The Pathway project proposed a model of a specialist MDT compiled by General Practitioners (GP), nurses, housing specialists, social workers, occupational therapists and peer advocates working in secondary care physical health services to promote better care coordination for homeless patients in hospitals (Dorney-Smith, Hewett, Khan, & Smith, 2016). The project aimed at improving health and housing outcomes for homeless patients admitted to hospital and at improving discharges by reducing delayed or premature discharges (Dorney-Smith et al., 2016). Following the success of the project, it was trialled in inpatient secondary care mental health services. This project provided specialist consultation and support around housing both for patients and teams. Their support involved advocating, developing links and liaising with GPs, community mental health services, housing services, hostels and outreach teams. The team offered support with applications for housing and benefits , it provided help in liaising with services and supported people to attend appointments. It also signposted people to

appropriate services and offered advice where necessary. The work by the Pathway team attracted positive feedback from the NHS teams they worked with the wards and community teams benefiting from the support provided by the Pathway team in planning and managing discharges and aftercare for people who were homeless.

The Pathway model has been successful and is now expanded to several NHS Trusts in the UK. Despite the benefits reported by service users and services, with better care-coordination and follow-ups after discharge (Dorney-Smith et al., 2016) it is important to note that the support provided is mainly around meeting the housing and social needs of people rather than meeting their mental health needs. Signposting to services and community mental health teams have been successful through the programme where the pathway teams work closely with community mental health teams to build better relationships with individuals before they are discharged.

1.8. Barriers to Accessing Care

1.8.1. Health Inequalities and Homelessness

Homelessness is an increasing social phenomenon (Edgar et al., 2004) and homeless people are among the most vulnerable and socially excluded in society, often finding it difficult to access the help they need (Equality and Human Rights Commission, 2016). It is evident that socially excluded groups, including people affected by homelessness experience higher levels of health inequalities and, are at higher risk of mortality (Aldridge et al., 2017) with shorter life expectancy (Hwang, Weaver, Aubry, & Hoch, 2011) despite using acute physical health services more (Stafford & Wood, 2017). Despite the increased health needs that people affected by homelessness have, it has been argued that they are less likely to access services for support (Stafford et al., 2017).

Attempts have been made to promote inclusion health services, which target the health care needs of socially excluded groups who experience additional health inequalities (Inclusion Health Clinical Audit 2015-16 Pilot Report-Organisational

Audit, 2015) and their needs are usually complex with a multi-morbidity of physical health needs, mental health needs, substance misuse, limited social support and limited personal resilience (Stringfellow et al., 2015). To promote health inclusion, though it is important for health-care providers, social services and other relevant service providers to identify and address those factors contributing to social and health inequalities as well as recognising the context and rights of people experiencing exclusion (Kerrigan et al., 2015). Services will need to come together and cooperate effectively to develop support aiming at alleviating health inequalities and prevents inequalities from happening. This would mean that services work systemically to address those systemic and structural factors contributing to health inequalities, as well as providing individual support to address some of the individual factors contributing to peoples' difficulties.

1.8.2. Service-related Barriers

It has been argued that the lack of specialised provision targeted at supporting specific disadvantaged groups can be a barrier in accessing services (Equality and Human Rights Commission, 2016). People who are homeless are more likely to have experienced traumatic life events which could have influenced their relationship to help and caregivers. This could contribute to difficulties in building trusting relationships with services and healthcare providers which could lead to negative experiences and increased mistrust in services (Jelinek, Jiwa, Gibson, & Lynch, 2008). This divide between service and service users is worsened due to services struggling to understand their needs and being unable to adapt their practices to meet the group's specific needs (Jelinek et al., 2008).

To contextualise the findings from their systematic review, Luchenski and colleagues (2017) conducted a workshop with experts-by-experience with a history of belonging in vulnerable and socially excluded groups (e.g. people who are homeless or with a history of substance abuse). They attempted to gain a better understanding of social inclusion, the factors that promote inclusion but also the barriers that increase exclusion. In identifying barriers for inclusive services, they identified restrictive practices imposed by services to hinder access. Furthermore, language and

communication barriers, as well as the lack of cultural awareness, were identified as barriers.

Seager (2011) theorised that people who are homeless experience a 'psychological exclusion', which was defined as the absence of 'a secure or stable sense of self, identity or belonging' (Seager, 2011 pp. 185). As a result, the need to offer services built on meaningful relationships, especially when working with people who experienced early deprivation and damaging relationships was stressed (Seager, 2011). Similarly, Hewett (2019) acknowledged that adverse childhood experiences resulted in psychological trauma which influences people's relational patterns with others, including services and healthcare providers.

Seager (2011) critiqued services offered for people who are homeless as being 'un-psychological, based on short-term and fragmented care relationships, where it is difficult even to think about, let alone meet, the [group's] core psychological needs' (pp.186). Seager (2011) proposed that services should be created based on Psychologically Informed Environments (PIE) aiming to build healthy and consistent relationships with people affected by homelessness. For services to be effective, this approach will need to be applied to the wider care system as well as the environments in which people who are homeless reside.

1.8.3. Staff Attitudes as Barriers

Negative and judgemental attitudes encountered by homeless people when accessing healthcare services have been identified as a barrier for accessing care (Campbell, O'Neill, Gibson, & Thurston, 2015; Elwell-Sutton, Fok, Albanese, Mathie, & Holland, 2016; Hewett, 2019; Lamb & Joels, 2014; Luchenski et al., 2017). Several research studies identified that attitudes held by professionals hinder engagement and can be a barrier for accessing care (Wen, Hudak, & Hwang, 2007). Hewett (2019), argued that people who are homeless attend services expecting that they will be addressed with negative and judgemental attitudes. Service users identified that judgmental attitudes, fear and lack of understanding by service providers and lack of awareness of the groups' specific needs can increase barriers in accessing services (Luchenski et al., 2017).

Martins (2008), conducted interviews with homeless people using health services in the USA, investigating their experiences of accessing care. From the interviews, participants described the health system as ‘non-caring’ and receiving poor quality of services while some participants expressed negative feelings towards the care system and reported being treated differently by staff describing being ignored by staff because they were homeless. Overall, it was described that they felt that they have been labelled and stigmatised while being disrespected by staff.

Mccabe and colleagues (2001), in their study with homeless people who attended a nurse-managed primary care clinic in the USA, explored the factors that made them feel satisfied with the care provided. The participants of the study identified that staff attitudes and perceptions of ‘support, caring, empathy, acceptance, and respect’ (pp.83) were important for them to feel respected without feeling that staff had pre-determined negative judgements about them being homeless.

In a study conducted by Wen and colleagues (2007), in Canada, they interviewed homeless people on their experiences with healthcare providers in general. The participants were asked to identify a health appointment and were asked to consider the factors which made them feel welcome or unwelcome in services. They identified that to feel welcomed by services factors such as being valued as a person and professionals’ willingness to listen, understand and empathise with them whilst attempting to reduce the power imbalance was important. On the contrary, participants reported feeling unwelcome when they were ignored or not been listened to, when staff had an agenda or when they were feeling disempowered. A lot of the participants reported that feeling unwelcome evoked strong emotions such as feelings of being discriminated against. The study also identified that feeling welcome or unwelcome by professionals is critical for future engagement with services and identified that unwelcoming experiences decreased the likelihood of seeking health in the future.

1.8.4. How Attitudes Influence Practice

It has been demonstrated that medical professionals’ positive attitudes towards a group are essential in the development of a helpful doctor-patient relationship

(Buchanan, Rohr, Stevak, & Sai, 2007) especially in providing appropriate care (Buchanan, Rohr, Kehoe, Glick, & Jain, 2004). On the contrary, negative attitudes toward the homeless can negatively impact on accessing health care services (Lester & Bradley, 2001).

1.9. Healthcare Professionals' Views on Homelessness

1.9.1. Healthcare Professionals' Views

As argued earlier, there is an extensive body of research documenting the importance of healthcare professionals' attitudes in enabling or hindering care provision, while it has been suggested that professionals' attitudes influence their practice and can influence therapeutic interactions (Fine, Zhang, & Hwang, 2013). It has been argued that healthcare professionals may have negative views for people who are homelessness, with some arguing that professionals view people who are homeless as 'dirty' and 'unworthy of care' (Jackson & McSwane, 1992, pp.186). More recent examples, Lester and Pattison (2000) identified that people who are homeless are considered by doctors to be 'troublesome and unwanted patients' (pp. 266). Moreover, in a study by Masson and Lester (2003), argued that some medical professionals hold views that people who are homeless are 'less worthy of medical care than other patients' (pp.870).

Lester and Bradley (2001) conducted semi-structured interviews with GPs in the UK investigating barriers in accessing care for people who were homeless. From the analysis, both positive and negative views were expressed by GPs. GPs who expressed negative views referred to people who were homeless as 'a waste of time' (pp.8). From the twenty-five participants, fifteen expressed more positive views and ten more negative. GPs with more positive views tended to humanised people who were homeless and acknowledged that homelessness can happen to anyone. They acknowledged that people who were homeless were powerless and interpreted their behaviour as a result of their experiences. On the contrary, GPs with more negative views described homeless people as 'untrustworthy timewasters' (p.8), while they

were viewed to be demanding and not complying with the treatment provided to them. Distinctions between those who were 'deserving' and 'undeserving' within the population were identified which was influenced by views on 'controllability' of their situation and whether their experiences were 'self-inflicted', with younger people or people abusing substances being considered as 'undeserving'. Feelings of hopelessness and helplessness when working with people who were homeless were also expressed.

In a study by Fine and colleagues (2013), in Canada, medical students and emergency medical services staff attitudes were investigated using the Health Professionals Attitudes Towards Homelessness Inventory (HPATHI). This inventory was developed to assess health professionals' attitudes, interest and confidence in delivering healthcare for people who are homeless (Buck et al., 2005). The inventory investigated personal advocacy (professional's willingness to work with people who are homeless), social advocacy (views on society's responsibility to care for people who are homeless) and cynicism, which measured negative attitudes and hopelessness when working with homelessness (Buck et al., 2005). Their study identified that the majority of respondents had positive attitudes towards homelessness. Differences between pre-clinical medical students and other staff were observed with pre-clinical medical students reporting more positively on statements such as 'Homeless people are victims of circumstances', while they also reported more interest in working with people who were homeless. Most medical students reported feeling overwhelmed by the complexity of the problems homeless people present with, while it was observed that participants with more positive attitudes tended to feel more overwhelmed by homelessness.

1.9.2. What Influences Healthcare Professionals' Views Towards Homelessness

1.9.2.1. *Training and direct experience working with the population:* Buchanan and colleagues (2004) investigated the influence of a two-week curriculum in caring for homeless patients. The curriculum included lectures on homelessness, discussions with people who were homeless, placements in homeless shelters and visits to homeless service providers. The study measured medical students' attitudes before and after completion of the two-week curriculum and direct contact with

homeless people. The study assessed attitudes with the Attitudes Towards Homelessness Inventory (ATHI) which measured causal attributions towards homelessness, willingness to affiliate with people affected by homelessness and a solution dimension (Kingree & Daves, 1997). This study demonstrated positive changes in attitudes as a result of the curriculum and the educational intervention (Buchanan et al., 2004). Medical students reported positive views that homelessness is caused by societal factors and reported more positive views on affiliating with people who were homeless. Despite these changes, views attributing homelessness to personal causes and that homelessness can be solved remained unchanged. This study demonstrated the impact the training in conjunction with direct experience working with people who are homeless have on attitudes, but these changes cannot conclusively be attributed to training or experience on their own.

1.9.2.2. *Supervisors' and peers' attitudes:* A study conducted by Masson and Lester (2003) demonstrated that medical students attitudes towards homeless people changed through their training. This study used the Attitudes Towards Homelessness Questionnaire (ATHQ) to investigate medical students' attitudes before they embarked on studying medicine and five years later. The questionnaire investigated professionals' attributions on causes of homelessness, their willingness to engage with people affected by homelessness and their motivations for becoming doctors (Lester et al., 2000). Based on their results the six students who scored more positively and six who scored more negatively were offered a semi-structured interview to explore the factors which influenced their attitudes assuming that their experiences in medical school influenced their attitudes. A comparison of the results between the questionnaires completed before and after training demonstrated a small shift of medical students' attitudes towards more negative attitudes towards homelessness. From the interviews, it was identified that attitudes held by supervisors and senior members of staff were a significant factor in influencing student's attitudes towards homelessness. Furthermore, it was reported that the nature of their encounters with homeless patients was important in shaping their views. Most of the students though reported that doctors viewed 'homeless people as less worthy of medical care than other patients' (pp.870).

Glennerster and colleagues (2017) conducted a study with hospital staff across four hospitals in the UK, two of those hospitals had dedicated homeless healthcare team and the other two did not. From the study, it was observed that staff from hospitals with dedicated homelessness teams had more encounters with homeless patients than the other hospitals. Their increased encounters with people who were homeless were considered to have contributed to staff reporting more positive attitudes towards homeless people. Moreover, the hospital with the dedicated homelessness teams which comprised of a full MDT and offered regular ward rounds worked closely with local services and staff training had the most positive impact on staff attitudes. These results demonstrate that staff attitudes are influenced by several factors including increased encounters with homeless people and receiving training on working with homelessness. However, these factors are not definite influencing factors for positive attitudes towards homelessness

1.9.3. How the Term 'Attitude' is Used by the Literature

It is evident that in evaluating professionals' 'attitudes', the literature identified several influencing factors. Some of the factors identified were attributional beliefs about the causes of homelessness (Kingree et al., 1997; Lester et al., 2000), and their views on their responsibility and willingness to work with people affected by homelessness (Buck et al., 2005; Kingree et al., 1997; Lester et al., 2000). Moreover, personal factors such as their motivation to became doctors (Lester et al., 2000) as well as their professional training were identified. Finally, the influence of trainers' and supervisors' views were identified as factors influencing the development of professionals own views towards homelessness (Masson et al., 2003).

The studies outlined above use the term 'attitudes' to demonstrate professionals' views towards homelessness. Fine and colleagues (2013) used the term attitudes and beliefs interchangeably without making a clear distinction between the two. Lester and Pattison (2000) used interviews conducted with GPs to develop their ATHQ questionnaire. By analysing the interviews with the GPs, the researchers identified positive and negative views held by GPs about their homeless patients as

positive and negative dispositions (Lester et al., 2001) which seem to have been interpreted as attitudes when developing the ATHQ questionnaire.

As demonstrated above, there is an extensive body of literature investigating healthcare professional's attitudes towards homelessness and how they influence their practice. The term 'attitude' is extensively used, but it is not always being clearly defined by the studies investigating professionals' attitudes towards homelessness. There have been several attempts in defining and researching attitudes more systematically by social psychologists - which will be demonstrated below, but this is now how parts of the literature – as demonstrated above - have used the term.

1.10. Psychological Understanding of Attitudes

Attitudes are defined as 'a general and enduring positive or negative feeling about some person, object, or issue' (Petty & Cacioppo, 1996, p.7). Attitudes are an 'evaluative judgement' influenced by cognitive, behavioural and affective information (Maio & Haddock, 2010). Fazio and Zanna (1981) suggested that attitudes are influenced by direct exposure to the evaluative object and supported that attitudes which were developed following exposure to the 'object' tend to predict behaviours better than attitudes that are not based on direct exposure.

