

**Preventing Homelessness: Exploring the Role of Clinical Psychology in
Adult Mental Health Services**

Hanna Yousefzadeh

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ABSTRACT

Aims: With homelessness rates continuing to rise, the government have attempted to address this issue over recent years by turning to public authority employees to take preventative action to those faced with threat of homelessness. How clinical psychology can contribute to the reduction of homelessness in adult mental health services is yet to be explored. This study aimed to better understand the role of clinical psychologists working in adult mental health services to prevent homelessness. Secondly, this study aimed to understand the facilitators and barriers that may get in the way of the profession contributing to the prevention of homelessness.

Method: Twelve clinical psychologists working within adult mental health services in the UK participated in individual semi-structured interviews. Thematic analysis was used to identify the participants' ideas on the role of clinical psychology in the prevention of homelessness within adult mental health services.

Results: Three themes were identified through thematic analysis; (1) 'Understanding Homelessness' describing how clinical psychologists define and understand homelessness in addition to what influences their understanding. (2) 'System Structures' describing NHS structures which may create barriers to prevention, how clinical psychologists have learnt from other organisations and professions and the role of professional bodies, and (3) 'Clinical Psychologists' Skills and Relevance' describing the skills clinical psychologists have to prevent homelessness in the profession before considering reasons why it may not be appropriate for clinical psychologists to intervene in this social issue.

Conclusion: This study reviewed the role of clinical psychology in the prevention of homelessness from the perspective of clinical psychologists working in adult mental health services. Clinical psychologists can intervene at an individual, service and political level to prevent homelessness. The profession is encouraged to work at all levels to address the distress caused by social issues that perpetuate homelessness.

LIST OF ABBREVIATIONS

ACP-UK	Association of Clinical Psychologists UK
ADHD	Attention Deficit Hyperactivity Disorder
BPS	British Psychological Society
CHAIN	Combined Homelessness and information network
CP	Clinical Psychologist
CMHT	Community Mental Health Team
DNA	Did Not Attend
HCPC	Health and Care Professions Council
IAPT	Increasing Access to Psychological Therapies
LGBT	Lesbian, Bisexual, Gay, Transgender
MHCLG	Ministry of Housing, Communities and Local Government
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
SHRIE	Strategic Review of Health Inequalities in England
SU	Service User
UK	United Kingdom

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CHAPTER ONE: INTRODUCTION

Homelessness in the United Kingdom (UK) has exponentially increased since 2010 (The Ministry of Housing, Communities and Local Government [MHCLG], 2020). In recent years, the government has attempted to address this issue with the introduction of The Homelessness Reduction Act (2017) and The Rough Sleeping Strategy (MHCLG, 2018). Research has identified there are individual and systemic risk factors which can make an individual more vulnerable to homelessness which include but are not limited to; poverty (Bramley & Fitzpatrick, 2018), brain injury (Norman, 2016; Oddy et al., 2012), care leavers (Gill & Daw, 2017), cognitive impairment including learning disabilities (Oakes & Davies, 2008; Van Straaten et al., 2017) and those from the Lesbian, Gay, Bisexual, Transgender (LGBT) community (MHCLG, 2018). These individuals may come into contact with mental health services and the clinical psychology profession throughout their lifetime, placing the profession in a favourable position to intervene prior to an individual becoming homeless. There is very little research exploring the role of clinical psychologists (CP) in the prevention of homelessness; what is currently being practiced and what more can be done by the profession. If the issue of homelessness is to be addressed, the role of clinical psychology in the prevention of homelessness must be better understood. This chapter provides a narrative literature review, presenting a broad introduction into the general topic of homelessness, offering a summary of the history of housing policy, outlining definitions, what contributes to homelessness and the implications of homelessness. This chapter will then narrow the focus to understand homelessness prevention and share relevant policies and frameworks. To conclude, the rationale and the aims of this research will be presented, and the research questions clarified.

1.1. Literature Search

A literature search was conducted utilising electronic databases including Google Scholar, EBSCO and PsycINFO. Key words used in these searches included 'Clinical Psychology', 'CP', 'homelessness prevention', 'mental health',

'Psychology'. The abstracts of the retrieved papers were then reviewed to identify papers that were relevant to the role of CPs in the prevention of homelessness. Reference lists were also used to identify further literature that could be helpful for this research. Publications posted on the British Psychological Society (BPS) website were also screened along with searches across third-sector organisation websites and government websites for relevant articles, policies and procedures related to both homelessness and homelessness prevention within the UK. This literature search has been rooted in this chapter.

1.2. A Brief History of Housing Policy in the UK From the Late Twentieth Century to the Early Twenty First Century

Following the First World War, there was a housing shortage due to the pause in residential building during the war, a growing birth rate and the return of soldiers (Keohane and Broughton, 2013). A house-building programme was seen as a way to help increase employment whilst also meeting the demand for housing (Malpass, 2003). Due to the economy, private developers were not able to meet the housing demand. In response to this, the government introduced the "homes fit for heroes" Addison Act which gave local authorities responsibility and subsidies to build homes (Keohane & Broughton, 2013). This was the beginning of a programme of building that spanned to the late 20th century (Shelter, 2021).

After the Second World War, demand for social housing increased again as a result of rented slums, the damage of war and the return of soldiers, in addition to the role housing programmes played to provide employment (Keohane & Broughton, 2013). In 1943, a target of 1.25 million building jobs over three years and a commitment to building 3-4 million homes was agreed (Malpass, 2003). The development of social housing provided long-term tenancy stability and low rent to millions (Shelter, 2021). For 35 years after the Second World War, 4.4 million social homes were built by local authorities and housing associations (Shelter, 2021).

Under Thatcher's government in 1980, the Right to Buy policy was introduced which drastically shifted social housing policy. This meant tenants were offered

the opportunity to buy social homes for at least 33% less than the market value (Lund, 2006). At the same time, mortgage tax relief provided a subsidy to those who took out secured loans to buy property (Keohane & Broughton, 2013). New restrictions were placed on Local authorities to build and manage social housing and the number of social builds had halved within three years. The deregulation of financial services increased competition and choice in mortgage provision, further facilitating home ownership and boosting house prices (Watson, 2008). The 1980s also saw the deregulation of rent in the private rented sector and the social rented sector, allowing costs to increase. This was to move rental prices closer to that which would be seen in a healthy economic market, and therefore to encourage supply to respond to higher levels of demand. It was expected that those who could not afford market rent would receive benefits to subsidise costs (Keohane & Broughton, 2013). The Housing Act 1988 was then introduced to try to return to social housing (Shelter, 2021). This was led by housing associations rather than councils and received private finance support.

Following the increase in house prices in 1997 – 2003, there were growing concerns around affordability and lack of housing supply (Keohane & Broughton, 2013). Inflexibility in wage policy may have motivated policy makers to use housing policy to offset the difficulties created by regulated wages. National public sector pay settlements have meant less flexibility for wages to rise in response to higher housing costs for workers. In the 2000s, affordability of housing for public sector workers began to be a concern. The government introduced the Starter Home Initiative in 2001 which was designed to support key workers to buy homes in areas they were usually priced out of. This was replaced by the Key Worker Living Scheme in 2004. It is likely there was a political driver for this scheme too, wanting to appeal to certain members of the public sector workforce who were facing affordability problems due to the mismatch between wages and housing costs. This was another example of where housing has been used as a tool to boost the macro-economy.

The potential impact of house building on employment and growth has been recognised by governments at different points in more recent times as already mentioned. The most recent example was the period that followed the 2007 -

2008 financial crisis and subsequent recession. Again, the boost of the construction industry was expected to improve the economy in the short-term.

In the early 2000s, the Labour government intended to increase housing supply towards the middle and end of their term in office. The “Sustainable Communities: Homes for all” introduced in 2004 included targets for an extra 200,000 homes in London and the South East to be built by 2016 on top of those previously planned in 2001 (Office for the Deputy Prime Minister, 2005). In 2007, “Homes for the Future: More Affordable, More Sustainable” was introduced and further increased the target to 240,000 homes per year by 2016 and 70,000 affordable homes a year by 2010 - 2011 (Lund, 2006). However, there was a loss of 30,000 private sector completions between 2007 and 2008 during the UK financial crash. In response, the government brought forward planned social housing construction and by 2009, public sector completions had grown by 25% compared to 2007 (Lund, 2006). By the time Labour left office in 2010, building completions were at the lowest levels since the end of the Second World War.