Ajzen and Fishbein (1980) with their Theory of Reasoned Action argued that attitudes influence actions. They considered behaviours to be determined by two factors, the intention to act and the subjective norms. Subjective norms refer to the perceived social pressures to act in a certain way. It has been suggested that understanding one's intentions for action would require an understanding of their attitudes towards an object, idea or theme.

In understanding attitudes towards stigmatised groups Weiner's (1985) Attribution Theory can also be considered. Attribution theory suggests that people make sense of peoples' experiences, particularly people who belong in a stigmatised group, through attributions on the causes of their circumstances and actions. Moreover, it

was suggested that perceived causes of success or failures share three properties: locus, stability and controllability. Locus focuses on where the causes of a situation are located, either being internal or external from the individual. Stability would assess whether these causes are changeable over time and controllability would assess whether the individual has control over the causes of their situation. More specifically, with regards to homelessness and assessing individual's views on homelessness it is important to consider where the causes of homelessness are located (e.g. within the individual factors or societal factors). Furthermore, based on the stability factor, it has been hypothesised that people might be less likely to offer support when they consider situations as less changeable, while if it is considered that peoples' situation can change they are more likely to offer support (Karafantis & Levy, 2004). Regarding controllability, it has been argued that when it is believed that individuals have more control over their actions then they tend to be blamed more for their circumstances (Baumgartner, Bauer, & Bui, 2012).

1.11. Role of Clinical Psychologists in Homelessness

Not every homeless person will experience mental health difficulties for which they will require the support of mental health services. Seager (2015), argued that mentally healthy people who experience homelessness will be able to navigate the system and exit homelessness early. People who have long experiences of homelessness such as people sleeping rough tend to experience more mental health difficulties of more severe nature (Fazel et al., 2008) as a result of early life adversities and trauma, while their mistrust in caregivers and services compromises the support provided to exit homelessness. While people with complex needs such as people who are homeless are at high risk of falling through the cracks in service provision (Mcdonagh, 2011) they also struggle to access NHS mental health services (St Mungo's, 2016). CPs can have a significant role to play in promoting the work provided for people who are homeless by supporting individuals, teams or working with wider systems.

CPs can help identify the appropriate interventions and support that enable service users and teams to develop healthy and trusting relationships, as a steppingstone in receiving the support needed to alleviate homelessness. Moreover, CPs' skills in formulating complex and chronic difficulties such as homelessness which incorporate the understanding of individual and societal factors can be instrumental in promoting better understandings of the phenomenon (Maguire, 2015). Through formulations, CPs can promote a better understanding of the complexity of homelessness and work with services and other professionals to develop strategies for alleviating and preventing it. Furthermore, through formulations providers of support, either health, mental health services, the charity sector or housing services can develop a comprehensive understanding of the complexity of the populations' needs. Moreover, CPs can support develop psychologically informed environments and promote trauma-informed approaches which help teams and services conceptualise service users' difficulties through a psychological lens while identifying the complexity that trauma can present with.

Furthermore, CPs can provide wider societal interventions tackling homelessness and the social determinants influencing of health with regards to social issues. Through their understanding of social systems, commissioning and policy development, CPs can be involved in developing services that will be able to meet the needs of all people, irrelevant to their presentations and complexity of needs. Finally, through social action and advocacy CPs can help promote a less stigmatising and more accurate view on homelessness for the wider population, a view that will challenge the dominant political views which blame the individual for their misfortunes and do not openly identify the major role structural factors have in homelessness, factors which will ultimately have to be addressed by the state.

1.12. Rationale for Research

Homelessness is a complex phenomenon which is increasing (Edgar et al., 2004) despite attempts at a global level to reduce and address it (Tsemberis, 2010). Difficulties defining homelessness have been evident for years (Amore et al., 2011).

With the development of the ETHOS definition and typology, which is more widely accepted and adopted by many countries (Edgar, 2012), the broad nature of homelessness was recognised. In England despite the presence of a legal definition of homelessness, the definition does not adequately conceptualise it with a lot of groups of homelessness not fitting the definition. Definitional problems lead to difficulties developing policies, strategies and services to alleviate homelessness, while it creates difficulties enumerating it.

Structural and individual factors interplay in the development and maintenance of homelessness. The difficulties experienced by people who are homeless can be understood through a tri-morbidity lens where physical, mental health and substance misuse interplay (Stringfellow et al., 2015) with the needs of the population being complex and complicated by the combination of these factors. However, people who are homeless are struggling to access services (Stafford et al., 2017). Staff attitudes have been identified to play an important role in enabling or hindering access to services. Studies conducted with healthcare professionals, primarily medical staff, medical students and nurses identified that negative attitudes towards homelessness can hinder the development of therapeutic interactions (Fine et al., 2013) and can be a significant barrier in accessing services (Campbell et al., 2015; Wen et al., 2007), while their attitudes influence practice (Lester et al., 2001).

Clinical guidelines have identified the need for developing targeted interventions for high-risk groups such as people affected by homelessness (Hewett, 2003). Statutory policies such as the NHS Long Term Plan (2019) and Rough Sleeping Strategy (2018) address the importance of preventing and alleviating homelessness, setting expectations for mental health services to promote inclusive care for all through improving access to services. CPs can have an important role in working with homelessness, with their expertise in formulations where they can understand complex phenomena such as homelessness (Maguire, 2015). CPs can work at an individual level working directly with people affected by homelessness or they can work with teams developing a psychological and trauma-focused understanding of homelessness. Finally, CPs can work at a policy level where they can use their psychological understanding of social issues to help develop policies and strategies that are relevant to the populations aimed at helping.

CPs have a significant role to play in working with homelessness but their views towards homelessness have not yet been investigated. An understanding of CPs attitudes towards homelessness can increase the understanding of how CPs view homelessness and other social issues. It will also enable a better understanding of how they conceptualise their professional role in supporting people who are homeless, supporting teams and their role in wider systemic interventions. Furthermore, in exploring CPs views towards homelessness not only gives a greater understanding of how they influence their practice, but it can also allow the investigation of factors which influence and shape their views and attitudes. This will help in understanding how CPs develop their attitudes and what helps them develop their identity and role as CPs.

1.13. Research Aims

This study aimed to interview CPs working in secondary care mental health services for adults to understand CPs' views towards homelessness, what influences them and how their attitudes influence their practice. Thus, a qualitative methodology was used. Qualitative research was chosen as it aims to develop knowledge based on human experience (Sandelowski, 2004). It is an important component in gaining a better understanding of how people conceptualise the world and their experiences (Willig, 2013). It can also provide an understanding of complex health and social interventions (Lewin, Glenton, & Oxman, 2009) such as the issue of homelessness which is investigated by this study.

The following research questions will be addressed in this study:

1. What are CPs' views towards homelessness?
2. What influences CPs' views towards homelessness?
3. Do the experiences of working with homeless people influence CPs views towards homelessness?
4. Do the views of peers and supervisors influence CPs views towards homelessness?

5. How do CPs' views towards homelessness influence their practice?

CHAPTER TWO: METHODOLOGY

This chapter will outline the methodology of this study. It will discuss the epistemological and ontological position of the study and the specific methodology used, namely Thematic Analysis. The design and process of analysis will also be outlined. Furthermore, ethical considerations will be addressed, and quality criteria will be outlined.

2.1. Ontology and Epistemology

The importance of outlining the theoretical foundations for a study, particularly when TA is being used has been widely documented (Terry, Hayfield, Clarke, & Braun, 2017). This is because both the ontological and epistemological underpinnings of the study will influence the study (Anfara & Mertz, 2006), which will be important to be considered when the study is reviewed. More specifically, the epistemological underpinnings are important to be considered as it guides the questions being asked and how the data is described, as well as how the analysis is being conceptualised and theorised (Widdicombe & Wooffitt, 1995).

Ontology is the study of the world. It questions the nature of reality and what there is to know (Guba & Lincoln, 1994). Furthermore, it identifies that the world is a build-up of structures and concepts that constantly interact with each other (Willig, 2013). This study assumed a realist ontological perspective, which assumes that the external reality is independent of influences, such as the researcher (Willig & Stainton-Rogers, 2017).

Epistemology predominantly addresses the theory and nature of knowledge and the relationship between ‘the knower or would-be knower and what can be known’ (Guba et al., 1994, pp. 108). This study assumed a critical realist perspective, which attempts to gain a better understanding of the world and people’s experiences while acknowledging that the data gathered might not be a true and accurate representation of reality (Willig, 2013). Rather, the data has to be interpreted by

considering underlying structures and their impact on the issues being investigated (Willig, 2013). In this case, how homelessness and the role of CP are being conceptualised by the participants.

Critical realism argues that despite there being an objective reality, there are multiple perspectives to peoples' 'reality' (Healy & Perry, 2000) and their perspective of 'reality' cannot be viewed as 'direct mirroring' (Harper, 2012, pp.88) of their world and experiences. Rather peoples' reality is influenced by socio-cultural meanings, which influence both the participants' and researchers' interpretations of their experiences. Through this lens, it is acknowledged that homelessness is a 'real' phenomenon in the world. However, the participants of the study interpret it through a 'filtered lens' which cannot be accessed directly by the researcher, but only interpreted (Bisman, 2010; Sayer, 2000).

2.2. Rationale for Thematic Analysis

TA was chosen for this study. TA is a method of analysing data by identifying patterns or themes in the data as well as organising and describing them (Braun & Clarke, 2006). Furthermore, TA can be used to identify repeated patterns of meaning and it attempts to theorise how these patterns cluster together and how they influence the data (Braun & Clarke, 2006).

A theme has been defined as a pattern of meaning (Joffe, 2012). However, it is important to note that it is not clear what constitutes a theme, or what proportion of the data needs to be covered to constitute a theme (Braun et al., 2006). It has been proposed though, that a theme should capture an important aspect of the research question (Braun et al., 2006), and a theme should be interpreted based on the research aims (Boyatzis, 1998).

Some researchers suggest that themes reside in the data set (Joffe, 2012), while others argue that themes reside within the researcher's mind and are influenced by the researcher's understanding of the data and the links developed to understand

them (Ely, Vinz, Downing & Anzul, 1997). Consequently, Ely and colleagues (1997) recognised the researchers' influence both on the analysis and interpretation of the data into themes.

TA can be conducted with either inductive or deductive methods of analysis. Deductive analysis is described as a top-down approach (Boyatzis, 1998) that is driven by pre-existing theory. Through this process, researchers attempt to recognise pre-identified themes in their data. On the other hand, inductive analysis is identified as a bottom-up approach (Boyatzis, 1998) which aims to identify themes that are strongly linked and derive from the data set (Patton, 1990). This is achieved through a systematic examination of the data and through the development of themes that are specific to the data set - rather than attempting to fit the data in pre-existing categories and theories (Braun et al., 2006). For this study, an inductive analysis was used as the data set was collected specifically for this study with no pre-existing thematic categories existing for the specific research aims.

2.3. Design

2.3.1. Participants

Twelve CPs participated in the study, which has been identified as an adequate sample size for a doctoral-level qualitative study (Braun & Clarke, 2013; Guest, Bunce, & Johnson, 2006). The study had broad inclusion criteria; with all CPs who work in secondary care mental health services working with adults being able to participate. No exclusion criteria were applied, as the aim of the study was to include a diverse group of CPs, working in a variety of settings.

Four men and eight women were interviewed. Participants' years of experience ranged from newly qualified (less than one year of experience) to sixteen years. A detailed table of participants' demographic details can be found in Table 1.

Participant	Gender	Ethnicity	Age	Service	Years of experience
P1	Male	White or White British	45-54	Community Mental Health Team (CMHT)	15
P2	Female	White or White British	25-34	Early Interventions Service (EIS) and Secondary Care Psychology Service	1
P3	Female	White or White British	25-34	Older adults CMHT and memory service	2
P4	Female	White or White British	35-44	Recovery Team for people with psychosis	9
P5	Female	White or White British	35-44	CMHT	14
P6	Female	White or White British	25-34	CMHT	2
P7	Female	White or White British	35-44	CMHT	5
P8	Male	White or White British	55-65	CMHT	16
P9	Female	White or White British	35-44	Older adults CMHT	13
P10	Male	White or White British	25-34	EIS and Inpatient services	Less than 1 year
P11	Male	White or White British	45-54	CMHT	7
P12	Female	White or White British	25-34	EIS and Inpatient Services	Less than 1 year

Table 1: Participant demographics

2.4. Procedure

2.3.2. Developing the Interview Schedule

Semi-structured interviews were developed for this study. Semi-structured interviews were chosen as they provide a guide for the interview while allowing some flexibility, to explore ideas presented by the participants that are not covered by the interview schedule.

The interview schedule (Appendix A) consisted of fifteen questions. These questions were developed to reflect the research questions and were based on existing literature involving healthcare professionals and members of the public. From the literature review, factors influencing attitudes towards homelessness were identified

as: specific training on homelessness (Kingree et al., 1997); exposure to people affected by homelessness; and attitudes held by peers and supervisors (Masson et al., 2003). Finally, the interview schedule was developed following discussions with the research supervisor.

2.3.3. Recruitment

The study was advertised on social media platforms such as Twitter and Facebook ('UK based Clinical Psychology Facebook Group') and on the 'Call for Participants' website (https://www.callforparticipants.com/). Additional snowball sampling techniques were used to widen the pool of participants (Atkinson & Flint, 2001). CPs participating in the research and CPs known to the researcher were approached and asked to advertise the study to other CPs. Four CPs were recruited through snowballing technique and the remaining eight through the Facebook advert.

CPs who expressed their interest in participating in the research were contacted by the researcher, who provided the Participant Invitation Letter (Appendix B) containing all relevant information about the study, and an appointment was offered. Before the interview, participants were asked to complete the Demographics Form (Appendix C) and a Consent Form (Appendix D). After the interview, participants were offered a verbal debrief.

2.3.4. Interviews

Interviews were conducted either face-to-face or through phone or video conferencing and lasted for up to one hour. The average time for the interviews was forty-seven minutes, with interviews ranging from twenty-nine minutes to sixty-five minutes.

2.3.4. Transcription

All interviews were transcribed verbatim from the audio recordings and checked again against the audio recordings to ensure the accuracy and quality of the data set. Due to the nature of the analysis, with it mainly concerning the content of the interviews, non-linguistic features were not transcribed. The transcript extracts used

in *Results* were ‘tidied up’ to ensure better clarity without altering the content of the extract (Willig, 2013).

2.4. Ethical Considerations

Ethical approval was obtained by the University of East London Ethics Committee (Appendix E). All participants gave written consent for their participation in the study and verbal consent for the interviews to be recorded, transcribed and quoted anonymously. Anonymity was achieved by assigning each participant a code.

2.5. Analysis

The analysis followed the TA steps as outlined by Braun and Clarke (2006). This process involved six phases, which will be described below.

Familiarisation with the data: this started from the interview stage of the study and during data transcription. Following transcription, familiarisation with the data was achieved through repeated reading of the transcripts. During this phase, a reflective log was kept, where both theoretical and reflective accounts were documented (Nowell, Norris, White, & Moules, 2017).

Generating initial codes: following familiarisation with the data, a list of reflections and interesting ideas emerging from the data was generated, which helped to develop initial codes. Initially, attempts were made to code the transcripts line-by-line or, for specific sections of the text, to code as many extracts from the data set as possible. This aimed to organise the data into groups (Tuckett, 2005) with the overall aim of the analysis to answer the research questions.

Identifying themes: this next phase involved organising the initial codes into themes. Diagrams were developed to identify and describe connections between the codes and the themes. Moreover, diagrams were used to identify possible hierarchies of concepts within a theme, and links between the themes (Nowell et al., 2017). By the end of this phase, a collection of themes and sub-themes were identified.

Reviewing themes: at the next phase, all initial themes were reviewed and redefined. Existing themes were reviewed for their usefulness, which led to a significant change in themes by the end of the analysis. Attempts were made to maintain coherence within themes whilst maintaining clear distinctions between the themes (Braun et al., 2006). Finally, the validity of the themes was reviewed against the whole data set and a thematic map was developed (Appendix F). The accuracy of the themes and the final thematic map was discussed with the research supervisor before finalising the themes.

Defining and naming themes: as a final step, a definition of specific themes and sub-themes was produced and detailed analysis for each theme was outlined.

Report writing: the thesis was then written up, aiming to create a coherent and comprehensive narrative which would best describe the themes identified.

2.5.1. Process of Analysis

It was argued that three levels of analysis can be used for TA, with the first being a 'descriptive level of coding and work upwards in a systematic manner towards more interpretative level' (Langridge, 2004, pp.267). The analysis performed for this study was on a latent level, aiming to understand the meaning and the underlying ideas that influence CPs' views on homelessness. This involved interpretive work (Boyatzis, 1998), which not only identified the semantic content of the data set but also attempted to theorise the importance of the themes identified (Patton, 1990).

Consistent with critical realism, participants' views were interpreted by identifying 'underlying ideas, assumptions and conceptualisations – and ideologies that are theorised as shaping or informing the semantic content of the data' (Braun, et al., 2006, pp.84). When analysing the data, considerations were made about how participants orientated towards the questions asked; their world view; assumptions expressed through their answers; and the expression of the implications of their actions toward themselves and others (Terry et al., 2017).

2.6. Reviewing the Quality of the Study

Throughout the study, it was important to continue reviewing and ensuring the quality of the research project. The quality of the study was maintained through reflexivity. By considering both personal and epistemological reflexivity, personal factors and biases which could influence the research and analysis were acknowledged (Braun et al., 2006; Willig, 2013). Moreover, Lincoln and colleagues' (1985) recommendations to assess the quality of the research, namely using credibility, transferability, dependability and confirmability were considered regarding this study. All the above will be discussed at length under the *Discussions* section of the thesis.

2.7. Relationship to the Research

It is important to consider my positioning towards this research project particularly as it is a qualitative study. This is in recognition of the instrumental role I held in the data analysis, where I was both an 'instrument' and 'interpreter' during the analysis as I was making decisions on coding, thematising, decontextualizing, and recontextualising the data (Starks & Trinidad, 2007).

When I initially started considering projects for my thesis, homelessness was something that stood out for me. I remember my first 'exposure' to homelessness being when I first moved to the UK. Coming from a country where 'homelessness', at least in the form of 'street homelessness' is absent, I was saddened and surprised to see how many people struggle with housing. This could have been my naivety, and very protected and somehow privileged upbringing, that prevented me from recognising the existence of homelessness around me. As an economic migrant, I was then forced to recognise the increased vulnerability ingrained in any changes to one's circumstances that can have a detrimental impact on their financial stability, particularly changes in employment could make homelessness a real possibility for people.

Having worked in primary care mental health services for adults there were times where I felt frustrated with a system which struggles to meet demands and would rationalise decisions based on psychological theories such as Maslow's hierarchy of

needs (1943). I felt that this was used in a way to ‘exclude’ people from the services - when they were experiencing the most vulnerable and distressing times of their lives. I would come across narratives such as: ‘once people sort their housing they can then come back to the service for support’. This left me, not only considering the importance of adequate housing for peoples’ wellbeing, but also the role mental health professionals and CPs can have in supporting individuals experiencing psychological distress as a result of social issues.

I am of the view that homelessness is a social issue caused by social, structural and economic inequalities. Similar, to Kingree and colleagues (1997), I conceptualise homelessness as the most extreme form of poverty, where an unjust and unequal society contributes to its creation and maintenance. I view the role of CPs as something more than just being therapists. I believe that as a body of professionals, publicly funded for our training, our role and aim should be to ‘serve’ the public, particularly people who have experienced several exclusions and injustices. I believe that CPs could have a significant role in the prevention of social issues such as homelessness, and they could (and should) contribute to working towards ending or preventing homelessness. CPs should also aim to prevent current health care systems from maintaining and perpetuating further injustices towards people affected by homelessness.

Despite my views and positioning on the causes of homelessness and the role CPs have in working with social issues such as homelessness, I attempted to remain impartial both during the interviews and during data analysis. It is important to note though, that despite my efforts to remain unbiased, my implicit expectations and views on the issue could have influenced the analysis and the hypothesis developed from the analysis.

CHAPTER THREE: RESULTS

This chapter will discuss the themes identified from the analysis of the interviews. From the analysis, three main themes were identified, with nine sub-themes. An outline of the themes can be found in Table 2 below. The themes will be described in detail and will be supported by selected quotes from the interviews.

Themes	Sub-themes
Homelessness is a complex social phenomenon	Homelessness is multi-layered
	It is not the individual to blame
	It can happen to anyone
	People affected by homelessness are not looked after
	It is difficult to overcome homelessness
Homelessness is not for psychology	Inaccessible services
	Homelessness is not appropriate for psychological therapy
Our role as Clinical Psychologists	Using our skills in formulation
	We are not just therapists
	Influence of clinical training
	Personal and professional experience
	Personal and professional values

Table 2: Outline of Themes and Sub-themes from the Analysis

3.1. Theme One: Homelessness is a Complex Social Phenomenon

The complexity of homelessness was recognised by all participants, who demonstrated a broad understanding of homelessness while recognising it as multi-layered. All participants reflected non-judgemental attitudes towards homelessness and the people affected by it, despite acknowledging that other professionals, including colleagues, could hold different, more judgemental views. This was met with disbelief though, and the wish for all professionals to share non-judgemental views, similar to the ones they held.

3.1.1. Subtheme One: Homelessness is Multi-layered

All participants acknowledged that homelessness is not just rooflessness. Homelessness was defined broadly, beyond the visible forms of rooflessness (i.e. street homelessness), despite being acknowledged that this is '*the main way most people think about it'* (Participant 11). Furthermore, participants acknowledged *'transient homelessness…where people are placed in temporary accommodation'* (Participant 7) as another form of homelessness, particularly as the main form of homelessness seen in services. This type of homelessness was described as being less visible and includes temporary housing, such as living in homeless hostels, temporary social housing, or living temporarily with family or friends i.e. sofa surfing. Finally, the analysis identified the factors associated with defining a home. A home was identified as a place which is fixed, permanent and provides safety.

The majority of participants reported that homelessness is as a result of a variety of factors which contribute to its creation, development and maintenance. An interplay of systemic, contextual and individual factors was identified by the participants to impact on homelessness. Predominantly, homelessness was conceptualised as a social issue, while acknowledging individual factors which are understood within the wider social context as demonstrated below:

> *Homelessness which is basically a social and political problem. Then there are the issues that are more psychological that might be around difficulties that we can locate a bit more in the individuals who are homeless but it's so weighted at the moment on the more social and political side where that's clearly where the help is needed.*

Participant 8

The lack of state and welfare provision, as well as the lack of social housing, were identified as significant factors which influence homelessness:

> *Unfortunately, a lot of changes to the welfare system that have come in has made peoples' housing a lot more vulnerable.*

Participant 11

A lot of the participants maintained the view that the welfare system, rather than working towards reducing homelessness, is one of the main factors contributing towards homelessness:

> *A lot of the benefits system leads to people being homeless so actually [the] government [is] saying on one hand we're going to improve services for homeless people but my attitude is: 'just make fewer of them in the first place'. You know universal credit's been a nightmare for people and it resulted in people becoming homeless and suicidal.*

Participant 3

Furthermore, the lack of a psychological understanding of homelessness by the state and welfare providers, such as the housing system, was identified as another factor which makes engagement with these services difficult:

> *People who are presenting with mental health difficulties which may [present with]extremes of emotional [dis]regulation either withdrawal … or getting very angry. How this is dealt with, the housing system may not be supportive in relation to the mental health difficulties.*

Participant 8

3.1.2. Subtheme Two: It is Not the Individual to Blame

The next two subthemes: *It is not the individual to blame* and *It can happen to anyone*, are closely interlinked. They suggest that individuals are not to blame for homelessness, rather social factors as described above play a significant role in homelessness. Moreover, it is acknowledged that because the individual is not to blame, homelessness can happen to anyone.

The majority of participants identified that several factors interplay in the development and maintenance of homelessness. As mentioned above, individual factors were recognised as influencing factors. But these were understood within the wider context, which was identified as the main reason for homelessness, rather than the individuals:

> *A lot of the problems that we see are a consequence of lots of other events rather than an individualistic kind of this is an illness this is a problem*
>
> Participant 12

> *People feel so negatively about the artificialness of their fault that being, becoming homeless is a fault of theirs and there may well be things that they may need to take personal responsibility for but there is also a sense of which other things happened around them probably that triggered these issues.*
>
> Participant 11

This was also conceptualised in terms of vulnerability and the recognition that, in an unequal society, the individual is not to be blamed for the social difficulties they are experiencing:

> *Vulnerability might also encompass social inequality as well, so people may be not having opportunities in the same way that maybe others in society [have].*
>
> Participant 9

This raised conversations around choice. How much choice do people affected by homelessness have about their homelessness? The participants of this study discussed these narratives, as it was recognised that such narratives exist in services to some extent.

> *I know that there are some negative views around homelessness and some narratives around people choosing to do that, that they have a real home and that they are sort of pretending. Quite extreme views around choice*
>
> Participant 6

On the contrary, other participants recognised that the reason why people might 'choose to be homeless' might be that the society is not taking care of them (which will be discussed in more detail as a separate subtheme):

> *It might be they turned their back on society because society did that to them. So this is the way that they found some kind of connection and community.*
>
> Participant 12

Views around choice were challenged by some of the participants as they argued the extend of choice that people have over their circumstances:

> *Homelessness is more than just a decision. To kind of say 'fuck you' to social norms I think there's more going on than that you know it's not like people have gone and lived in a kind of separate community.*
>
> Participant 12

> *If you had a real choice, then I'm not sure that you would choose to put yourself in that kind of position.*
>
> Participant 6

3.1.3. Subtheme Three: It Can Happen to Anyone

As the analysis identified that it is not the individual to blame, it has also identified that homelessness is a possibility and can happen to anyone, regardless of their current circumstances.

> *I hope I never forget that that can happen to anyone that really can happen to anyone … or that could be someone that I care about.*
>
> Participant 12

> *I think it could happen to anyone at any time and it's easy for people to ignore that a lot of the time. People don't intend to get into these situations where they're at the lowest point.*
>
> Participant 6

The current wider economic context, with insecure employment contracts such as zero-hour contracts, and difficulties buying a house, were identified by participants as factors that increase vulnerability for homelessness.

> *Only two pay slips away from being homeless.*
>
> Participant 7

> *And I think that's a big social argument that traditionally in the UK people have owned their own homes and then sold them to go into care. We now know that current generations may never own their own homes so there is no money there to pay for care so what will happen to those cohorts when they reach older age is quite scary.*
>
> Participant 3

This was supported further by the participants of the study who identified the importance of contextual factors in homelessness - factors in which people might have no control over. Some of these factors were identified as loss of employment, relationship breakdowns which result in loss of housing, reduction of income and consequently impact on the affordability of housing, and increased rent arrears or debts.

> *A combination of life stresses happening all at once meaning that it's really difficult to keep up with rent payments.*
>
> Participant 9

> *Broader societal type of homelessness when someone losses their job, they can't pay their bills they can't meet mortgage or the rent or [get] evicted.*
>
> Participant 4

The above also demonstrates that contextual factors are to blame, rather than the individuals, for their circumstances and homelessness. Furthermore, understanding peoples' coping strategies, such as the use of substances, were expressed and conceptualised, as a way of coping rather than being a problem with the individual:

> *People have the view that using substances is a bad thing in some services, but for me I want to think about those things as coping strategies a way of*

dealing with this particular thing so how can we help somebody to have other ways of managing.

Participant 6

3.1.4. Subtheme Four: People Affected by Homelessness Are Not Looked After

From the analysis, it can be inferred that people affected by homelessness are not being looked after either by society or by the systems developed to help:

When people are homeless, they're not necessarily being looked after by society in any type of way.

Participant 12

Challenging systems that make it easier for people to end up on the street…not much of a safety net anymore and people falling through the net.

Participant 11

It was also suggested that *'non-expert understandings are quite threatening'* (Participant 4), particularly certain political narratives which influence wider understandings of homelessness as demonstrated below:

The political narrative about homelessness is disgusting and fuelled by governmental messages [and] media… on one hand they're saying 'oh it's a national tragedy' on the other hand we still have this kind of scrounger begging type narrative going on, these people choose to be homeless, 'the only reason they're there is because they made worse life choices than you'. There's no kind of broader societal thinking about how people end up homeless.

Participant 3

Broader society is labelling the homeless people as the cause of the problem. I think we need to very clearly label the underlying political issues and society issues about the provision of housing as the cause of the mental health issues rather than the other way around.

Participant 8

This narrative could have contributed to reduced efforts by recent governments to address homelessness, despite efforts by previous governments, which have been successful to an extent:

> *The last decade there hasn't really been a political will to address these kinds of issues.*
>
> Participant 8

> *So, we're talking about a real reversal … I've been in housing for 10 years things have changed since then so I acknowledge that it's not as good as it once was…. such a shame to see that so much progress got made [regarding increased numbers of people sleeping rough]*
>
> Participant 11

Finally, it was identified that homeless people are not looked after by the society, and it was stipulated that this might contribute to homeless people losing their sense of self-worth and struggle to see beyond homelessness:

> *Conscious of my own judgments over the years, I suppose… street homelessness you get treated terribly by a lot of people and you don't think you are treated badly I think you're viewed differently. In a similar way I suspect as to how people who are serious drug users also seen there's a sort of loss of you as a respectable person and then there's only the sort of the drug using you or the scruffy kind of smelly street you and the self-respect is gone… lack of self-esteem probably a lack of belief of self-worth but these things all compound once your circumstances change and then you adjust to it maybe cognitively by thinking 'oh maybe I don't deserve to have a place maybe I don't deserve to be living in different circumstances'.*
>
> Participant 1

3.1.5. Subtheme Five: It is Difficult to Overcome Homelessness

It has been identified that it is difficult to overcome homelessness, once people get ingrained in it. It was identified that this was due to lack of support from the society and services, as discussed above. It was also attributed to a lack of personal support from family or friends and lack of opportunities that people can utilise to change their circumstances:

It's incredibly difficult to climb your way back up again… I think what we're going to see more and more of is people never actually getting the chance to have a steady environment.