In 2010, the coalition government came into office and capital spending on social housing was cut. This was accompanied with an “affordable rent model” which required housing associations to offer tenancies at rates closer to market rent levels. This enabled money to be raised and reinvested into new social housing development. As affordability continued to be an on-going problem, the government introduced schemes such as Help to Buy whereby the government loaned money to homebuyers and was another way to increase new supply and contribute to economic growth (HM Treasury, 2013). Since the introduction of the Housing Act (1988), housing associations have been mostly responsible for the provision of new social housing builds, although in the these are currently at a very low rate. Due to limited resources, this supply has fallen short of the demand and currently, there are approximately one and a half million fewer social homes available than there were in 1980 (Shelter, 2021).

Since 2010 the government have focussed on reducing the UK’s budget deficit, reducing welfare dependency and incentivising paid employment. This has contributed to political, policy and social debates which have stigmatised those

who receive benefits, blaming individuals for their circumstances and ignoring the structural factors which have contributed to their situation. Since the Conservative government came into office in 2015, a number of reforms have been introduced impacting upon the benefits system. These include changes to the remit of housing benefit, the introduction of the 'bedroom tax' whereby money has to be paid by social housing tenants for additional bedrooms, a new cap on the total payments received per household, 10% reduction on council tax support, the replacement of Disability Living Allowance to Personal Independence Payment which includes more regular medical tests, the removal of Employment and Support Allowance, reductions in both Child and Working Tax Credit payments including the required number of work hours increasing. The working-age benefits system has undergone a further reform which has resulted in benefits and tax credits currently being replaced by Universal Credit. This transition should be completed by 2024 (Office for Budget Responsibility, 2019). Those who fall within the lowest 10% income of the UK population will on average lose the most from the transition to Universal Credit with a 1.9% fall in their income, equivalent to £150 per year per adult. 77% of those who are most financially affected by University Credit fall under one of the following groups: those with financial assets; the low-earning self-employed; couples where one member is above state pension age and the other below; and some claimants of disability benefits. Due to unregulated rent prices, government funding has had to be allocated to provide housing benefit to help families cover the cost of unaffordable private rentals instead of investing in new low rental social housing builds (Shelter, 2021).

1.3. Understanding Homelessness

1.3.1. Defining Homelessness

Section 175 of the Housing Act (1996) outlines a range of circumstances which would deem someone homeless. These circumstances include: an individual or a household who do not occupy accommodation or who do not have the legal right to occupy the accommodation they are staying in, an individual or household who have access to accommodation however there is no secure access to it or if the

accommodation is moveable and there is no place the individual or household has been allowed to settle and reside in it, an individual or household has accommodation however it is unreasonable to continue to reside in it, for example due to risk of domestic violence, or an individual or household is threatened with homelessness and likely to become homeless within 56 days.

This definition encompasses those who are 'street homeless', those who have sought refuge from domestic violence, those referred to as 'hidden homeless' who rely on friends and family for accommodation and people who live in hostels or shelters (Housing Act 1996). Despite the legal definition, there are discrepancies about who else is considered homeless. This can be centred around those who are refugees, asylum seekers, those in transitional accommodation such as care leavers and people in hospitals with no other accommodation. Tenants who are faced with no-fault eviction notices are also not encapsulated within this definition. This disparity in who is considered to be homeless could lead to further barriers which perpetuate homelessness (MHCLG, 2018).

1.3.2. Scale of the Issue

The government's austerity initiative has seen a 141 percent increase in the number of people who slept rough on a typical night in Autumn 2019 compared to 2010, despite this including a ten percent reduction on the average number of people sleeping rough since a peak in 2017 (MHCLG, 2020). The National Housing Federation (2019) summarise there are currently approximately 250,000 households and 400,000 people either homeless or at risk of homelessness in England. The Rough Sleeping Strategy (MHCLG, 2018) reports the largest increase in rough sleeping since 2010 can be observed in urban areas although numbers have also increased in rural areas. In autumn 2017, for every 10,000 households the rate of people sleeping rough was 3.1 for London and 1.8 for the rest of England, averaging 2.0 across England overall. It is important to hold in mind this shows a snapshot of this issue but does not capture the context, with some people being first time street homeless, others who are street homeless all year round and others who are intermittently street homeless which affects the accuracy of these rates.

There is a higher migrant street homeless population in London than the rest of England with people originating from EU countries accounting for 30 percent of the people sleeping rough in London compared to 12 percent in the rest of England (MHCLG, 2018). The migrant homeless population is generally understood to have less support needs such as substance abuse and mental health difficulties but face accommodation, employment, language difficulties and lack of knowledge of UK systems instead (Spencer et al., 2007).

It is also important to consider the 'hidden homeless' who do not have a place of their own, are not receiving support and are hidden from official statistics (London Assembly Housing Committee [LAHC], 2017). The LAHC (2017) estimate there are thirteen times more homeless people in London that are hidden homeless, suggesting homelessness is an even greater issue than statistics reflect.

Insecurity of housing is of concern for many who rent contributing to both physical and mental health difficulties (Marmot et al., 2020). The MHCLG (2018) noted the least reliable form of housing is private rentals as landlords can evict and refuse rentals, affecting the mental health and wellbeing of tenants. Marmot et al. (2020) identified rates of people renting from the private sector made homeless has quadrupled between 2010 and 2017 (Fitzpatrick et al., 2018) and one of the biggest contributors to homelessness is the loss of private tenancy.

As alluded to in the above reports, the number of homeless people is difficult to quantify due to the varying methods used to monitor the scale of this issue. This leads to discrepancies within reporting. Another consideration is that many who are homeless are not reflected in any of these statistics unless they come into contact with certain government agencies or services, particularly those who are hidden homeless or living in poor conditioned homes.

Sanders and Albanese (2016) highlight the frequency of violence and theft that people sleeping rough are subject to. They established from a survey of 458 homeless people who were street homeless in the past 12 months, one in three people reported that they had been intentionally hit, kicked or violently harmed

and experiences of personal belongings being stolen was reported by more than half of the people surveyed. These experiences can contribute to poor physical wellbeing due to injury and poor mental wellbeing due to trauma and feelings of vulnerability.

1.3.2.1. The Impact of the Coronavirus Pandemic on Homelessness. At the start of 2020 the UK became more affected by the global coronavirus pandemic. It was recognised that those who were street homeless were vulnerable to coronavirus as they are more likely to have underlying health conditions than the wider population and were more likely to face difficulties to follow advice on self-isolation, social distancing and hygiene and to access public health information and healthcare (Cromarty, 2021). Cromarty (2021) also recognised facilities such as day centres, hostels and night shelters increased the risk of transmitting coronavirus.

Since the global COVID-19 pandemic, Pennington and Rich (2020) identified over 250,000 people were living in temporary accommodation during the initial period of the national lockdown. This is the highest number of people in temporary accommodation in 14 years and almost double a decade ago. It is estimated 17 percent of homeless households are in emergency bed and breakfasts (B&Bs) and hostels which are often in poor condition and overcrowded (Pennington & Rich, 2020).

In March 2020, the Government introduced the 'Everyone In' initiative where they asked local authorities in England to ensure that people sleeping rough and in accommodation such as shelters or assessment centres where it was difficult to self-isolate were safely accommodated to protect them, and the rest of the general public, from coronavirus. In order to meet this request, local authorities booked hotel rooms and other en-suite accommodation such as B&Bs, student accommodation and holiday rentals. They also worked with other organisations to arrange food, medical care and support to those accommodated (Cromarty, 2021). By November, this initiative had supported approximately 33,000 people who were either sleeping rough or at risk of sleeping rough (MHCLG, 2021).

The use of emergency B&Bs alone has increased by 371 percent over the last ten years. It is important to also acknowledge that this number does not account for the people who are sleeping rough, sofa surfing and those helped by councils through the government's 'Everyone In' initiative (Pennington & Rich, 2020). This would suggest that the 'Everyone In' initiative has been successful to reduce street homelessness, however other forms of homelessness including temporary accommodation has increased.

1.3.3. Risk Factors

Research has identified there can be a number of risk factors that may predispose people to homelessness. These risk factors can be categorised into individual and structural risk factors.