Participant 3

People haven't got strong friends and family networks they can find themselves having difficulty with regards to how they are doing.

Participant 5

Difficulties exiting homelessness were understood within the wider context of the problem, homelessness, getting worse, which was largely attributed to current austerity measures, which impact on state provision and consequently in increasing numbers of homelessness:

Just isn't enough housing so it's interesting that they are running austerity alongside 'we are ending homelessness'.

Participant 2

Some of the clients that I am aware of in the team are struggling more now than say they were 10 years ago in terms of housing and affording to be adequately housed. It's not everybody but I think that might impact on people.

Participant 5

Austerity measures have been identified to impact on service provision. It was identified that, with reductions in service provisions and support offered, the threshold for offering support has increased. Consequently, fewer people are offered support before reaching a crisis point, which increases the possibility of people becoming homeless as a result. A crisis was conceptualised, broadly with it being either a relapse in mental health, a breakdown in housing, or a breakdown in supportive systems.

Nurses [are] under resourced, there are less care coordinators…the point of which people become eligible to get a care coordinator is I think more and more high. You have to be more and more complex, more and more needy and I think that leads to people who could've done with some help they are not getting it.

Participant 11

Recognising the increasing numbers of homelessness alongside the impact of austerity measures on the wider society and service provision have left a lot of CPs feeling hopeless and frustrated with their inability to help people:

> *It is also very hard to not feel hopeless because it has to be really quite radical changes to make any difference to this*
>
> Participant 12

> *It's very frustrating for us to feel that we can't help the person with one of their basic needs and …basically having a safety and a good roof over the head*
>
> Participant 2

The role services (housing services, social care and mental health services) have in contributing and maintaining homelessness, through practices that do not enable people to overcome it, was also acknowledged by the participants:

> *We literally maintain homelessness…we do not provide a better alternative*
>
> Participant 12

Finally, when discussing street homelessness, it was acknowledged that maybe people find a sense of belonging through the 'street community', which they might not be unable to find in the wider society. This could be another factor preventing people from exiting homelessness.

> *People get institutionalised into the street.*
>
> Participant 4

> *Because some people find it really hard to get off the streets not only because there isn't somewhere for them to go but also because of complex interpersonal factors and what it means to them to live on the street and have maybe camaraderie with other people and have the social network around.*
>
> Participant 10

3.2. Theme Two: Homelessness is Not for Psychology

The second theme identified argued that homelessness is not for psychology, with the majority of CPs reporting that they are not directly working with people affected by homelessness. This was service-dependent with some mental health services and CPs working with people affected by homelessness and others not. However, it appears that the main presentation of homelessness in secondary care mental health services is houselessness rather than rooflessness. Despite, people affected by homelessness being present in secondary care mental health services it appears that they are not seen by the psychology teams, while the participants of this study acknowledged that CPs have a role in supporting other professionals in the wider teams when they are working with people who are homeless.

From the analysis of the interviews, it became obvious that services are difficult to be accessed by people who are homeless with services, to an extent, being unable to accommodate for homelessness. This is particularly relevant as services are struggling to offer individualised support for the different groups that present with homelessness such as victims of domestic violence, refugees, asylum seekers or care leavers.

3.2.1. Subtheme One: Inaccessible Services

This subtheme discusses that mainstream services are struggling to accommodate for homelessness. This is primarily conceptualised to be due to difficulties in accessing services, with many of the participants of this study questioning whether people affected by homelessness would be able to access mainstream services. This was mainly associated with street homelessness and questions were raised whether there are specialist services working with street homelessness:

> *I've probably worked in a lot of services before were actually even if people would benefit from the service it's just no way of accessing it.*
>
> Participant 12

> *People that are out on the streets probably don't make it to CMHTs potentially.*
>
> Participant 3

Don't know how, certainly street homeless people I don't know how they access services or what services can even work with them directly

Participant 1

For a lot of the participants, this raised questions about service accessibility and how this can sometimes act as a barrier between people accessing the support they need. Accessibility was considered not only as a form of physical access to services but also developing services which are relevant and truly accessible to people and their needs.

Broader conversations about what makes a service accessible cause I think the NHS has been quite pig-headed in the past… narrow minded conversation and we need to be thinking about not just the practicalities of what makes something accessible but culturally what makes something accessible… even if you are physically able to walk in there it does not mean it's accessible to you

Participant 3

There are questions around service access …. I think that's a huge problem in a lot of services and their expectations on clients to come to us and show commitment demonstrate their commitment …there are a lot of barriers in place

Participant 6

Furthermore, it was identified that despite the participants of this study conceptualising homelessness as multi-layered, which encompasses several different groups with different presentations and needs, they reported that services tend to assume that the group is homogenous sharing the same characteristics and needs. Thus, the support being provided by services tend to be the same for all without considering individuals' needs.

We talk about homelessness as if it's one homogenous group I think actually breaking it down into who those groups are and what their needs are.

Participant 3

Assuming people would want XYZ and I think the system around we assume that everybody wants or needs certain things

Participant 12

Attending a therapy session in a formal setting is a huge thing to ask of people and I think we need to appreciate that the NHS has had a 'one size fits all' approach, 'if you attend our clinics the way you've been doing them for years or you're not engaging'.

Participant 3

The participants of the study identified that services fail to recognise the different subgroups and their individual needs, resulting in services offering inadequate support. Furthermore, it was stipulated that there is a lack of support for some of the groups that are at high risk of entering with homelessness. Some of the groups identified by the participants of this study were victims of domestic violence, people from the LGBTQ community, care leavers, people who have been incarcerated, migrants, refugees and asylum seekers.

I think in services making the assumption that everyone needs the same things is probably quite dangerous so we know that women with young children fleeing domestic violence probably need a very different type of support to someone who is under asylum status and can't work to an older adult with a placement breaking down to someone who's previously been seen to have a quite middle class lifestyle but that's now gone due to a number of factors

Participant 3

Still don't think we are very good at supporting people who come out of prison

Participant 11

It might be people who are refugees who'd been refused asylum who then get kicked out of their accommodation

Participant 8

I don't think there is very much support for particularly young people who might have had quite a tricky time growing up and came out of the social care system or given somewhere to live but they've never been shown how to maintain a property

Participant 12

CPs identified the need for services to facilitate conversations with people affected by homelessness, to better understand their needs and develop interventions that are relevant and meeting their needs more adequately.

> *How do we fit the work to those different groups and that's going to need a lot of listening to individual groups and then promoting their individual needs*
>
> Participant 3

Moreover, it was claimed by some of the participants that current practices used by the NHS could be worsening homelessness. It was identified that services might be reinforcing people's homelessness whilst long waits can worsen homelessness.

> *[with waiting lists] somebody who's really worried about their housing or they are homeless then you put them back on a waiting list and say 'this is not the right time for you because you've got all these social issues going on' but then you are perpetuating the problem you are just handing it back*
>
> Participant 7

> *I think that what we do in our service is sometimes reinforcing people's helplessness and I think how that kind of thinking apply to homelessness*
>
> Participant 1

Furthermore, it was identified that current NHS structures which prevent practitioners from working creatively and flexibly can sometimes be restrictive and prevents practitioners from meeting service users' needs.

> *I have to think quite creatively and in a way that the NHS doesn't really support at the moment in terms of thinking preventively*
>
> Participant 9

> *Not the same restrictions as the NHS and I think that means we can be much more fluid in responding to people's needs. The NHS culture that we have about recording contacts and payment by results doesn't quite fit with the type of approach you might want to use*
>
> Participant 3

3.2.2. Subtheme Two: Homelessness is Not Appropriate for Psychological Therapy

Another theme that emerged from the analysis was that homelessness is not appropriate for individual psychological therapy, something that was shared by all participants in this study.

> *Homeless seem to fall into a category where people would frequently say not appropriate for psychology*
>
> Participant 10

> *There's lots of other things that need to be sorted out first before they start prioritizing kind of primary care mental health needs*
>
> Participant 12

Furthermore, it was reported by the participants that people affected by homelessness are not suitable for psychological therapy. This was justified with Maslow's hierarchy of needs. It was indicated that housing as a basic need, will need to be addressed first before any psychological work could be considered.

> *People aren't considered for psychology perhaps if it's perceived that their basic needs such as housing isn't met or that they wouldn't be able to come to regular psychology appointments if they live in precarious situations*
>
> Participant 2

> *Maslow's hierarchy of needs comes to mind thinking 'well actually hang on a second before we do this we need to think about what gets in the way of you being able to have a place to live or being able to hold down a place to live' and working on that level, on the more immediate kind of day to day thing.*
>
> Participant 10

> *This person obviously had a really difficult life so we will refer them to psychology …and you think about Maslow's hierarchy of needs it's a bit like let's sort out the shelter and then maybe we'll move on*
>
> Participant 9

From the analysis, it is evident that most CPs maintain that individual therapy is not suitable for people affected by homelessness. This raised questions around suitability

for therapy with a lot of the participants questioning the usefulness and the rationale behind these narratives.

> *There's this idea of suitability for therapy so we need to be able to unpick what that is and maybe challenge some of our assumptions about what that is*
>
> Participant 3

At the same time, the usefulness and appropriateness of types of therapy offered were discussed by participants who questioned whether they meet peoples' needs.

> *Types of therapies that we offer, do they make sense to someone from that context?*
>
> Participant 3

> *Incredible arrogance in trying to provide a highly specialist therapy to someone without taking any consideration of what their day to day life… my question is always what can we do that gives people the same chance of recovery as anybody else who walks through our doors.*
>
> Participant 3

Furthermore, the role that CPs have in developing therapies that truly meet service users' needs was discussed:

> *How do we develop our therapies, to meet that need rather than saying you're not suitable for the therapy I've been trained to deliver.*
>
> Participant 3

3.3. Theme Three: Our role as Clinical Psychologists

The role of CPs has been extensively discussed by the participants, particularly when working with homelessness and other social issues. Despite the participants of this study identifying that homelessness is present in services, homeless people are not seen by psychology teams. This could be due to CPs' view that peoples' basic needs should be addressed first before they would be able to engage in individual therapy. Our participants though, identified that CPs work with homelessness

indirectly. CPs' skills in formulation and their understanding of wider systemic factors were identified to be used to help teams and services built on their understanding of homeless peoples' experiences and needs. Moreover, it was identified that CPs who participated in this study maintained that CPs are more than just therapists, rather, they envisioned a wider role for CPs. Moreover, the influence of clinical training was discussed: both in the development of professional identity; as well as in the conceptualisation of the role of CP. Finally, personal and professional experiences and values were identified and discussed as factors influencing the development of CPs views on their professional role.

3.3.1. Subtheme One: Using Our Skills in Formulation

Formulation was identified as the key skill acquired by CPs that makes the profession unique among other professions. Using their formulation skills to gain a better understanding of homelessness and the impact it has on peoples' lives was discussed by the participants.

> *Our key skill as psychologists is formulation it's that sense of understanding what's happened to somebody and how this is manifesting in their life now and in a way we're the only profession that do this at a psychological level. We are the only person who can create the narrative, create the story that helps other people to understand.*
>
> Participant 4

The participants of this study spoke extensively about CPs skill to understand wider systems and include their systemic understanding when formulating peoples' difficulties. CPs spoke about their ability to paint a bigger picture by considering all factors that influence peoples' life such as life adversities, poverty, and trauma. Furthermore, it was argued that CPs' understand peoples' social context and the impact these factors may have on peoples' relationships with society, which might aid in explaining the reasons why people end up where they are.

> *Understanding how much what's happened to people, how much the trauma that people have gone through, how much that might impact on their relationship with society and when it feels that's got big impact and therefore, they are going to have problems with accommodation there's more understanding.*

Participant 4

> *Thinking about a person in their social context and what happened to them and how they ended up where they are. It's how we can meet peoples' needs more flexibly if it's the right time for them to access psychological support or what other services are doing.*

Participant 6

CPs identified that sharing their knowledge in formulation with colleagues from different professions is an important part of their role, as it aims to increase the psychological understanding of service users' experiences:

> *Awareness of bigger systems and I think because [mental health services] are more medically orientated the medics and the nurses tend to see things very much as this is an event happening to an individual or this is the individual's experience of it they kind of place the issue inside the individual. And I think we can paint a bigger picture and we can think with our clients about how much of this is about the way the system's working at the moment having that kind of conversation and thinking about more systemic issues which may be other people can't deal with but it might be about some people end up homeless because their family situation.*

Participant 11

It was also identified that, despite Maslow's hierarchy of needs being used as a rationale to not offer individual therapy, it can be a useful tool when helping teams formulate their service users' difficulties. Furthermore, it can help other professionals recognise and understand the importance of housing in relation to mental health wellbeing and provision of psychological therapy, as illustrated below:

> *When I do my team formulations we start with Maslow hierarchy we do think about it in a basic way of how they got not just accommodation but steady accommodation that gives them peace of mind which is actually suitable to live in, those kind of things safety, security it always starts with the basics.*

Participant 3

3.3.2. Subtheme two: We Are Not Just Therapists

Most of the participants of this study identified that the role of CP is broad, '*we are not just therapists, but we can do much more than just direct work'* (Participant 6).

CPs can work with wider teams, systems and at a societal level through social action, advocacy and campaigning. Moreover, it was identified by the participants that CPs can work at a political level by influencing policies and the commissioning of services.

It was suggested by the participants that there are divisions between the profession as to the role of CPs, with some CPs maintaining that they wish to only be a therapist. This view was not shared by the participants in this study.

> *We still got a big group of people who will say 'yes I am just a one to one therapist and stop asking me to do all these other things'.*
>
> Participant 3

> *Split between the thinking of us as psychological therapists where our role is to offer psychological therapy compared to thinking of our role as inputting more widely and giving a psychological perspective in providing psychologically informed intervention. I think [if] you go more from a psychologically informed intervention approach then that is more likely to influence towards thinking there's more that we could be offering in terms of doing something helpful working with people working with teams.*
>
> Participant 8

CPs spoke about their role working and supporting teams and helping increase their understanding of homelessness.

> *Supporting the team to arrive at a formulation about why the person might have ended up there and I guess in doing that hopefully increase empathy for that person… reach some understanding about how things have happened*
>
> Participant 9

This can also be achieved by providing training provided by CPs, which aims at developing psychologically informed services:

> *Psychologically informed pathway there might be training as well, we do some trauma informed training. Trauma informed training brings into it lots of issues that relate to people who may be presenting with homelessness issues.*
>
> Participant 8

Furthermore, the participants of this study argued the importance of developing relationships with third-sector agencies and housing services working with homelessness.

> *Where the staff may not be trained to think psychologically and trying to understand why people behave the way they do and trying to make those links so we can get involved early enough before placements breakdown rather than trying to patch up placements that are already well gone in terms of their success.*
>
> Participant 3

All the participants valued the role they have working with wider teams, and they identified that working with wider teams could be more efficient compared to working with individuals, as the intervention can aim to be more preventative, rather than reactive.

> *One-to-one work I feel like I'm sort of ticking off one person at a time I could see one person and see 50 people this amount of time but if I can work with the staff team or if I can deliver training then that multiplies so it has a wider influence and then if I can influence even higher even if it's a local level whether it's supporting third sector providers or thinking about other public and non-public organisations to think about what kind of work they're doing and how we can help them to think about people.*
>
> Participant 6

CPs identified that they have an important role to play in conducting social research, which can develop the understanding of homelessness and those determinants that influence it. Furthermore, this research can support policy decision-making and the commissioning of services, through increasing awareness of the psychological impact of homelessness and adequately identifies the needs of the population.

> *Research into what the problems actually are what the indicators are of homelessness and what are we talking about when we are talking about homelessness. Are we talking about street homelessness are we talking about people that can't find a permanent address what are we really talking about here?*
>
> Participant 12

Most of the participants identified that it is CPs' role and duty to work with social issues such as homelessness. It was argued that identifying the need for societal change and raising awareness on the impact of social issues on psychological wellbeing is vital for those social issues to be addressed.

> *We are trained to be able to advocate for social change so if we find that difficult then we should do something about it because people that aren't accessing housing I mean is that really going to be their top priority and are they really gonna think that they're worth that for them to do that for themselves probably not. [referring to advocating for people who are homeless]*
>
> Participant 12

> *Role of psychology in terms of societal change and things like availability of housing and the benefits system and social class and a lot of those difficulties. Actually maybe psychology needs to get more involved in campaigning to address some of the underlying inequalities that lead to some people just living with very little money and housing being quite expensive especially in London.*
>
> Participant 10

> *When you work for that long and you see these issues in front of your face and you think who else is doing it like who else is doing the advocating*
>
> Participant 12

Moreover, it was argued that using the 'status' and 'title' that the profession offers can support any work done towards social change: the status inherent within the professional title opens up avenues for people to listen to CPs more and for CPs to be taken seriously in what they are advocating and campaigning for. Additionally, it was argued that a responsibility CPs hold is to address psychological distress. It was identified that CPs are well equipped to do so, as they have been armed with the necessary skill set which enables them to have a good systemic understanding of social issues; and to conduct the social research that provides the evidence to rightly argue for social change. Furthermore, it was identified that they have the skills and the status to communicate all the above with commissioners and public bodies, to influence the decisions about commissioning and policies that can impact people affected by homelessness.

Having an understanding of what happens to people and having an understanding of the way that their experiences in childhood and the trauma that they're left with then impacts on people's capacity to form and maintain relationships and it can be helpful for people who are making policies and making these decisions and making budget decisions and at council level or general level.

Participant 4

Advocating levels of social justice because we think a lot of the problems that we see are a consequence of lots of other events rather than an individualistic kind of this is an illness this is a problem… this is a social problem and I think that we are equipped very well to communicate with organizations like the government or politicians and with commissioners… we are of equal standing with them and so I do think it's our responsibility…we're in a very privileged position in terms of the service of our training and the knowledge that we have and the research skills that we have. I think we are in a very good position to advocate quite strongly for homelessness for any of the injustices that we'll see across our work.

Participant 12

To achieve the above, the need for a stronger political voice and presence of the professional group was argued. From the interviews, a lot of participants expressed their disappointment that the BPS has been traditionally apolitical, something that most of the participants disagreed with. Most of the participants argued that for social change to be achieved, an organised professional body would be necessary to advocate for such a social change.

What psychology could be doing as a profession we're not very well organised as a profession in terms of being able to have political influence… the BPS and psychologists for social change there are some sections that are trying to influence on those kinds of areas

Participant 8

Huge potential all the different levels so that's more in a kind of systemic teams type level actually what we need to see is much more on a political level. The BPS famously is not that political it would be lovely to have some strong leadership at a political level.

Participant 3

The importance of early intervention was raised as well:

> *Prevent homelessness from happening rather than trying to help people recover from the trauma of homelessness. We know there are some wounds that we can heal and there are some things that happened to homeless people that we are potentially never going to be able to undo that damage. So to prevent in the first place will be the way to go…That is kind of the key isn't it? Because we have the position that I've been so far describing it is always the firefighting end of it which is obviously ultimately not very effective because if there isn't enough houses to house people in the first place it's always going to be an issue with finding people the right housing. Or if there's people that the benefits system is failing people so badly that they can't pay their rent and they end up being evicted and all those kind of things.*
>
> Participant 3

3.3.3. Subtheme Three: Personal and Professional Experience

CPs argued that their views on homelessness and the possible role of CPs were shaped by their professional and personal experiences. The interviews demonstrated that the nature of the service in which the participants of the study were employed influenced their views on the role CPs have in working with homelessness, as well as on the services offered. Moreover, the type of support offered was dependent on the prevalence and type of homelessness in the service. For example, in Early Intervention Services, Inpatient Services and Assertive Outreach Services, it appeared that the prevalence of homelessness was much higher compared to other services. In those services, it was reported that homelessness might be conceptualised differently compared to other services, and CPs offer more direct work with people regardless of their housing status.

> *I work in two different services who would probably see the issue very differently in terms of how the services are set up and what we what we are set up to do*
>
> Participant 2

Participants identified that professional experience working with social issues shaped their attitudes towards homelessness. Having direct experience working with homelessness or other social issues appeared to have impacted on their attitudes towards homelessness. It seemingly shaped what they believed their roles were

when working, or not working, with homelessness, and also the type of support that should be provided to people experiencing such issues.

> *When I was in the assertive outreach team the client group was very complex and challenging there was much higher incidences of social issues such as homelessness. I think the way of working was a bit non-traditional, I would quite often do home visit, you had to think outside the box a lot more and it was a lot about the engagement with people. And I do think that that have probably shaped my views around working with people with quite severe social problems in terms probably being more embracing of it more willing than maybe some of my colleagues with another mental health teams.*
>
> Participant 5

> *Own experience of seeing and doing that kind of work… it exposes you to an understanding of how a system or how politics impact our clients and how it impacts all of us… you have a lived experience because that person who is there in front of you, you have to process it you have to deal with it somehow yourself.*
>
> Participant 11

Personal experiences witnessing adversities, working with them or as survivors of mental health difficulties, not only demonstrated that difficulties can be experienced by all but also demonstrated the influence they can have in shaping and influencing CPs' attitudes.

> *My personal life I have witnessed and been part of a psychiatric system and I can see how easy it is to come undone from a position of being okay and things going well to things being really pretty awful. And so when I follow people with work we can see where their life was and then how they ended up maybe in a state where they would be identified as a homeless person you can kind of empathize with that.*
>
> Participant 12

3.3.4. Subtheme Four: Personal and Professional Values

From the analysis of the interviews, it was identified that values play an important part in shaping CPs views on social issues, but also on their role in addressing and working with such issues. The values that CPs had which drove them to pursue a career in psychology were identified to be influencing their views on the role of a CP.

I think a lot of other people might have come into clinical psychology which is about wanting to be doing something that feels like it is making things better for people.

Participant 8

Furthermore, CPs expressed values around their sense of responsibility and duty to help people who are less fortunate and might be unable to fight or advocate for themselves due to their circumstances.

Caring about those people that everybody else doesn't care about. Fighting their corner so the people who don't have a voice and who are neglected

Participant 6

I identify as a Christian and so for me that is part of what I believe is that we have to do things to be able to support people that are in a worse off position

Participant 12

Additionally, the participants emphasised human rights, and the right of all people to have their basic needs met.

All people should have a right to have somewhere secure to live, their basic needs met, warmth, food and a home.

Participant 7

Political views have been identified by participants as important influencing factors on their views on homelessness, which can also influence the views they have about their professional role as a CP:

I have a personal view of the world that influences how I then approach these issues… I'm more to the left of the political spectrum and I also tend to think it's very hard not to be when you are confronted with so much evidence.

Participant 11

My political views influence my views on what I should do as a psychologist.

Participant 12

Finally, some CPs identified values that continue to influence their professional identity and their beliefs about what the role of CPs should be. It has been argued that CPs should have a role in addressing psychological distress regardless of where the causes are situated, whilst it is also argued that CPs need to do something to address both the distress and its causes.

> *In a position where you can see how privilege works and how all of those things work I think if you don't use this to try and make some kind of difference it's just not acceptable we've signed up to do this training to have this professional responsibility and actually is our duty in the same way with a nurse like it is their duty if they see someone having a heart attack in the street they have to go and help them even if they're not at work and I think sometimes as psychologists because we are not held accountable we don't have an agreement where if we see psychological distress we have to stand up and do something about it*
>
> Participant 12

3.3.5. Subtheme Five: Influence of Training

Finally, apart from personal and professional experiences and values, clinical training has been identified by the participants of this study to be influential in the development of CPs' professional identity. Clinical psychology training course orientation was identified as an important factor in shaping CPs' attitudes. This includes their understanding of psychological wellbeing and the impact social issues have on wellbeing. Clinical training was also identified to influence trainees' views on developing their understanding of their future role as CP and their identity as CPs:

> *Being trained to think quite holistically about people and think about complex social issues and how to address them in other ways other than just therapeutic work… [training and] community psychology and the role psychology can play on those levels, so I think some of it is definitely shaped by those sort of teachings and lectures*
>
> Participant 10

> *Drawing on the training of all the different levels in terms of thinking about our training both in terms of thinking about across the lifespan but also in terms of thinking about the various different influences on people ranging from both the individual what may be going on in terms of thinking about brains or minds or whatever but also thinking about the more social and political aspects.*

Participant 8

Training we know is hugely influential and the ideas that you give people on training will shape them as clinicians the difference between an a-political Manchester course and a credibly culturally informed UEL course got to see differences in the practitioners that come out with that I think it's at that really early steps and actually to argue it's earlier than that it is in your assistant psychologist position it's the way you talk about it on your undergraduate courses it is forming that identity at very young age and it then gets shaped further down the line and then I think it's finding ways to scale people up when they come out into those newly qualified roles where you're completely trying to find your feet as a clinician in general, how who helps you see what your role is. Actually, that was my first my first kind of insight as a newly qualified is this role is nothing like people told me it would be.

Participant 3

Training was identified by most participants as an important factor in supporting CPs practice. Training could include increasing the understanding of current provision and services available. Furthermore, practice could be enhanced through an increased understanding of homelessness and how to work psychologically with it.

Training or a way of discussing homelessness and how to work with people that are homeless

Participant 12

Specific teaching on the psychological work with homelessness

Participant 10

Though psychological knowledge is great sometimes we lack practical skills I think and that that would help sometimes

Participant 2

A different view on training was also raised, which argued that providing more training for CPs on homelessness, whether that is practical skills training or training in understanding homelessness better, might not be helpful. Arguably this is because the problem of homelessness is located in wider systemic factors that need to be addressed before any significant improvement on homelessness happens.

I wouldn't be looking for more training for psychologists to be doing that in doing that specific in my area I'm not saying I would be wanting is more resource going into housing and the availability of housing because I don't think it matters I mean it's great that you know how to write a letter to more successfully get your clients to get housing through council but the fact is if the council don't have enough housing somebody down the bottom there is still not getting housed they've been made homeless so it's needing more housing but that's what's needed

Participant 8

CHAPTER FOUR: DISCUSSION

This study attempted to investigate CPs perspectives towards homelessness, something which has not been previously attempted. The study assumed the importance of gaining a better understanding of CPs' views towards homelessness; the factors which influence them; and how their views influence their practice when working with homelessness.

This chapter will discuss the key findings of this study in light of the current literature and will answer the research questions as outlined in the *Introduction*. Furthermore, a critical appraisal of the study, including attempts to ensure the quality of the research, will be outlined. Finally, the implications that arise for clinical practice, for services, policymaking and future research, will be discussed.

4.1. Research Questions: The Findings in the Context of the Literature

4.1.1. What are Clinical Psychologists' Views Towards Homelessness?

The first theme identified was '*Homelessness is a complex social phenomenon'.* CPs demonstrated non-judgemental and non-blaming views towards homelessness, with all participants acknowledging the impact wider systemic and structural factors have in the development and maintenance of homelessness. It was recognised that homelessness is not just rooflessness - it can take several forms. Structural factors, such as the lack of adequate social housing and poverty, were identified as the main causes of homelessness. Individual factors were also identified, but those were understood within people's wider context and experiences. Causal attributions of homelessness were important to be considered, as the recommendations for interventions to address homelessness were based on CPs' attribution of the causes of homelessness. Similar to previous studies determining healthcare professionals' views on the causal attributions of homelessness were instrumental in deciding which interventions to offer (Brewin, 1984; Marteau & Riordan, 1992).

Participants in this study acknowledged that homelessness can happen to anyone, due to the current economic and welfare system, which leave people without a safety net and contributes to increased financial vulnerability. A different understanding of this was provided by Bramley and Fitzpatrick (2018) who argued the harmfulness of such narratives. They argued that narratives such as this promote the idea that everyone is 'two payslips away from homelessness' as dangerous and problematic. They argued that these understandings of homelessness promote narratives that the causes of homelessness cannot be understood, thus attempts to predict or prevent it are considered to be unsuccessful. The intentions behind these narratives were critiqued, arguing that they intend to cause distractions and ignore the true risk and vulnerability existing within structural inequalities embedded in society. These risks are known and preventable – with many studies demonstrating the nature of health exclusion for disadvantaged groups (Bramley et al., 2015; Luchenski et al., 2017; Mcdonagh, 2011), studies which can be used to guide policies and strategies to tackle them. For this to be achieved, it will need to be a collective attempt guided by the political will to address these inequalities.

The second theme identified by this study was: *'Homelessness is not for psychology'.* Through this study, it became evident that homelessness is not being discussed within psychology teams in secondary care mental health services, despite some discussions happening in wider services. This could be due to CPs conceptualising homelessness as a social issue rather than a psychological issue, thus individual interventions are rarely offered. This might demonstrate what the dominant narratives about what the role of psychology in services are and the influence these narratives have on the support being offered. It is important to note though that despite the majority of psychology teams not discussing homelessness, this is service dependent with some services discussing homelessness and its impact more than others. Services such as the Pathway Teams, Specialist Services working with homeless people, Triage teams utilising outreach models to support people affected by homelessness, as well as Early Intervention Services and inpatient services seem to be discussing homelessness more and mainstream this conversations with other service providers as well. This discrepancy between services raises questions as to what enables some services and CPs to discuss homelessness more than others while considerations need to be taken about

enabling and promoting these conversations to happen and become part of the mainstream support offered by services. This will enable conversations about the support that psychology teams and services can offer in implementing strategies which aim at addressing homelessness.