1.3.3.1. Individual risk factors. Individual risk factors encompass the personal circumstances which influence vulnerability to homelessness. These include those with experiences of trauma (Seager, 2011), particularly childhood trauma (Fitzpatrick et al., 2013), learning disabilities (Oakes & Davies, 2008; Van Straaten et al., 2017), brain injury (Norman, 2016; Oddy et al., 2012) and those transitioning from care or prison (Gill & Daw, 2017, Hewson, 2016). People who have been involved in institutional systems such as prison, the care system or the armed forces are more likely to sleep rough (Hewson, 2016). Data indicates that of people sleeping rough in London, 11 percent were within the care system during childhood, 36 percent had served custodial sentences and three percent had previously been in the UK armed forces (CHAIN, 2020).

1.3.3.2. Structural risk factors. Structural factors are societal, systemic and economic issues which impact someone's opportunities, environments and outcomes (Gaetz & DeJ, 2017), locating the reasons for homelessness within external factors to the individual. Examples of these factors include poverty (Fitzpatrick & Bradley, 2018), benefit changes (Marmot et al., 2020; McNeil et al., 2019), affordable housing (McGuinness, 2019), housing conditions, (Gibson et al., 2011; Krieger, 2002; Thomson et al., 2013) and social inequality (Gulliver, 2016; Homeless Link, 2018; MHCLG, 2018; MHCLG, 2020; Strategic Review of Health

Inequalities in England post-2010 [SRHIE], 2010) which will be outlined within this section.

Fitzpatrick and Bradley (2018) highlight poverty, particularly childhood poverty, as one of the greatest influential predictors of homelessness of all forms. Murali and Oyeboode (2004) outline poverty as the inability for an individual to satisfy basic needs, have a lack of control over resources, receive a lack of education and poor health. Townsend (1979) argues that it is important to differentiate between absolute and relative poverty, stating there are countries where people generally have sufficient resources, yet many are in disadvantageous situations with poor housing, diet and amenities that do not meet the standards of the wider society they live in, experiencing relative poverty. It is relative poverty many will experience in the UK.

Ali and Lees (2013) pose the need for CPs to acknowledge social factors, particularly poverty, to create positive change within psychological interventions. Ali and Lees (2013) emphasise the importance of attending to the emotional needs of those affected by poverty to engage in social justice. This includes acknowledging the link between someone's immediate setting, community, and psychological wellbeing. To support this, there is a vast range of research which concludes people in poverty face negative implications to both their physical and mental health (Astbury, 2010; Belle & Doucet, 2003; Lorant et al., 2003). Poverty can be isolating and distressing with direct and indirect effects on emotional, behavioural and psychiatric problems (Murali & Oyeboode, 2004). However, Bullock (2004) suggests clinicians often do not feel skilled to work therapeutically with clients experiencing poverty because they don't understand the economic constraints people in poverty experience. These clinicians can feel frustrated with the unpredictable nature of these service users' (SU)s' immediate environments. Fahmy et al. (2016) propose an interrelationship between poverty and domestic violence. As aforementioned, domestic violence falls within the Housing Act's (1996, Section 175) definition of homelessness. Research has also identified important social relationships such as family can be a vital protective factor against homelessness (Johnson et al., 2015; Lemos, 2000; Tabner, 2010),

however these relationships can also be strained by the adversities associated with poverty (Johnsen & Watts, 2014; Pinderhughes et al., 2007).

Research has acknowledged the impact of changes to the benefits system made in 2010. These changes included the introduction of Universal Credit, a freeze in benefits and tax credit changes, affecting low- and middle-income households, penalising the poorest the most (Marmot et al., 2020; McNeil et al., 2019). Consequently, this has increased poverty, debt, stress and anxiety for many households (Marmot et al., 2020) placing those affected at higher risk of homelessness. Between 2008 and 2016, social renting costs increased by 40 percent in England (Office for National Statistics (ONS), 2017), forcing many into poverty, or further poverty and 35 percent of privately renting households living in poverty due to housing costs in 2017/18 (McGuinness, 2019) further deteriorating mental and physical health (Marmot et al., 2020). The European Typology on Homelessness and Housing Exclusion (ETHOS), considers problems paying rent or mortgage bills risking threat of eviction is the main form of housing insecurity.

As mentioned within *A Brief History of Housing Policy in the UK in the Late Twentieth and Early Twenty First Century*, there is currently a small supply of social housing due to the lack of public investment, low support through the planning system and the increased costs of land and development.

Consequently, families are living in overcrowded, temporary accommodation or unsuitable private rentals yet many are fearful to raise concerns about the conditions of their accommodation in case they are faced with eviction. Whilst those who have received social housing may have been moved out of area from social support or felt they had to accept properties which do not meet their needs (Shelter, 2021).

1.3.4.1. Social inequality. Social inequality is the unequal access and distribution of societal resources, services and positions (Kerbo, 2003). This inequality consequently influences opportunities for education, employment and overall quality of life (Warwick-Booth, 2019). Social stratification across age, gender, 'class', religion, 'race', ethnicity, sexual orientation and physical and mental health have developed socially constructed hierarchies which lead to

disproportionate access to resources (McLeod, 2013). It is also vital to acknowledge the social oppression and inequalities that result from the intersection of multiple facets of an individual's identity in relation to these socially constructed 'categories' (Hopkins, 2017). Within this section, research will outline the impact that social inequalities including 'race', ethnicity, sexual orientation, gender, age and health will have on housing and risk of homelessness.

The Marmot Review (SRHIE, 2010) identified the people most at risk of eviction threat among disadvantaged groups are those who are perceived to be less educated, unemployed, receiving lower incomes or from a minoritised ethnic background (Alley et al., 2011; Burgard et al., 2012; Cannuscio et al., 2012; Pollack and Lynch, 2009; Rojas and Stenberg, 2015).

Four in ten private landlords reported they excluded people in receipt of housing benefit from renting during a survey in 2017, with another 18 percent stating they would choose not to rent to those receiving housing benefit but would if they had to (Shelter and Federal Housing Association, 2017). Shelter (2018) report women and people with disability are disproportionately affected by the discrimination against those who receive housing benefit as they are more likely to be in receipt of housing benefit in the privately rented accommodation than men and people that do not have a disability. This evidence demonstrates how social inequalities are central to the process of eviction, contributing to health inequalities within the population (SRHIE, 2010) with housing being a mediating factor to ill health (Marmot et al., 2008; Navarro and Benach, 1996; Rose and Marmot, 1981).

A number of pieces of research recognise the association between homelessness and a range of disabilities including cognitive and neurological impairments (Backer and Howard, 2007 and MacReady, 2009) which may encapsulate people with experiences related to (ASD), Attention Deficit Hyperactivity Disorder (ADHD), traumatic brain injury and learning disabilities. Such impairments may lead to a person experiencing communication, emotional and adaptive functioning difficulties (Headway, 2018) leading to a person being misunderstood, undersupported and experience prejudice at an individual and policy level (Aiden and McCarthy, 2014). This can have an impact upon a

person's ability to secure or maintain suitable accommodation and once homeless, identification and support for an individual's needs becomes difficult (Stone et al., 2018).

Anecdotal evidence suggests people who have ASD are more at risk of homelessness, however there is very limited empirical evidence to support this (Churchard et al., 2018). Churchard et al (2018) provide initial evidence that illustrates people with traits of ASD are overrepresented within the homelessness population. They acknowledge further research needs to be undertaken to develop these findings in order to understand the needs of this population.

O'Regan et al. (2017) highlight those who have a diagnosis or symptoms of ADHD are more likely to become homeless. This may be because those with ADHD are more likely to experience circumstances which can exasperate the risk of homelessness. For example, children and young people with ADHD are reported to have more behavioural problems including fighting and consumption of alcohol in excess (Caci et al., 2014) which may impact upon education. Additionally, in adulthood those living with symptoms of ADHD are nine times more likely to receive a prison sentence (Mannuzza et al., 1989), to be dismissed from work and experience interpersonal difficulties in the workplace (Barkley, 1998) and to experience relationship difficulties (Pitts et al., 2015). It is also important to consider, people experiencing symptoms of ADHD are more likely to find transitional periods particularly stressful and these periods may be when some use substances (O'Regan et al., 2017). Failing to realise a person may need additional support during transitions is likely to lead to long lasting consequences on a person's development (Young et al. 2016) and it is believed the needs of children with symptoms of ADHD during transitions are poor (Singh, 2009). These difficulties may be something to consider for those with symptoms of ADHD leaving institutional systems such as the care system or prison.