Through the interviews it was reported that homelessness is not for psychology, with a lot of CPs arguing that people who are homeless do not tend to prioritise their mental health needs when their basic needs are not met, as suggested by Timms and Balázs (1997). Maslow's hierarchy of needs was often cited as a justification for this, in which people with no stable or safe housing were not deemed to be able to engage therapeutically, at least not until their basic needs were adequately met. Maslow's hierarchy of needs (1943) suggested that there are four levels of needs: physiological needs (food and water); safety needs (feeling safe and secure including the presence of housing); love needs (affection, connection and belonging); and self-esteem. It was assumed that all levels of needs will need to be achieved fully and consecutively before progressing to the next level before self-actualisation is achieved. Self-actualisation was defined as 'to become everything that one is capable of becoming' (Maslow, 1943, pp.382) which is the way recovery is being conceptualised as helping people 'reach their full potential' (SAMHSA, 2012, pp.3). Contradicting his initial hypothesis that each level needs to be fully achieved before moving to the next level, Maslow later argued that the frustration of not having one's needs met can also lead to self-actualisation (Maslow, 1970). Thus, it was argued that unmet needs, such as housing or experiences of adversity, can result in self-actualisation. This was also supported by Henwood and colleagues (2015), who by interviewing participants entering different housing programmes (treatment-first model or housing-first model), aimed to understand how the housing programmes and their unmet needs could impact on self-actualisation. Their results demonstrated that self-actualisation was achieved when more basic needs were not met, supporting Maslow's later argument - that frustration of not having needs met might promote self-actualisation (Maslow, 1970). This contradicts the participants of this study's views that people whose basic need for housing is not met they cannot use therapy towards recovery. As a result, Maslow's hierarchy of needs should not be used as a way of excluding people from therapy, nor should be used as a way of not offering support in meeting peoples' basic needs.

The view that people whose basic needs such as housing are not met cannot engage in therapeutic work was also contradicted by the outcomes of St Mungo's LifeWorks project (St Mungo's, 2011) and Crisis Skylight mental health project (Pleace & Bretherton, 2013). The LifeWorks project at St Mungo's offered psychotherapy sessions for their service users, with 75% of attendants reporting improvements in their wellbeing (St Mungo's, 2011). The Crisis Skylight mental health project offered several mental health interventions, including counselling sessions (Pleace et al., 2013). The outcomes from these projects demonstrate homeless peoples' willingness to address their mental health needs, and their ability to attend psychology services, including individual sessions and/ or workshops, without having their housing needs fully met. This contradicts CPs' views described above and provides further support that that people affected by homelessness can engage in individual therapy and thus their housing status should not be used as a way of excluding them from certain forms of psychological support.

Finally, the last theme identified was '*Our role as Clinical Psychologists'.* The role of CPs was discussed by all participants, the majority of which maintained that CPs are not just therapists. Rather, they argued that CPs can also have an important role in working with teams and wider systems. It was indicated though, that this might not be shared by all CPs, with some participants reporting that some of their colleagues would prefer to only offer individual support and therapy, rather than offering systemic interventions. It appears that these views on the role CPs have vary between CPs and the opinions on this seem to be divided within the profession, with some arguing that CPs' role is solemnly in therapy rooms, whilst others argue that the role of CP is much wider. This study identified CPs' views that CPs have a duty of care for all people experiencing mental health difficulties and psychological distress, despite their difficulties being rooted in social issues or homelessness. This was also met with frustrations by some of the participants as to how they can support people through the social problems they are experiencing within their role as CPs, when this is not possible with how the services are structures and with the expectations on how CPs should work and demonstrate they work they do in services.

Moreover, it was identified that despite CPs not offering individual psychological therapy for people affected by homelessness, they identified having an important role in working indirectly with teams and wider systems when addressing homelessness. CP's identified that their skills in formulating and applying psychological knowledge to understand peoples' experiences as a core skill when working with homelessness (BPS, 2011). It was argued that CPs' holistic understanding of one's difficulties can promote a better understanding of peoples' experiences and causes of their distress. Rahim and Cooke (2020) argued that, through CPs' understanding of wider systems, they can better identify the root of peoples' psychological distress. Furthermore, the participants in this study argued that through systemic formulations, the impact of social issues on psychological distress can be better understood.

Practice guidelines for CPs, as set by the BPS (2017), guide psychologists' practices when working with people who are socially excluded, such as people affected by homelessness. CPs are encouraged to identify disadvantaged groups, ensuring their needs are addressed. It encourages CPs to identify wider structural inequalities and promote social inclusion. Moreover, CPs are encouraged to acknowledge and respect the diversity of the people they serve, through adapting their practice and recognising that social exclusion has its root in structural issues, which will need to be addressed. As CPs work closely with MDTs it was identified that a key role for them is to share their knowledge with teams and to influence practice and identify appropriate interventions (Tarrier & Calam, 2002). This will allow for awareness of the reality of homelessness to be promoted for all - including employers, policymakers and services users - on current policies and practices, and how resource distribution can be unfair, oppressive and harmful (BPS, 2017).

Most participants argued that CPs have a significant role to play in both social action and advocating for people affected by social issues and homelessness. Moreover, it was argued that CPs as a professional group, should have a stronger political voice, despite identifying that the BPS has traditionally maintained an apolitical stance. Something which all the participants, apart from one who had not discussed this issue, disagreed with. It has to be acknowledged though, that the BPS has been taking steps towards having a more active role in responding to governmental

strategies and initiatives. As seen in BPS' *Response to the Department of Health and Social Care Advancing our health: preventions in the 2020s* (British Psychological Society, 2019). Furthermore, the BPS policy team has expanded with three workstreams including the 'Psychological Workforce', 'Psychological Government' and the current Senate Campaign 'From poverty to flourishing'.

CPs' views on their role in social action demonstrated their willingness to have a clearer position on social issues and the factors that contribute to the maintenance of social inequalities, that consequently influence psychological wellbeing. This was further supported by the view that CPs' professional role and status enables them to use it – that allows them to raise issues that otherwise would not be raised, as they have a stronger positioning and stronger voice to advocate for social justice and social equality. By acknowledging the privileged position that their profession offers, a lot can be achieved through influencing practice, policies and service commissioning.

The two themes above, ' Homelessness is not for psychology' and 'Our role as Clinical Psychologists' are seemingly conflicting themes but the themes demonstrate a conflict within individuals and possibly a division within the profession about CPs role in addressing social issues, which might be considered to have not been caused by psychological distress but have a clear psychological manifestation. Despite CPs' initial reaction as 'homelessness is not for psychology' CPs were able to reflect on their practice and identified that they are already working with homelessness, despite not offering individual work rather working with teams and services through consultations and supporting teams understand social issues and their impact on psychological wellbeing. The two themes give a better understanding and an insight into the narratives held by psychology teams where the initial reaction to working with homelessness is 'we do not work with it', whilst after careful considerations, it is understood that 'we do work with it' in a different way than our 'traditional way of working' - that being offering individual therapy. This demonstrates that CPs can have a significant role to play in working with social issues and homelessness.

4.1.2. What Influences CPs' Views Towards Homelessness?

Similar to other healthcare professionals, CPs' attitudes are complex and influenced by several factors, such as their training, personal experiences (Servais & Saunders, 2007), and professional experiences: for example, working directly with homelessness (Glennerster et al., 2017; Masson et al., 2003), interactions with colleagues and supervisors (Masson et al., 2003), and personal values.

One of the most influential factors for CPs' views was their clinical training, with course orientation being recognised as a great influence on how trainee CPs began to conceptualise social problems and their possible impact on psychological distress. It has been argued that these conceptualisations also influence their views on the role of a CP, especially when dealing with social issues. The BPS (2019) through their report on *Standards for the accreditation of Doctoral programmes in clinical psychology*, acknowledged the differences between clinical programmes. They argued that differences can be found in the emphasis placed on their curriculum content, different therapeutic modalities, and the clinical groups they work with. Differences between clinical programmes were argued to promote diversity within the profession. However, despite these differences, clinical programmes need to provide training which is based on the commitment to promote psychological wellbeing while reducing psychological distress. They should aim at providing trainees with a holistic, integrative understanding of psychological theory, whilst providing varied practical experience that will demonstrate the 'foundation for the range of skills and knowledge demonstrated by the profession' (pp.21).

This study identified the large influence personal experiences have on CPs' attitudes. Personal experience within their families and background, as well as experience as mental health survivors, were identified to influence views. These experiences also influence CPs' values about their work and their role in working with people affected by homelessness.

CPs expressed that their values influence their views on homelessness, other social issues and their role as a CP. CPs spoke about their duty to care and protect, as well as their sense of responsibility for the people who are in less privileged positions,

people who experience social exclusion, and people who are marginalised by society. It was acknowledged that people experiencing social exclusion might not have the voice to advocate for their situation. But CPs, as argued above, have the status, training and skills to advocate for the people they are working for.

4.1.2.1. Does direct exposure to homelessness influence CPs views towards homelessness?

Professional experiences working with people affected by homelessness, or other social issues, also influence CPs' views on the issue as well as their practice. CPs with more direct experience working with homelessness reported that, through their experience, they gained a better understanding of the realities of homelessness. This influences their practice, as they can be more flexible and are often more open to working with people affected by social issues - when compared to other colleagues who might not be inclined to do so. Professional direct experience and exposure working with homelessness results in more favourable views, which influence CPs practice. This was similar to studies conducted with medical students and healthcare professionals, whose direct exposure working with the population predicted more positive attitudes towards homelessness (Buchanan et al., 2004; Glennester et al., 2017).

4.1.2.2. Do the views of peers and supervisors influence CPs views towards homelessness?

Previous research indicated that supervisors' and senior staff members' views can influence medical doctors' attitudes towards homelessness (Masson et al., 2003). In this study, participants reported that homelessness is not discussed amongst CPs. Only one CP reported that they discussed homelessness in supervision, with everyone else reporting that homelessness does not come up a lot with the people they work with, thus it is not discussed in supervision. This demonstrates how little homelessness is being considered or discussed in services, and more specifically amongst psychologists.

The work by distinguished CPs working with homelessness has been described as influential and inspiring for some of the participants. Their work was described to demonstrate the feasibility of working with parts of the population which have been considered difficult to work with, through adaptations of CPs' practices to accommodate the needs of the people they work with. Work done by other services in different areas of the country have not been widely known by professionals, but efforts have been made to share information and increase communication through social media, such as the monthly Twitter discussion #HomelessPsychology.

4.1.3. How do CPs' Views Towards Homelessness Influence Their Practice?

CPs' views towards homelessness impact significantly on their practice, with their practice being influenced on three levels: their work with individuals, their work with teams, and their work with wider systems.

As argued earlier, CPs maintained that homelessness is not for psychology, thus people affected by homelessness are not regularly seen or offered individual psychological therapy. This could be influenced by problems defining homelessness. It was noted that, despite the recognition that homelessness is broad and incorporates both visible and less visible forms when CPs were discussing the presentation of homelessness in mental health services and psychology teams, it was inconsistent in how homelessness was conceptualised. Discussing the presentation of homelessness in wider teams, it was reported that it presents in different forms, with street homelessness presenting less frequently. In psychology teams though, despite not being frequent, it was obvious that most CPs were conceptualising homelessness as street homelessness. This was more obvious whilst discussing the reasons why CPs do not work with people affected by homelessness. The main presentation CPs were referring to was street homelessness, despite all acknowledging that street homelessness does not present so frequently amongst their service users. This could reflect the generalised view of homelessness, which is predominantly conceptualised as street homelessness. Additionally, this discrepancy on what constitutes homelessness could be attributed to the lack of a clear statutory definition and typology in England, which could provide clear guidelines for service provision. Difficulties conceptualising

homelessness might also contribute to increased frustration and apprehension in working with it, as it is unclear as to how it will present, and what may be the best interventions to address it.

Consistent with research on attitudes and their influences on behaviour, it is evident that CPs' views towards homelessness influence their practice. It has been suggested that behaviours are determined by both subjective norms and intentions to act - with subjective norms defined as the social pressures to act in a certain way (Ajzen & Fishbein, 1980). Participants in this study discussed the role of CPs, how they currently practice and how they should and would like to practise, whilst several barriers have been identified that prevent them from practising the way they would like to. This is important to consider, particularly when attempting to understand the impact attitudes can have on CPs' practice. It appeared that a lot of participants had intentions to work in different ways, such as work more systemically and take social action. However, at the same time, there were no expectations from services to do this type of work - rather they were expected to offer more individual work (however, still not for people who were homeless). This gave rise to conflicting views on how they should practice and how they were expected to practice - which caused a lot of frustration on behalf of the participants, perhaps as a result of conflicting subjective norms and intentions to act.

Weiner (1985), through his Attribution Theory, argued that provision of help and support for a disadvantaged group can be influenced by causal attributions on locus, focus and control. This study identified that the CPs in this study held non-blaming attitudes towards homelessness. They all attributed homelessness to structural factors (locus) while recognising that people who are homeless often have little control over their situations (control), so can be assumed that they might also have little control over changing their circumstances (stability). This could have influenced the extent of support offered as the CPs in this study could have assumed that homelessness is a social issue caused by structural factors, such as lack of social housing and poverty, which people have no control over or could change. Thus, it could be hypothesised that this is another reason why support might not be offered, as homelessness is viewed as a social problem - not necessarily a psychological

problem. This is despite acknowledging the psychological manifestation that homelessness can result in.

CPs in this study identified that their role in working with homelessness is predominantly in working with wider teams, with the work focusing on providing supervision, consultations and training. Their work with wider teams aims at promoting PIE. These practices enable psychological thinking and understanding to be considered for service users, who might not be offered individual psychological therapy (McChesney, 1990). PIE was introduced to meet the psychological and emotional needs of service users (Johnson & Haig, 2010) in a flexible way, that empowers them to make the changes they want to make in their lives (Keats, Maguire, Johnson, & Cockersell, 2012). Keats and colleagues (2012) suggested that PIE should be developed through consultations with service users and staff. It was proposed that to develop a PIE, a psychological framework will need to be identified and followed, which will be embedded in service structure and commissioning. The necessary physical environments will need to be considered, to follow on from the psychological framework used. Training and support for staff incorporating reflective practice will be necessary. One of the most important components of building a PIE is building on therapeutic relationships between staff and service users, which promotes change and development. Finally, evaluating the work to identify shortcoming and improve the provision of services was identified as an important component of PIE (Keats et al., 2012).

CPs recognised that people who are homeless must have had experienced significant trauma in their life, while they acknowledged that homelessness can be a traumatic experience as well. It was also identified that people who experienced significant trauma can present with significant behavioural and emotional difficulties (Fitzpatrick, Johnsen, & White, 2011). Hopper and colleagues (2009) suggested that trauma-informed care constitutes of services which promote an understanding of trauma (its presentation and its effects), through training, supervision and consultation, with training being identified as particularly important in creating trauma-informed services (Dawn, Huntington, & D'Ambrosio, 2004). Recognising that trauma can result from individuals and systems abusing their power, while homelessness can leave people feeling unsafe, services will need to remain aware

of the power they hold and ensure collaborative care - which promotes both physical and emotional safety - to avoid re-traumatising people (Hopper et al., 2009). This was supported by people affected by homelessness, who reported that they require services that prevent re-victimization and empower people to regain their sense of identity (Padgett, Hawkins, Abrams, & Davis, 2006). This can be achieved through strength-based approaches rather than approaches that are based on deficits. This is particularly relevant for people who are homeless, as it may not be obvious or often recognised that by being able to survive a life of adversity, it can only make people more resilient to their experiences. Finally, it was suggested that integrated services which work holistically to meet the variety needs that people who are homeless present with, tend to have better outcomes than non-integrative services (Cocozza et al., 2005).

4.2. Critical Review and Reflections

4.2.1. Reflexivity

It has been theorised that research can be influenced by the researcher - both as an individual (personal reflexivity) and as a theorist (epistemological reflexivity). Reflexivity should therefore not only consider personal 'biases', but it should also include the researcher's views and responses to the research (Willig, 2013). To ensure the quality of this study, I attempted to remain reflexive throughout the project - from the initial stages of conceptualising the idea to the last stages of finalising the write-up of the study.