Oddy et al. (2012) identified that out of a sample of 100 homeless individuals, 58% had experienced a brain injury. Of those with brain injury, 90% reported acquiring a brain injury prior to becoming homeless, suggesting a brain injury is a predetermining factor for homelessness. Research recognises the impact of

cognitive and behavioural impairments upon engagement. They highlight these can negatively impact the level of support an individual will receive, which places them at increased risk of homelessness (Mason et al., 2017; McMillan et al., 2015). Additional research identified the further potential impact of brain injury upon psychosocial issues. These include unemployment, isolation, relationship breakdown, substance misuse and homelessness which can be a result of their struggle to manage and accept the impact their injuries have had on their functionality (Juminsko et al., 2005; Velikonja et al., 2009; Hesdorffer et al., 2009; Oddy et al., 2012). Silver et al. (2004) recognised the impact of brain injury can include impairments to physical, mental, cognitive, emotional, and social functioning in the individual. They suggest these impairments are often subtle and can go undetected. It could be hypothesised that the needs of these individuals are not recognised or provided for and can contribute to the psychosocial consequences placing them at risk of homelessness. Norman (2016) highlights those with brain injury who experience poor social integration and executive impairments may struggle to maintain accommodation and risk facing homelessness. St. Mungos (2014) illustrated 51% of homeless people did not have the basic English skills needed for everyday life. Additionally, Thamesreach (2010) recognised that dyslexia and other mild learning difficulties were common with ten percent of their clients being unable to read or write. The London Housing Foundation (2016) highlight it is common for the homeless population to have undiagnosed learning difficulties which has impacted upon education, mental health and substance misuse.

Research reflects that marginalised households are overrepresented in homelessness services and statistics (Gulliver, 2016; Homeless Link, 2018). Garvie (2017) highlighted that between 2012 – 2017, statutory homelessness increased by 22 percent. Nine percent of this increase was attributed to White households whilst homelessness among marginalised households rose by 48 percent. When looking into this discrepancy further, Garvie (2017) reported homelessness among Black households increased by 42 percent, Chinese households increased by 35 percent and mixed-race households by 33 percent and finally Asian households saw an increase of 71 percent, clearly signalling the discrepancy in homelessness rates across ethnicity. Garvie (2017) proposes this

may be due to the lack of social housing meaning people must rent privately. People who identify as Black, Asian or from other minority ethnic households on average receive lower incomes (Shelter, 2016) which can influence the affordability of suitable private rentals. Additionally, individuals within communities that are marginalised are more likely to experience benefit sanctions (De Vries et al., 2017), and are less likely to have excess finances to rely on during delays in payment (Sandhu, 2017). This overrepresentation can also be explained by structural factors. For example, communities that are marginalised are more probable to be living in poverty (Garvie, 2017), to live in low quality or overcrowded housing and to be hidden homeless (Gulliver, 2016). The English Housing Survey 2019- 2020 found that overcrowding is more common for marginalised households compared to White British households (MHCLG, 2020). This survey identified overcrowding was at the highest rates within Bangladeshi (24%), Pakistani (18%), Black African (16%), Arab (15%) and Mixed White and Black African (14%) households whilst two percent of White British households were overcrowded. It is important to consider overcrowding as this can contribute to poor quality housing and research has illustrated overcrowding has adverse consequences on physical and mental health (Ferguson et al., 2013; Joseph Rowntree Foundation, 2018). Additionally, the government introduced Right to Rent checks in 2016, which legally requires landlords to assess the immigration status of all prospective adult tenants before the start of a tenancy. A survey carried out by Shelter (2016) found 44 percent of landlords said that Right to Rent checks would deter them from letting to people who 'look' or they perceive to be immigrants, with a similar proportion of feedback saying they are hesitant to Let to people who do not have British passports.

The Rough Sleeping Strategy (MHCLG, 2018) report that people from the LGBT community are more at risk of homelessness. Reports suggest they may have experienced family relationship breakdown, abuse and violence. It is important to acknowledge the report concedes the evidence base is insufficient to draw conclusions on how these experiences may influence homelessness and acknowledges a need to further understand the causes and needs of LGBT people experiencing homelessness.

The Rough Sleeping Strategy (MHCLG, 2018) summarised that in 2017, of those sleeping rough, an estimated 83 percent of people were men, 14 percent were women and the last three percent were unknown. Although it is understood that men and women are equally likely to be hidden homelessness, these figures recognise there are higher numbers of men rough sleeping. This may be understood that when women sleep rough, to protect themselves they will endeavour to make themselves less visible and therefore are not captured in the statistics. Consequently, there is less awareness about these individuals and their needs. The Strategy also acknowledged that typically, more women will have particular support needs when sleeping rough and will have endured difficult life events which include domestic abuse, mental health difficulties and substance misuse. As mentioned within *The Scale of the Issue* there is extensive international evidence collated which indicates the connection between poverty and domestic violence (Fahmy et al., 2016). This can mean women and children are more vulnerable to this contributing factor for homelessness (Hutchinson et al., 2015), as women are statistically more likely to be a victim domestic violence than men in England and Wales (ONS, 2020). This illustrates how poverty and gender can intersect.

The austerity policies which have been introduced by the government since 2010 have negatively impacted under 25s the most (Lupton et al., 2015). According to the Equality and Human Rights Committee (2015), there is an age inequality gap in the UK with young people facing the worst economic prospects for several generations. This is likely attributed to the decrease in employment and in incomes young people face compared to older generations. MacInnes et al. (2015) supports this, reporting young people are now the most probable generation to be living in poverty. The Rough Sleeping Strategy (MHCLG, 2018) shared most people who sleep rough often first become homeless in their twenties. This emphasises the need for early, targeted intervention to reduce homelessness. The LAHC (2017) estimate a further 225,000 hidden homeless young people are in London, arranging their own temporary accommodation with family and friends.

MHCLG (2018) estimate approximately 31 percent of homeless people have 'complex needs', which means someone has two or more physical or mental health support needs. There is also evidence that the level of support needs increases with someone's age and the longer they stay on the streets. MHCLG (2018) report those who are homeless may have difficulties with finances or interpersonal skills and would benefit from support to allow them to engage better with society, gain employment or to maintain a home. Harker (2006) summarised bad housing conditions, which include street homelessness, temporary accommodation, insecurity, overcrowding and housing that is in poor condition contribute to risks to health. Harker (2006) conducted research which suggested children are more likely to have mental health problems when living in bad housing conditions, in addition to have physical health difficulties such as meningitis, respiratory problems, long-term ill health and disability, impaired growth or delayed cognitive development. The Marmot Review (SRHIE, 2010) argues reducing health inequalities is a matter of social justice. Due to health inequalities, people in the UK are dying prematurely each year who would otherwise have a cumulative 1.3-1.5 million extra years of life to live (SRHIE, 2010). Thomas (2011) quantified the average age of a homeless person to die in England is 47 years old compared to 77 years old for the general population. In this report, it was estimated that alcohol or drugs accounted for approximately 35 percent of people who die whilst sleeping rough or living in homeless accommodation compared to two percent in the general population. It is important to recognise there is an overlap in definition and so some deaths classified as drug-related or alcohol specific may be death by suicide (ONS, 2020).

Public Health England (PHE) (2019) have offered new guidance with 'All our Health' (PHE, 2015) to call upon all healthcare professionals to utilise their skills and relationships to positively influence avoidable illness, protect health and encourage wellbeing. Within this guidance there are particular directions outlined for healthcare professionals to take action on homelessness within their professional practice and highlights the importance of improving integrated health and social care and to help people access physical health, mental health and substance misuse services in order to maintain accommodation. Furthermore,

the BPS have developed a 'Public Health and Prevention Sub-Committee' which encourages awareness, innovation and practice in preventative work within the clinical psychology profession and across the wider mental health community. These developments further position clinical psychology as a profession who should contribute to the prevention of homelessness within mental health services.

1.4. The Impact of Homelessness on Mental Health

There is a moral argument for CPs to address and prevent homelessness as it greatly impacts upon peoples' mental health. This section will highlight the consequences of homelessness on mental health before considering the role of CPs within a social justice framework. It is important to note that although diagnostic terminology can and should be challenged as valid constructs, for the purposes of this review they will be used here as a reflection of the literature.