4.2.1.1. Personal reflexivity: By acknowledging that my attitudes towards the research could influence the research process, it was important to maintain an ongoing reflexive stance. This involved reflecting on my personal 'contributions' to the study: analysing my views and beliefs about homelessness, as well as my analytic process (Braun et al., 2006). This was following suggestions that qualitative researchers need to embrace and accept their active role and involvement in their research (Golafshani, 2003), as they are the main instruments conducting their

research (Patton, 1990). Efforts were made to remain aware of my assumptions, expectations, bias and possible 'overinvolvement' in the research process, and specifically the interviewing process. This was done through the use of a personal reflective log and discussions with my thesis supervisor and colleagues. My views on the role of CPs, and the nature of their work, was considered alongside my own experiences, political affiliations and epistemological perspective, as outlined in the *Methodology* chapter – *Relationship to the Research*.

4.2.1.2. Epistemological reflexivity: As outlined by Willig (2003), epistemological reflexivity involves reflecting and acknowledging the factors that influence the initial conceptualisation and development of the research questions (epistemological positioning of the research). Furthermore, how these research questions may influence or 'guide' the outcomes of the study. Similarly, it involves reflecting on how the methodology used for the analysis of the data influences the results, as well as considering how different methodologies could have resulted in different understandings and outcomes.

My epistemological perspective in conceptualising the world, and homelessness, in particular, influenced how the project was initially conceived and shaped the research questions asked. Guided by critical realism and the assumption that, despite the presence of an 'objective reality', there can be multiple perspectives (Healy et al., 2000) I was aware that the data collected might not be a true and accurate representation of reality. Rather it will need to be interpreted and filtered through the structures that impact on homelessness (Willig, 2013). This involved my own 'reality' engaging with other peoples' realities, resulting in an understanding of the results that can be unique in their interpretations. However, through constant reflexivity and guidance through supervision, I attempted to remain as 'critical' as possible and continually aware of the influence of personal reflexivity on the study.

4.2.2. Quality of Research

Lincoln and Guba (1985) suggested that for qualitative research to be 'trustworthy' its credibility, transferability, dependability and confirmability needs to be considered instead of reliability and validity. Credibility suggests that there is a good 'fit' between

participants' views and the representations of them as assumed by the researcher (Tobin & Begley, 2004). To achieve this, time was spent engaging with the data to ensure a good understanding of what was conveyed through the interviews. Furthermore, the analysis and the themes identified were shared with the thesis supervisor, and discussions around shaping and finalising themes were held before final themes were concluded.

Transferability refers to the generalisability of an inquiry (Nowell et al., 2017). For this to be achieved, the researcher is required to provide descriptions of their findings for them to be transferable and promote a better understanding of the phenomenon. Dependability assumes that the research process is documented and follows a logical and traceable route (Tobin & Begley, 2004). To achieve dependability the process needs to be monitored (Kiesler, 1991). During this study, the research process was discussed at length with the thesis supervisor. Furthermore, a reflections log was kept, in which all the steps of the research were clearly documented, as were reflections from the process - including the interviews.

Finally, confirmability addresses how the interpretations were reached, by checking that the research findings and interpretations were as a result of the data set. To achieve this, the researcher needs to demonstrate how their findings are reached (Tobin et al., 2004). Koch (1994) suggests that to ensure confirmability, the research needs to explain the reasons behind their choices for any 'theoretical, methodological or analytical' choices made - which are described at length under *Methods*.

4.2.3. Limitations of the Study

The study involved twelve CPs who were recruited through social media and snowballing techniques. This raises questions about the specific characteristics of the CPs who volunteered to participate in the study, with them possibly being particularly interested in social issues such as homelessness or having uniquely positive attitudes towards homelessness. Thus, any results from this study will need to be carefully considered, as they might not be representative of the majority of the profession.

Thematic analysis was used for the analysis of the interviews, with an inductive method of analysis being used. To ensure the reliability of coding, two independent coders are recommended to code the data (Terry et al., 2017), however, this was not possible for this study. To ensure the quality of the analysis though, the data was coded by the researcher with the thesis supervisor reviewing the coding during different stages of the study. Moreover, due to time constraints, feedback could not be gathered from the participants of the study about the themes identified, which could have helped validate the findings of the analysis.

4.2.4. Strengths of the Study

As far as we are aware, this study is the first of its kind. The study aimed at gaining a better understanding of CPs' views towards homelessness, what influences their views and the impact CPs' views can have on their practice. This study enabled participants to express their views on homelessness, something which is not traditionally considered in the remit of psychology. CPs had the opportunity to consider their role when working with social issues and in addressing the social determinants of health. This way, CPs were able to consider the wider role of a CP. Additionally, the study captured the impact Doctoral training has on CPs' attitudes, their practices, and the development of their professional identity.

This study included twelve participants with a wide range of professional experiences, ranging from newly qualified to some CPs with sixteen years of experience. The participants of the study worked in a variety of secondary care mental health services throughout the country, both in rural and urban areas. Overall, the participants provided a sample containing a wide breadth of knowledge and experience of CPs employed in secondary mental health services.

4.3. Implications of Research

4.3.1. Clinical Implications

CPs voiced that the prevalence of homelessness in services is service-dependent, but people affected by homelessness are not frequently seen by psychology teams and are rarely offered individual therapy. The rationale for this was Maslow's hierarchy of needs. CPs argued that when people's basic needs of stable and safe housing are not met, they will not be able to engage in psychological therapeutic work. Furthermore, participants theorised that homeless people would not prioritise their mental health needs before their housing needs.

However, the fact is that people affected by homelessness do not get adequate access to psychology teams. This could be due to psychology teams imposing exclusion criteria based on peoples' social circumstances, rather than offering support to people based on their psychological distress. This could also be due to service constraints, such as focusing on contact numbers or payment-by-results, which are both focused on individual work. These restrictions may inexplicably make services less inclusive or flexible for certain groups of the population that may be more complex and need more support to enable engagement. This can have detrimental effects on meeting marginalised groups' needs, and also raises questions on the focus of CPs' work and notions about suitability for psychological support. Not offering psychological support based on peoples' social circumstances essentially excludes a large proportion of the people that mental health services are supposed to be supporting. CPs will need to reconsider their role and practices when addressing social issues. If no individual psychological support is offered, then CPs' should consider ways of addressing peoples' social needs at a wider level.

While individual therapy can be helpful for psychological distress, it does not tackle the roots of the distress, which in many cases, is rooted in structural, social and historical systems (Rahim & Cooke, 2020). Ending homelessness not only requires intervention on existing homelessness but also requires preventative work on the social determinants of homelessness (Stafford et al., 2017). Luchenski and colleagues (2017) suggested that health inequalities experienced by disadvantaged

groups, including people who are homeless, are rooted in structural systemic disadvantages. CPs have the skills and qualifications to maintain an active role in the prevention of health disparities through social action (Harper, 2016). Rahim and colleagues (2020) proposed the question of: 'why are we offering individual therapy to casualties of a broken society rather than getting involved in the public health agenda?' (pp.83). It calls for CPs to fight for social change, which would help in the early prevention of psychological distress.

CPs should be encouraged to recognise that their work is political (Rahim et al., 2020). They should use their status and power to influence and promote social justice and address social determinants of health, thus consequently reduce psychological distress. A CP's role should be reconsidered and restructured to not only focus on working with individuals in clinical spaces. Rather for individual support to be offered reactively, CPs could promote proactive preventative interventions (Harper, 2016) that aim at targeting the social determinants of health that are rooted in social inequalities.

4.3.2. Implication for Services

CPs in this study identified that mainstream mental health services are struggling to accommodate homelessness despite being present in certain forms in services. This was service dependent and the aim and focus of the service influenced the type of support being offered. This could be due to the differences in commissioning of services indicating the differences in the aims of services and the populations they work with. Moreover, it was identified that mainstream services work with homelessness through care coordination. It has been argued though that due to austerity measures, budget cuts and reductions in staffing, have resulted in less provision whilst the inclusion criteria for care-coordination has increased and people have to reach a 'crisis' point before any support is offered. As suggested by Wright and Tompkins (2006) as long as community intervention are offered the type of intervention is not as important when working with homelessness. Services will need to identify ways of working with people who are homeless to provide support and reduce incidences of crisis which could be contributing to homelessness.

Hewett and Halligan (2010) argued that homeless peoples' needs are being discriminated against by a system which excludes people who do not fit their inclusion criteria. Improving access to services for all should be of primary importance for services. This could be achieved through consultations with experts-by-experience. CPs can work with experts-by-experience to co-develop accessible services, by attempting to understand better the barriers that services are posing to the population. Moreover, considerations about practices that make services accessible and how to provide interventions relevant to the population could be considered further.

Moreover, it has been suggested that people are being 'recycled' around services of which they do not fit the criteria set by services for their 'client groups' (Cornes et al., 2007). This is more prevalent for people with multiple co-morbidities like people who are homeless who present with a mixture of social needs alongside mental health, physical health and substance misuse needs (Stringfellow et al., 2015). Whilst services who are working to support people with one of those needs might not be able to offer any support due to the presence of the other needs. This raises questions as to the rigidness of the services' expectations about the presentations of their 'client groups' while it demonstrates the barriers that people with multiple and complex needs will need to overcome to get support. This suggests the need for joined-up services with better communication to tackle fragmentation of services. The Faculty for Homeless and Inclusion Heath with the Pathway Charity supported by several other professional organisations have developed standards for service providers to promote better inclusion in services for marginalised groups (Hewett, 2003). They recommend that support provided for these groups should be coordinated and include teams with expertise working with mental health, substance misuse, physical health, social care and housing.

CPs can have a leading role in services where they will promote awareness of how practices, policies and distribution of resources can become oppressive, unfair and harmful and strive to help employers, policy-makers and service users remain aware of that (British Psychological Society, 2008). While it has been identified that services can perpetuate traumatic experiences of homeless people and can make homelessness worse, services will need to reflect on their harmful practices and

should be striving to provide safe trauma-informed practices (Luchenski et al., 2017). Practices which exclude people from services might promote feelings of neglect due to the failure to meet their needs, with services colluding with this through practices that fail to make the necessary adjustments to increase accessibility for all (British Psychological Society, 2008). The role that services have in re-traumatising people will need to be acknowledged with services identifying ways to provide safe and appropriate services.

Summarising, this study identified that services through their practices can impose several barriers on the accessibility of services for people who are homeless. This was identified to be through their rigid accessibility criteria, fragmentation of services, and potential role in re-traumatising service users through their practices. Services should strive to create 'supportive, unbiased, open, honest and transparent services in inclusive spaces and places' (Luchenski et al., 2017, pp.8). CPs are well suited and trained to be able to conduct research, work with service users and services to help design accessible and relevant services.

4.3.3. Implications for Policies

CPs can have a significant role in developing policies that promote a psychological knowledge and understanding of social issues while taking steps to ensure that disadvantaged groups such as people affected by homelessness are not overlooked in policies and decisions about service provision and fund allocations. CPs can use their wider understanding of systems and their impact on psychological distress and can highlight the impact of social adversities and inequality to commissioners and people influencing policies. Through social research, CPs can provide the evidence needed to influence changes in practices that promote social inclusion and reduce the health inequalities experienced by marginalised groups. For this to be achieved, organisations and services within which CPs are employed will need to provide support and nurture CPs to be involved in this line of work (Browne, Zlotowitz, Alcock, & Barker, 2020).

4.3.4. Implications for Clinical Training

Feedback from participants of this study indicated that homelessness is largely absent from the clinical training curriculum. All participants but one reported having had no lectures or discussions about homelessness while training, even though it was acknowledged that there were some discussions about social issues. Even though CPs' interviewed were able to consider the causes and influencing factors for homelessness it was evident that they were not aware of the research on homelessness. This could be since homelessness is considered a social issue rather than something which is in the remit of CPs' work.

Clinical training should prepare future CPs in working holistically, integratively, considering all the factors influencing one's circumstances and guiding practice and interventions based on psychological knowledge (British Psychological Society, 2019b). Contrary to what it was suggested by our participants, clinical training should not only focus on working with individuals rather it should provide opportunities for trainees to learn about working with systems and develop leadership skills in consultancy, supervision and training (British Psychological Society, 2019b). Different clinical courses can develop their curriculum based on the values and ethos of the course, with possibly some programmes putting less weight on teaching about social issues or the role that CPs have in addressing and working with such issues. Participants in our study demonstrated a willingness to work with social issues in all capacities such as offering individual therapy, working with teams, developing services, influencing policies and working towards preventing homelessness. Feelings of frustration and hopelessness were shared as to not being knowledgeable enough on how to approach this work. Training courses should provide the appropriate teaching and training for future CPs to feel confident in working with social issues and people experiencing many exclusions and adversities, who is a large proportion of the people that NHS services and secondary care mental health services should be working with.

Through clinical placements, training courses could aim to provide trainees with a diverse experience working with populations which would not traditionally have worked with. This could be achieved by offering placements in a variety of settings

such as homeless shelters, the charity sector, public health placements or specific leadership placements. This could enable trainees to work more creatively and to identify different ways of working which might not be available in mainstream mental health services. Furthermore, opportunities to work outside the NHS could provide trainees with different challenges faced by those placements and learning ways to overcome them. Finally, community psychology placements where services are co-produced with marginalised populations can enable trainees to gain an invaluable understanding of how social issues and life adversities can impact on people and the challenges, they have to overcome to change their circumstances.

Educating healthcare professionals on social determinants of health can promote a better understanding of the factors influencing the development and maintenance of inequalities in health, to improve health outcomes and reduce health disparities (O'brien et al., 2014). Training courses will need to explicitly acknowledge the impact social and structural factors have in the development and perpetuation of social issues such as homelessness. It will need to be recognised that for interventions to be successful social reform is vital with CPs being skilled and suited to take social action to achieve that. Health professionals' training will need to prepare and enable them to recognise and address the social determinants of health and mental health (McNeil, Guirguis-Younger, Dilley, Turnbull, & Hwang, 2013). Sharma and colleagues (2018) when discussing training provided for medical students identified that approaches which emphasise on 'knowing *about* rather than knowing *how*' (pp.25) to intervene on social determinants maintain the current situation without promoting ideas of engaging in social action. Understanding homelessness without contextualising it within structural inequalities do not challenge or change the status quo. Despite CPs' training enabling them to understand social adversities and social issues and their psychological impact on people (Rahim & Cooke, 2020), this knowledge is not always used to challenge and change those adversities. This raises questions about the training provided for CPs and how clinical training not only should aim to provide information of how things are rather it should enable and support trainees to develop an awareness and the willingness needed to fight for social action and social equality. Training courses will need to identify ways to nurture ideas about being active in social action, advocacy and campaigning for social change.

4.3.5. Implications for Future Research

This study explored CPs' attitudes towards homelessness and included CPs working in secondary care mental health services. The perspectives of CPs working in other settings as well as other professionals' attitudes working in secondary mental health services could be explored further by future research. Moreover, service users' views about the help provided by NHS mental health services and NHS mental health professionals would be important to be considered for services to adapt their practice based on the needs of the population. Furthermore, the participants in this study predominantly had had positive views towards homelessness, conducting more interviews with CPs who might have different views could help better understand CPs' attitudes towards homelessness.