Research by Krieger (2002) and Thomson et al. (2013) recognise the negative impact poor-quality housing such as housing with damp, mould or noise has on both physical and mental health. The amount of time someone is exposed to poor conditions, the greater the effect on their mental and physical health (Daly & Allen, 2017). Additionally, Gibson et al. (2011) state living in poor conditioned, cold or overcrowded housing as well as unaffordable housing is associated with elevated stress levels, a loss of sense of control over one's own life and 'depression' and 'anxiety'. Shelter (2017) supports such claims, highlighting 21 percent of adults in England reported a housing issue impacted their mental health negatively, with housing affordability being most commonly identified as the cause. Singh et al. (2019) rationalise that individuals and families spend a considerable amount of time at home throughout their lives and that housing therefore has a vital influence on their health. These findings reinforce the argument that housing is a central social determinant to mental health, therefore policy interventions which are directed at reducing housing disadvantage may also result in substantial mental health improvement to those this directly impacts (Braubach, 2011). There is research supporting the argument that housing stability, appropriate mental health intervention and improved income can lead to

better quality of life for an individual (Buhrich & Teesson, 1996; Rosenheck et al., 2003), clearly illustrating a role for psychological intervention.

The impact that the threat of eviction has on someone's health includes negative mental and physical health. There could be a number of explanations for this relationship such as a sense of lack of control, isolation, stigma, embarrassment and the use of maladaptive coping strategies which are also risk factors (Vasquez-Vera et al., 2017). Nelson et al. (2001) critique the traditional medical model for mental health and promote the role of empowerment to address mental health needs. In their study, Nelson et al. (2001) identified an empowerment-focused approach positively influences three aspects of mental health: choice and control, community integration and access to valued resources. Nelson et al. (2001) argued that these three aspects are imperative to move beyond the medical model goal which only focuses on the absence of illness. The authors concluded that to develop an all-inclusive understanding of mental health, clinicians need to consider what positive and adaptive qualities the individual holds. This may address a sense of lack of control over their lives as identified in the previous study by Vasquez-Vera et al. (2017). This also amplifies the importance of eliminating negative structural influences of homelessness as stated within *Structural Risk Factors* in this chapter.

It can also be useful to consider Maslow's Hierarchy of Needs (1943). This identifies the most basic needs individuals have are their physiological needs which encompasses food, water, shelter, clothing, and sleep. The next need is safety and security, embracing health, employment, property, family and social stability. These two needs are relevant to the topic of homelessness. According to this model, if someone cannot get these two needs met, they will be unable to progress to the needs of love and belonging, self-esteem and self-actualisation. This provides the rationale that CPs should prioritise physiological and safety and security needs over traditional psychological therapy. However, it is widely believed that until these two more basic needs are met, effectiveness of psychological therapy will be limited although research conducted by Henwood et al. (2015) contradicts these claims. Henwood et al. (2015) aimed to explore how housing circumstances and unmet physiological needs could impact upon the

achievement of self-actualisation. Within their study, participants who experienced homelessness and mental health difficulties were enrolled into one of two housing programmes: a treatment-first programme or a housing-first programme. The results established self-actualisation was still able to be achieved irrespective of if physiological needs were not met. Additionally, the St. Mungo's LifeWorks project (St. Mungo's, 2011) illustrates the positive impact offering individual therapy sessions can have on individuals who are homeless or at risk of homelessness. The evaluation of this project reflected high engagement rates with regular attendance of sessions. The evaluation also highlighted 75 percent of SUs reported improvement to their wellbeing and reduced use of emergency and crisis services. Results from this project and Henwood et al.'s study (2015) challenge the utilisation of Maslow's Hierarchy of needs to justify withholding psychological intervention from someone.

1.4.1. Social Justice Framework

There is persuasive data which argues that mental health is so enmeshed to social and economic circumstances, that psychologists cannot support improved mental health within the community without trying to tackle the mental health risks linked with poverty (Goodman et al., 2010; Lorant et al., 2003). A social justice framework places emphasis on the interaction between structural circumstances in a person's life and the personal experiences they have due to the impact of such circumstances (Ali & Lees, 2013).

1.4.1.1. Advocacy. Social justice advocacy is the deliberate and persistent action which plans to effect public policy outcomes, with or on behalf of an individual, community or the general public (Marshall-Lee et al., 2020).

Toporek and Williams (2006) define advocacy as actions a mental health practitioner takes which aids the achievement of an individual's therapy goals by participating in the individual's environment. Marshall-Lee et al. (2020) argue that psychologists have a moral responsibility to advocate for individuals and the public across health, service accessibility and overall wellbeing. By advocating for individuals, a psychologist can amplify or give a voice to those who are less able

to protect themselves and CPs have the power or resources to improve public services and hold organisations or systems accountable.

Bronfenbrenner's Ecological Systems Theory (1979) can be used to illustrate how advocacy can be relevant in clinical practice when working with an individual. The Ecological Systems Theory (Bronfenbrenner, 1979) demonstrates mental health challenges and the interventions provided are best conceptualised by a model that considers both individuals and their wider context also known as systems. Each system has a bidirectional influence on the development of the individual. This effect can influence the individual's understanding, access and use of mental health services (Pickover et al., 2018 and Pinder-Amaker & Bell, 2012).

Holding Bronfenbrenner's ecological theory in mind, advocacy can be initiated at the point where CPs are directly engaging with people with mental health concerns at the micro level. At this level, the individual's beliefs, knowledge and perceptions will influence their perceived ability to advocate for themselves. Furthermore, CPs can advocate at policy level to challenge the systems that uphold social inequalities and poverty and ensure equal access to mental health services.

1.5. The Cost of Rough Sleeping

In addition to homelessness negatively impacting individuals, there is also an economic argument for addressing and preventing homelessness. The Rough Sleeping Strategy (MHCLG, 2018) maintains prevention of homelessness will reduce costs to the wider public sector due to the range of public bodies required to address the multiple needs of people who sleep rough. The multiple needs often relate to health needs of individuals. When looking at the needs of the street homeless people in London during 2017/18, half of this affected group had mental health needs, 46 percent had physical health difficulties, 43 percent had alcohol misuse difficulties and 40 percent misused drugs. Costs can include services to provide health care, substance misuse treatment, use of emergency services and the criminal justice system. Bramley et al. (2015) estimated the cost of rough sleeping falls between £14,300 and £21,200 per person, per year with

the higher estimates encompassing substance misuse and offending costs. This valuation is approximately three to four times more than the average cost to public services for an average adult. However, it is important to be aware that estimates of the costs of street homelessness vary depending on the methodology and data used. Referring to *Social Inequality* and *The Impact of Homelessness on Mental Health* there can also be an assumption that reducing all forms of homelessness can further reduce mental and physical health costs.

1.6. Relevant Policies and Framework

1.6.1. Homelessness Reduction Act 2017

This Act was introduced to promote early intervention for people at risk of homelessness. It was intended to increase the number of successful long-term housing solutions and ensure local housing authorities work proactively. The Act doubles the period of time a person is classed as “threatened with homelessness” from 28 to 56 days, thus ensures people are supported earlier. All staff who are employed by public authorities now have a legal duty to identify the housing status of everyone they work with and refer people who are homeless or at risk of becoming homeless to the relevant agencies if they consent, irrespective of intentionality or priority need. These public authorities include prisons, youth offender institutions, social services, in-patient wards, emergency services, probation services and Jobcentre plus (Homeless Link, 2018). It is important to note that mainstream mental health services have not been included as responsible authorities. Homeless Link (2018) propose that whilst this is the case, these professionals are instrumental in the development of local homelessness strategies and can play an influential role in this culture change. The statutory guidance has been made stronger to clarify at what point an applicant should be regarded as at risk of homelessness due to unreasonable accommodation, capturing those who are facing no-fault eviction previously not covered by the definition of homeless.

1.6.2. NHS Long Term Plan

As previously stated, particularly within *The Impact of Homelessness on Mental Health*, many people who are homeless experience poor mental health. This is

supported by the NHS Long Term Plan (NHS, 2019) which reports 50 percent of those who are street homeless have mental health needs, however in many areas of the country there is no specialist mental health support available and gaining access to mainstream services can be challenging perhaps due to the perceived level of complexity of their needs. The NHS Long Term Plan confirms there will be an additional investment of up to £30 million aimed to meet the needs of those who are street homeless. This will be achieved by ensuring the areas in England identified as the most affected by street homelessness will have improved access to specialist homelessness mental health support within the NHS and to integrate care with existing outreach services.

The Plan also encourages innovative ideas to address health inequalities within the homeless population identifying 100,000 social enterprises in the UK, with 31 percent positioned in the top 20 percent of the most deprived communities. The consequence of this innovation is the introduction of jobs, improving support provision and addressing wider predisposing factors of health and wellbeing such as debt, housing and other support often provided in mainstream services which people from the homeless population may struggle to access.

1.6.3. The Rough Sleeping Strategy

The Rough Sleeping Strategy (MHCLG, 2018) states that the insufficient number of available homes has resulted in a broken housing market. It testifies the government is dedicated to rectifying this, and since 2010 more than a million homes including affordable homes and rental homes have been built. In 2017, there was the largest increase in overall housing supply for England in almost a decade. However, despite the increase in available housing, homelessness has continued to increase illustrating homelessness is not just a housing issue. Therefore, alternative methods to address homelessness including maintenance of accommodation and mental health should be explored.

Local Authorities have a legal obligation to house particular homeless people due to their needs, for example, those with children or those with health needs which make them more vulnerable. This strategy focuses on people who are street homeless and those who are at risk of street homelessness. There is an

expectation enforced by the government that local authorities and their delivery partners will develop new strategies to record and assess street homelessness to allow there to be an improved and more accurate understanding of who is street homeless and what their needs are. By increasing this knowledge new solutions can be developed to end street homelessness. The Rough Sleeping Initiative (2018) was anticipated to support this work in local areas to improve the recording of street homelessness by autumn 2018. Upon evaluation of the Rough Sleeping Initiative, the MHCLG (2019) report an overall reduction in rough sleeping levels by 32 percent in the areas involved in the initiative. Interestingly, since Autumn 2017 rates of rough sleeping continued to increase by 13 percent in London compared to other areas, which will require further in-depth qualitative research to understand this discrepancy (MHCLG, 2019). It is also important to acknowledge this does not address other forms of homelessness.

1.6.4. Rough Sleeping Initiative: 2020 to 2021 funding allocations

The government announced funding allocations of £112 million to the Rough Sleeping Initiative to deliver local support for street homelessness. This funding has been distributed amongst Councils across England and has been used by Local Authorities, charities and other organisations in around 270 areas. Funding allocated for 2020-2021 is a combination of the Rough Sleeping Initiative and the Rapid Rehousing Pathway into one funding programme.

The new package included a Rough Sleeping Team comprised of homelessness experts with specialist knowledge across a wide range of areas from housing to mental health who were sourced and funded by government departments and agencies. This team works with local authorities with the highest numbers of street homelessness to support the development of localised interventions to reduce their street homelessness rates. Further funding was also provided to support frontline Rough Sleeping workers to ensure they had the relevant skills to work with this vulnerable population. Furthermore, the government is also working with the National Housing Federation to provide more, coordinated accommodation for rough sleepers across England. This builds upon the existing 3,750 'clearing house' homes already provided in London, however it's important to acknowledge this would still not be providing secure housing.

1.6.5. 'A New Deal for Social Housing' (2018)

The paper (MHCLG, 2018) aims to balance the relationship between tenants and landlords, challenge stigma and guarantee social housing can be both secure for when people need it whilst still encouraging social mobility.

The Paper sets out five core themes: firstly, tackling stigma and enjoying prosperous communities. This paper aims to tackle inequalities in social housing and ensure tenants feel part of their community instead of feeling it is just a place to live. Secondly, by expanding supply and supporting home ownership with plans to build more social housing in addition to the use of affordable home ownership schemes such as shared ownership opportunities. Thirdly, effective complaints resolution aiming for tenants to influence decisions and challenge landlords to improve living standards. The next theme entails empowering tenants and reinforcing the regulator. The final theme focuses on ensuring homes are safe and appropriate for tenancy by reviewing the current regulations to provide safe, good quality social homes with relevant services from landlords.

Cromarty (2021) has summarised concerns with these proposed measures, highlighting overall the proposals lack detail. More specific concerns include the slow rate of the social housing reform, how the paper has failed to address the supply of social rental homes and who and what these homes are for, that the paper has failed to address stigma of social housing and the absence of a representative body to represent tenants. Due to the lack of detail given to the measures, further consultation and engagement with social landlords and tenants will be required as the proposals are developed, and this will mean it may take a number of years for proposals to be actioned. There is no timeframe or deadline to deliver the measures set out in 'The Charter for Social Housing Residents' (MHCLG, 2020) White Paper which followed the Green Paper. An example of this can be seen when looking at the Regulator of Social Housing which plans to engage with stakeholders and consult on the new tenant satisfaction measures throughout 2021 – 2022, with plans to roll these out in 2023. It is also important to recognise the availability of social rented homes have fallen since affordable rented housing and other alternative affordable products have become more common. Barton and Wilson (2021) report approximately 93% of social housing providers' stock were let at social rent in 2018 to 2019, compared with 98% in

2012 to 2013. More recently, there has been a significant decline in the new supply of homes for social rent. In 2019 to 2020 there were approximately 6,600 new homes for social rent, accounting for 11% of all new affordable housing supply. Some of this reduction may be understood by the stock lost by the social housing sector through Right to Buy sales and demolitions. As previously identified the Green Paper aimed to tackle social housing stigma, however, there has been concern over the lack of reference to this within 'The Charter for Social Housing Residents' (MHCLG, 2020) White Paper. Moreover, there is a chapter within the White Paper which emphasises the goal for people to become homeowners, reinforcing the idea that social housing is undesirable and further contributing to stigma (Prestwich, 2020). During the Green Paper consultation 31% of respondents advised there should be less emphasis on home ownership as the tenure of choice (MHCLG, 2020).

1.7. Understanding Prevention

As illustrated within this chapter, homelessness has been vastly growing in the UK since 2010. Most efforts have been made to reduce street homelessness (The Rough Sleeping Strategy, 2018; The Rough Sleeping Initiative, 2020) or support this affected population (NHS Long Term Plan). The introduction of the Homelessness Reduction Act (2017) and 'A New Deal for Social Housing' (2018) have broadened efforts to prevent homelessness altogether. This section will outline the meaning of homelessness prevention along with a homelessness prevention framework.

The government have defined homelessness prevention as a means to provide people with the resources to resolve housing issues or support other needs (MHCLG, 2013) and have recognised that homelessness can be avoided at various stages (MHCLG, 2013). Firstly, they propose early identification whereby people who are at risk of homelessness are identified. This will then ensure accommodation and any relevant support is arranged for them. The second stage is categorised as the pre-crisis intervention. This refers to advice and mediation for example, supporting landlord negotiations to permit people to keep their tenancies; and targeted services at known risk points, such as transitional

periods out of care, prison or the armed forces. The final stage is preventing recurring homelessness. This refers to ensuring the maintenance of a tenancy to prevent repeated homelessness and includes providing ongoing support to someone to allow them to keep their home. These government stages appear to map onto the new Homelessness Reduction Act (2017) which enforces a legal duty for public authority staff to identify when someone is in any of these stages and with consent from the individual, to refer to the relevant local authority. Opportunities to undertake homelessness prevention within the clinical psychology profession including at assessment and during interventions would also map onto these stages.

The Homeless Link (2018) acknowledge there is a lack of research to explore the effectiveness of interventions to prevent homelessness. They suggest this is mostly due to homelessness prevention outcomes being unobservable and unmeasurable. They conclude specific evaluation of individual prevention services will be needed for conclusions about which prevention intervention approaches achieve better outcomes to be drawn.