This study demonstrated that CPs are interested in taking an active role in understanding and targeting social issues such as homelessness. CPs were particularly interested in considering their role in preventing homelessness. Future studies could investigate the role CPs could have in the prevention of homelessness.

The participants of this study reported that they would like to work more systemically in services, but it was felt that this was not possible within the expectations of their role. Future research could consider how services can nurture CPs to work more systemically within services.

The study demonstrated the important role clinical training has in developing CPs views but also their identity as future psychologists and their role in addressing social issues. Future research could explore the effectiveness of current training on addressing social issues and how clinical training can prepare people better to work with them. Future research could also explore how CPs views develop through clinical training and the factors which influence them the most. Additionally, a comparison of CPs attitudes over the span of their professional life, how they change and what influences those changes could also be investigated.

4.4. Conclusions

No previous studies have been conducted investigating CPs' perspectives towards homelessness. Homelessness was attributed to structural causes with individual factors being recognised within the context in which they emerge. It was argued that homeless can happen to anyone with non-blaming attitudes being observed. It was also recognised that people who are homeless are not looked after by the society or services which could potentially hinder exiting homelessness.

It was argued that mainstream services struggle to accommodate for homelessness, while the prevalence of homelessness being service-dependent. CPs who participated in this study argued that homelessness is not for psychology and individual therapy is rarely offered for people who are affected by homelessness. This was justified with Maslow's hierarchy of needs (1943) with participants arguing that unless peoples' basic needs of housing are firstly met, they would be unable to engage in therapy. This contradicts previous studies which demonstrate that people who are homeless are willing and able to engage in therapy.

The role of CPs was also discussed in this study. CPs acknowledged their skills in formulation as a key skill which can increase understanding of homelessness and help teams and wider systems to increase their understanding of the phenomenon. Furthermore, the participants of this study argued that CPs are not just therapist, rather they can have a much wider role in consultation, service development, service provision, policymaking, advocacy, social action and raising awareness for social inequalities impacting on psychological distress.

Factors influencing CPs' attitudes were explored and it was identified that clinical training is a significant factor. Through clinical training, CPs develop their understanding of social issues and the role they could have in addressing and working with those. Furthermore, through training, CPs start developing their professional identity. Finally, experience working with people who are homeless as well as their personal experiences, values and the work of inspirational peers have been identified as factors influencing CPs' perspectives.

CPs have a role to play in addressing social issues and homelessness. The participants in this study reported that CPs have a significant role in addressing homelessness, but they were unsure about how to work with homelessness. This study identified that CPs can have a role in ending psychological distress rooted in health and social inequalities through social action and addressing health disparities. Furthermore, CPs will need to reconsider their views towards offering psychological support to people who are homeless in the light of evidence contradicting their views. Services will need to consider their role in developing more welcoming and inclusive services through improving accessibility and addressing the fragmentation of services. Clinical training will need to educate trainee CPs on the social determinants of health and help them develop skills to address them. This could be achieved by developing their skills in consultations, training, supervision and working with wider systems to prepare them adequately to work with social issues outside ‘therapy rooms’.

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APPENDIX A: Interview Schedule

Interview Schedule

Thank you for agreeing to take part in this interview. As you know, this research is focused on homelessness. For an hour or so we will discuss your views and experiences as a clinical psychologist working in secondary care adult mental health services. There are no right or wrong answers; this is just an opportunity to discuss your own personal experiences and views.

Opening question about homelessness:

1. Firstly, how would you define homelessness?

Knowledge and experience of working with homelessness

2. How often do you come across homelessness in your work?
    a. Could you provide some examples of how homelessness presents?
3. How often is homelessness being discussed in services?
4. What training, if any, have you had in relation to housing difficulties or homelessness?

Attitudes towards homelessness:

5. What do you think are the main causes of homelessness?
6. What views do other professionals in your service hold about homelessness?
7. What views have you come across amongst your peers and supervisors?

Role of Clinical Psychologists

8. What role do you think Clinical Psychologists have in supporting people who are homeless?
9. What influences your views on the role of Clinical Psychologist in supporting people who are homeless?
10. What role do you think Clinical Psychologists have in preventing homelessness?
11. What influences your views on the role of Clinical Psychologist in preventing homeless?
12. How do your views on homelessness influence your practice?

13. What if any would better support your practice?

Closing questions

14. Is there anything else you would like to add about this topic area?
15. Is there anything you would like to ask me?

Thank you for participating in the interview.

APPENDIX B: Participant Invitation Letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a Trainee Clinical Psychologist studying at the University of East London. As part of my Doctoral Studies I am conducting the study you are being invited to participate in.

What is the research?

This study aims to investigate Clinical Psychologists' views and experiences of homelessness in relation to their clinical practice. Developing a better understanding of clinical psychologists' attitudes towards homelessness and the factors influencing them could help to inform future training and the development of specific guidelines on addressing homelessness in clinical practice.

The present research has been approved by the School of Psychology Research Ethics Committee. This means that the research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking to involve Clinical Psychologists who have experience of working in secondary care adult mental health services.

Do I have to take part?

No. You are free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to take part, you will be asked to participate in an interview with myself. This will be an interview where you will be asked about your views and experiences of homelessness in relation to your clinical practice. The interview will last

approximately one hour. The interviews could be facilitated through Skype or could be held at the University of East London at the Stratford campus depending on your preference. The interviews will be recorded on encrypted audio-recording equipment and later transcribed.

I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop our knowledge and understanding of the research topic.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. Participants will not be identified by the data collected or in any write-up of the research. You do not have to answer all questions that are asked of you and you can stop participation at any time.

What will happen to the information that you provide?

All names and contact details will be stored separately from any data collected through the interviews. Transcript files will be recorded under a participant number, which you will be able to choose, if you wish. Data will be stored on an encrypted and password protected memory stick as well as a password-protected file that can only be accessed by the researcher. Participant numbers will be used to refer to participants throughout the study. Real names and any other identifiers will be omitted from the reporting of all data and transcripts. Audio files will be destroyed immediately after each file is transcribed. All study data will be kept for two years in order to submit future publications. All names and contact details of participants will be destroyed at the end of the study.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you wish to withdraw your data from the analysis you will have 3 weeks from the date of the interview to contact me with your request. After that time, I would reserve the right to use any anonymised information that you have provided.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Name: Elena Xenophontos

Email: u1725733@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: l.farquharson@uel.ac.uk

Or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: t.lomas@uel.ac.uk)

APPENDIX C: Demographics Form

Demographic Information

Date: _____

Please fill in the following information:

Gender: _____

Ethnicity:

____ Asian or Asian British

____ Black or Black British

____ Mixed or Multiple ethnic group

____ White or White British

____ Other

Age group (please tick):

_____ 25-34

_____ 35-44

_____ 45-54

_____ 55-65

Please describe the service you are currently working for.

_____

_____

How many years have you been qualified as a Clinical Psychologist? _____

APPENDIX D: Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw; the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

APPENDIX E: UEL Ethics Approval letter

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Katy Berg

SUPERVISOR: Lorna Farquharson

STUDENT: Elena Xenophontos

Course: Doctorate in Clinical Psychology

Title of proposed study: Clinical psychologists' attitudes towards homelessness

DECISION OPTIONS:

1. APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer)*:

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature)*: Student number: Date: *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

	HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

	MEDIUM (Please approve but with appropriate recommendations)
x	LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Katy Berg

Date: 10.6.2019

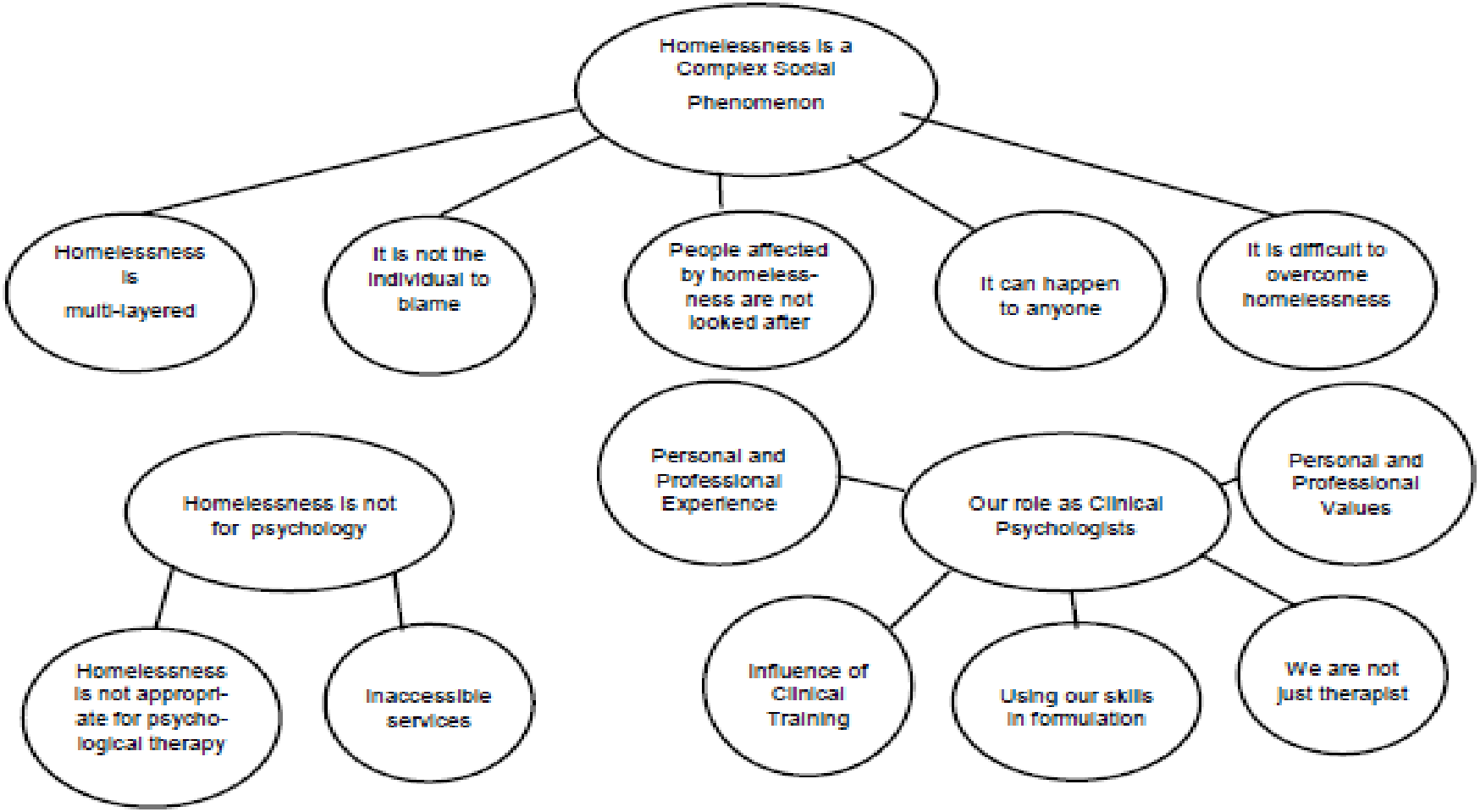
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

APPENDIX F: Thematic Map



APPENDIX G: Transcription Conventions

(Banister, Burman, Parker, Taylor, & Tindall, 1994, pp.64)

In order to improve readability of the quotes used to support analysis, minor changes were made.

Repetitive words or filler words (such as, ‘you know’, ‘sort of’) were removed for better readability and clarity.

Conventions added for presenting quotes from transcripts:

…	omitted words or sections
[text]	addition of content for clarity

APPENDIX H: Coded Transcript

	INITIAL CODES
Interviewer: What we are talking today is we have about an hour to discuss your views and experiences as a clinical psychologist working in secondary mental health care around homelessness so clearly there is no right or wrong answers we are not looking for experts in the area we are not looking for people who directly work with people who are homeless that we just want to capture what clinical psychologists actually think what is our role maybe in the prevention of homelessness and how does it affect our work So I guess my first question would be how would you define homelessness?	
Participant: Such a good question yeah I think yeah I think there are two strands I've come to when I think the first one I would say I think the general population's idea of homelessness is somebody on the street I think we know that really homelessness includes you know sofa surfing staying with extended family use of kind of state services where you don't have somewhere to go back to afterwards so I think I try and bear in mind a really broad definition of homelessness in that sense I also think the extra level so I work with older adults [Okay] and what we find is that we might have people who are in what they call things like insecure placements or being moved on placements and I would I'd consider them in that because actually if they leave those placements they have nowhere to go so they're kind of our sort of equivalent of unseen homelessness [Hmm absolutely] technically they have a roof over their heads but you know it's not secured	Two strands general population idea Street homelessness Multiple forms Sofa surfing Staying with extended family Use of state services No stability Temporary Broad definition Extra level Population- depended (older adults) Insecure placements No alternative Unseen homelessness Homeless with a house Insecurity

Interviewer: Hmm you actually see at work actually in a very broader way it's not about who live in the street people who don't have a roof over their head but actually it's the security of of the housing [yes] and how often would you say you come across homelessness in your work?

Participant: Interesting one so yeah so again now that I've moved to older adults probably less frequently than when I was working with working age adults but again [okay] with our older adults it's more that they're in these insecure placements they're attending appointments from you know somewhere that wouldn't be seen as as as a home

Service-dependent
Not often in older adult services
Population- dependent
Insecure placements

Not viewed as a home

Interviewer: Sorry I was just gonna say it seems like there's a different face with em homelessness in older adults

Participant: Yeah okay yeah that's probably the argument there if what I see is a bit of a biased population because actually people that are out on the streets probably don't make it to CMHTs potentially

Street-homeless don't make it to CMHT

Interviewer: So can I ask where did you work before before you you worked in older adults

Participant: Yes so I worked in neurorehab so working with people with brain injuries where homelessness was a massive problem that wasn't technically the CMHT setting there so I don't want to vary too much into that if that's not helpful for your work [yeah yeah okay okay fair enough]

Brain injuries prominent in homelessness

Interviewer: And so could you provide so I guess you you you provided some examples of how homelessness presents and but is there any could you provide a bit more information about how homelessness presents in older adults for example or in your work

Participant: Yes like I said we we see people a lot when they're at the point of leaving what's being their long term home [Okay] actually needing to move into care and that could be due to kind of physical health like things like dementia so in my CMHT cause we're linked with a memory assessment service we see people with long standing mental health needs but also with dementia [Yeah] and so yeah we see that side of thing and then like I said placement breakdowns so usually when they leave a placement without an alternative no support through transition people's behaviour isn't understood and is seen as too challenging for their providers to handle basically and we see that as well where they're kind of they're told they have to leave a placement but there isn't an alternative [Okay] and who supports through that transition who is responsible to support people through moving

Changes in circumstance
Moving into care

Physical health
Dementia

Long-term mental health needs

Placement breakdowns
No alternatives
Lack of support through transition
Behaviour not understood

Too challenging for providers to handle

No support through transition

Nobody takes responsibility