1.7.1. Homelessness Prevention Framework

Fitzpatrick et al. (2019) have proposed a homeless prevention framework to conceptualise five different levels to disrupt homelessness and encourage prevention. The first level is “universal prevention” where homelessness risks can be minimised across the larger population. Unfortunately, due to housing insecurity, unaffordable housing and cuts in housing allowances, England’s recent outcomes for homelessness prevention at a universal level is poor (Fitzpatrick et al., 2019). The second level is “targeted prevention” focusing on groups of people who are particularly at risk of homelessness. These include vulnerable young people, and those at transitions points such as leaving local authority care, prison, or mental health inpatient treatment. Despite this awareness, Fitzpatrick et al. (2019) argue there needs to be improvements in many parts of the UK for care leavers, whilst there have been improvements recognised for some populations including the implementation of new standards for prison leavers in Scotland (Fitzpatrick et al., 2019). Thirdly, the “crisis prevention” level focuses on avoiding impending homelessness expected within

56 days, complementary to the Homelessness Reduction Act's legislation of 'threatened with homelessness'. Fitzpatrick et al. (2019) state this intervention level has been the main focus most recently, which can be seen with the introduction of this new legislation. The fourth level is "emergency prevention" whereby support for those at immediate risk of homelessness is provided, for example street homeless people. In England, initiatives such as the Rough Sleepers Initiative and No Second Night Out have targeted getting new street homeless people back into accommodation as quickly as possible (Fitzpatrick et al., 2019). These initiatives have been considered effective to reduce rough sleeping in the short term, however the numbers of rough sleeping rise again when political priorities change (Mackie et al., 2017). It is also important to consider councils do not have a legal obligation to provide emergency accommodation to single people in England, Wales and Northern Ireland (Fitzpatrick et al., 2019). The final level is "recovery prevention" which focuses on the prevention of repeated homelessness. Housing First aims to rehouse homeless people with complex needs into mainstream housing, whilst providing intensive support needed to sustain this accommodation (Fitzpatrick et al., 2019). However, these individuals need access to mainstream mental health, substance misuse and social services in order for Housing First to be successful (Fitzpatrick et al., 2019). Moreover, funding for programmes such as Supporting People has been drastically cut since 2010 (Homeless Link, 2013), reducing funds that can be used towards services that support the homeless community.

1.8. Rationale for this Research

Sanabria (2006) argues that the role of a CP includes encouraging health and empowerment within individuals, working towards preventing problems within communities, groups and individuals and promoting distributive justice.

Distributive justice is the right for everyone to have access to a fair share of all social resources (Prilleltensky & Nelson, 2002).

As a CP, you can expect to encounter a number of people who will endure one or more factors which can exasperate their vulnerability to homelessness. It would be within the CP's remit to explore and support the individual to problem solve

and receive support from relevant agencies to protect them from this devastating consequence.

Statutory policies including the NHS Long Term Plan (2019) and Rough Sleeping Strategy (MHCLG, 2018) focus on the importance of the prevention and reduction of homelessness, looking to mental health services to improve access to services. The Rough Sleeping Strategy (MHCLG, 2018) outlines the Rough Sleeping Initiative; a plan formulated by the government which clarifies the government's current plans and progress of endeavours that aim to reduce rough sleeping in the UK by half by 2022 and end rough sleeping entirely by 2027. This strategy is grounded on three proposed core pillars: prevention, intervention and recovery. The initiative emphasises the role of prevention which is at the core of the plan. It highlights the importance of adequate support prior to someone becoming homeless and that to end rough sleeping there must first be secure and affordable housing. This strategy acknowledges the importance of accessible support systems to provide the necessary help to the people affected. As discussed within *Risk Factors*, there are factors which may predispose someone to homelessness. These factors may bring people into contact with CPs, however barriers such as clinicians not feeling skilled to support someone who is in poverty (Bullock, 2004) and psychological concepts such as The Hierarchy of Needs (Maslow, 1943) can prevent the profession from providing helpful interventions to this affected population. Additionally, this chapter has highlighted the mental health needs of this population which can be supported by this profession. Although government initiatives aim to end street homelessness by 2027 (MHCLG, 2018), a more inclusive view of what we define as homeless should be embraced for this to be achieved.

As discussed, recent policy developments within the UK have begun emphasising the need to reduce levels of homelessness (Homelessness Reduction Act, 2017; Rough Sleeping Strategy 2018). It is critical for CPs to engage in prevention, working with people and their housing needs before the point of homelessness. This may avoid a decline in mental and physical health, whilst also alleviating social and housing pressures. However, there is no research that look into the preventative action within the clinical psychology

profession. Consequently, this research will consider what preventive work is currently being undertaken and the opportunities there may be to further develop these interventions within the profession.

1.9. Research Aims

The overall question the researcher will be exploring is "What can CPs do to contribute to the prevention of homelessness within adult services?"

The researcher hopes to understand this more by asking the following research questions:

1. What can CPs working in adult mental health services do to prevent homelessness?
2. What are CPs' perceptions of the facilitators and barriers to preventing homelessness?

CHAPTER TWO: METHODOLOGY

2.1. Overview

This section will discuss the use of thematic analysis to explore the role of CPs in the prevention of homelessness within the UK using responses given by CPs working within adult mental health services. Firstly, the researcher will outline their ontological and epistemological position. Following this, the recruitment process, the sample and the development of semi-structured interviews used to collect data will be discussed before outlining the ethical considerations related to this study. Finally, the data analysis process will be described.

2.2. Ontology and Epistemology

Ontology is concerned with what there is to know in the world and questions the nature of reality, whilst epistemology is concerned with what it is possible to know (Willig, 2019) and the theory of knowledge about the world; how it is acquired and accepted (Bisman, 2010). Epistemological positions relate to both epistemology and ontology and are observed on a spectrum which spans between realism and constructivism (Willig, 2012). The need to specify the theoretical underpinnings for the research is widely recognised (Holloway & Todres, 2003; Braun & Clark, 2006). This is because the ontological position taken will influence the researcher's views of the world and what is considered to be 'real' (Bisman, 2010), whilst the epistemological position will influence the study (Anfara & Mertz, 2006) and underpin knowledge claims (Harper, 2011).

This research will be conducted using the lens of critical realism and will be ontologically realist. This means the data collected attempts to understand people's experiences and the world better, however this may not be a direct mirroring of the reality (Harper, 2011). Consequently, there are multiple perspectives to people's 'reality' regarding one single objective reality (Healy & Perry, 2000). Judgemental rationality allows the researcher to consider and evaluate these different perspectives to decide which perspective most reflects

'reality', and which are constructed given the level of knowledge (Hu, 2018). Critical realist research aims to identify and confirm the fundamental mechanisms or structures which lead to actions and events that can then be experienced in reality (Fitzpatrick, 2005). This position differentiates between the observable reality for example the social practices and witnessing homelessness, and the unobservable reality for example, the underlying social and psychological structures which form the observable phenomena, in this case, homelessness. It is then the researcher's task to examine the relationship between these two realities (Willig, 2019). Consequently, the conclusions following critical realist research is accepted as probabilistic truth rather than an absolute truth (Bisman, 2010). This approach reflects external issues of power which include social inequality, legislative and policy contexts, all of which can influence a person's interpretation of reality. Therefore, the researcher believes that these respective experiences of politics, social inequality and legislation may mediate and underpin someone's vulnerability to homelessness, and the actions taken or not taken by a CP. Subsequently, the researcher is interested in the complex factors that influence the decisions and actions taken by CPs to prevent homelessness within adult mental health services.

Within the critical realist position, although there may be a reality, the participant's own beliefs, experiences and assumptions will impact upon how they view the world and therefore their responses (Clarke & Braun, 2013). By rooting this research in a critical realist epistemology, the researcher considers homelessness to exist as a recognised entity beyond the data provided by participants. Participants will provide an interpretation of this phenomenon which the researcher will not have direct access to, but will interpret (Bisman, 2010). Furthermore, the researcher will interpret the data from these interviews through a lens which is influenced by their own beliefs, experiences and assumptions and therefore the participant responses cannot be accessed objectively (Harper, 2011).

2.3. Thematic Analysis

The researcher used thematic analysis to analyse the data. Thematic analysis is a qualitative method that identifies and analyses patterns of meaning within a data set. Qualitative research is usually concerned with accessing the subjective aspect of the human experience to better understand people's motivation and behaviours (Willig, 2019). The researcher set out to understand the subjective experiences of the CPs and to understand the meaning behind the responses. Qualitative research would achieve this to a greater extent than what could be apprehended through a quantitative method.

Patterns or other meaningful data identified during thematic analysis can be organised into themes which capture their importance and can then be described in further detail (Braun & Clarke, 2006). Researchers can often go beyond descriptions of the themes to provide interpretations on various features of the research (Boyatzis, 1998). For this study's analysis process, the researcher intended to generate themes across the data set which could develop an understanding of what the CP's role is in preventing homelessness.

Thematic analysis was selected for this research as it can provide the opportunity to collect a detailed, yet complex account of data (Braun & Clarke, 2006), which can be particularly useful in this under explored research area (Willig, 2012).

Thematic analysis was selected as it can be used flexibly with a range of epistemological positions and can be independent of theory (Braun & Clarke, 2006), complementing the critical realist position this research has taken (Harper, 2011). Thematic analysis encourages researchers to consider how their role, including their personal beliefs, may impact on the research process by utilising reflexivity, and these processes should be outlined (Terry et al., 2017). Within the critical realist position, this acknowledges that although there may be a reality, this cannot be accessed objectively by the researcher (Harper, 2011) as our own personal beliefs and assumptions will impact upon how we view the world (Clarke & Braun, 2013).

Thematic analysis can also be a contextualist method, whereby the research position can sit in between essentialism and constructionism, and categorised within critical realism (Willig, 2013). This recognises the way individuals make meaning of their experience whilst considering the ways the wider social context impacts these meanings. Consequently, thematic analysis can both reflect and look beyond the reality (Braun & Clarke, 2006).

Thematic analysis can use either a deductive or inductive method of analysis. Deductive analysis identifies themes that are driven by previous theory and pre-existing thematic categories (Braun & Clarke, 2006) whilst inductive analysis identifies themes which come directly from the data set (Patton, 2001). For this research, an inductive analysis was used to identify themes which derived from the data set independently from any previous theory or pre-existing thematic categories.

Specifically, 'reflexive' thematic analysis was employed as this method embraces the subjective skills brought by the researcher and a research team is not required to maintain quality. An inductive analysis is a reflexive process as coding is an open and organic process and themes are the final 'outcome' of data coding (Braun and Clarke, 2021).

2.4. Design

2.4.1. Participants

Twelve CPs participated in this study. Three male and nine females took part who worked in a variety of adult mental health settings within the UK, using a variety of therapeutic frameworks in their clinical work. The numbers of years since qualification varied across the participants. Table 1 provides a summary of the participants' demographic information.

Table 1*Summary of Participant Demographics*

Participant	Gender	Service	Job Title	Years Since Qualifying
1	F	Community Mental Health Team (CMHT)	CP	25 Years
2	F	Psychology in Hostels	CP	Under a year
3	M	CMHT	Consultant CP	28 Years
4	M	Mental Health and Homeless Team	Clinical Lead	Six Years
5	F	Early Interventions Service	CP	Two Years
6	F	Older Adults Mental Health Service	CP	Four Years
7	M	Older People's Mental Health Team	CP	Under a year
8	F	Psychology in Hostels	CP	Two Years

9	F	Mental Health and Homeless Team	CP	Three Years
10	F	Specialist Therapies Team	CP	Under a year
11	F	CMHT	CP	Under a year
12	F	CMHT and Homelessness Project	Principal CP	12 Years

2.4.2. Recruitment

Recruitment posters were published on various social media platforms including Twitter and LinkedIn, in addition to the specific Facebook page; 'UK based Clinical Psychology Facebook Group' and during specific monthly Twitter conversation events (#HomelessPsychology) to advertise the research. Participants were also recruited via snowball sampling to recruit CPs within networks already known to the researcher or other participants. Five CPs were recruited through snowball sampling, of which two were already known to the researcher and three heard about the research through other participants. The remaining seven participants were recruited through social media advertising.

CPs who expressed an interest to take part in the research were provided with the Participant Invitation Letter by the researcher (Appendix A). Following this, if the CP was happy to take part in the study, a time to conduct the interview was agreed and the researcher sent the participant a Consent Form (Appendix B) to be completed and returned to the researcher ahead of the interview.

2.4.3. Recruitment Criteria

The following inclusion criteria were set to ensure that the participants in the research were appropriate to take part in the interviews (Willig, 2013):

- Individuals could only take part in the study if they were a qualified CP.
- Individuals needed to be practicing clinical psychology within an adult mental health service in the UK at the time of the research.

2.4.4. Developing the Interview Schedule

The researcher used semi-structured interviews to collect detailed and ideographic data (Oppenheim, 2000; Smith et al., 2009).

As recommended by Clarke and Braun (2013), the researcher aimed to develop questions which were jargon-free, succinct and open-ended to allow participants to engage fully and to avoid leading questions that could lead to response bias. The researcher designed a schedule that could be used flexibly, accommodating spontaneous prompts to allow responses to be built upon and gain in-depth, rich data. A pilot interview was carried out and the schedule was revised, amending the wording of some of the questions and adding further prompts, which was then re-discussed with the Director of Studies before finalising the schedule for the interviews (Appendix C).

2.4.5. The Interview Process

Interviews took place remotely on the online platform 'Microsoft Teams' to allow participants to be involved safely in response to the COVID-19 pandemic. The interviews lasted for an average of forty-eight minutes with interview duration ranging from twenty-seven minutes to seventy minutes.

2.4.6. Resources

Interviews were recorded using an encrypted recording device. These recordings were then saved with all related documentation on a password-protected computer.

2.5. Ethical Considerations

2.5.1. Ethical Approval

Ethical approval to conduct this research was received through the University of East London Ethics Committee (Appendix D), which was sufficient for participants to be recruited from a non-clinical population, outside of any healthcare systems. This included all the appropriate considerations and solutions (Appendix D).

2.5.2. Informed Consent

An invitation letter was provided to all individuals who showed an interest in taking part in the research. This letter described the research and included information on participants' rights such as the right to withdraw at any time, to take breaks or to reschedule (Appendix A). Participants were encouraged to ask questions or voice concerns they had. Participants were then required to read and sign a consent form before the interviews (Appendix B). Participants consented for interviews to be recorded and for quotes to be used in the research write up. The researcher verbally reiterated the information sheet at the start of the interview to ensure the participants understood all aspects of consent.

2.5.3. Confidentiality and Anonymity

Participant names were converted into unique unidentifiable codes and all identifying information were anonymised or removed in the transcripts and in any extracts included in the write up to maintain the anonymity of those involved in the research.

Consent forms and transcripts were kept in a locked environment including a password-protected computer and the researcher was the sole transcriber of the interviews. Only the researcher, research supervisors and examiners have access to these transcripts and only access these when necessary.

Data was collected and stored in line with UEL and NHS data protection guidelines and regulations. Personal data including audio-files will be destroyed within six months following completion of the research project. Research data will

be stored for five years after research completion in line with UEL policy.

2.5.4. Debriefing

Participants were provided with a debrief letter (Appendix E) which included information about what will happen to the data they have provided and their right to withdraw their contribution within three weeks of the data collection. This document also provided signposting for further information on the topic of homelessness and related organisations. Additionally, this document provided the contact details for the researcher should they have had questions or concerns following the interview.

2.6. Data Analysis

Data were transcribed verbatim by the researcher from the audio recordings, an example of a transcript extract can be found in Appendix F. Filler words, for example 'you know', and non-linguistic features were removed from the transcripts to improve clarity during analysis based on Banister et al.'s (1994) conventions (Appendix G). To ensure transcriptions were accurate, they were repeatedly checked against the original recordings. As a critical realist epistemological stance informed the data analysis, latent codes and themes were generated (Braun and Clarke, 2006). The analysis was inductive, therefore codes and themes were rooted in the data gained in the research instead of being driven by previous theory (Braun and Clarke, 2006). Data was analysed following Braun & Clarke's (2006) six phases of analysis which the researcher will outline below. The analytical process required the researcher to move through the phases bidirectionally throughout the process as appropriate.

1. Familiarising self with the data

It was important for the researcher to immerse themselves in the dataset to ensure they were familiar with the breadth and depth of the content. The researcher found that the process of manually transcribing recordings into written format began the process to familiarise themselves with the context of the interviews. After transcribing, the researcher continued to familiarise themselves with the content by repeatedly reading through each transcript.

This offered the opportunity to begin the search for patterns which were noted down as recommended by Braun and Clarke (2006).

2. Generating codes

Once the researcher was familiar with the data, initial codes were produced to identify any meaningful features. To code the data, the researcher recorded notes throughout the transcript documents. The researcher followed guidance as outlined by Braun and Clarke (2006) to code the content of the entire data set and recognise all potential patterns. As the researcher employed an inductive approach to analysis, generating codes came from the data itself rather than being driven from theory. Extracts from the data set were then matched to the codes. It was important to include some of the surrounding data around the code to provide context.

3. Searching for themes

Once all data had been initially coded across the data set, the researcher was able to begin categorising different codes into potential overarching themes and sub-themes. The researcher used a spreadsheet to organise codes.

4. Reviewing themes

Once initial themes and subthemes had been proposed, these were refined. This refinement included merging some themes together, whilst other themes were broken down. Braun and Clarke (2006) propose this stage is split into two substages.

Firstly, it was important to consider that data within each theme should be closely connected whilst themes remained distinct from each other. It was also important to review the coded data extracts to ensure they formed a clear pattern that fit within the theme. The researcher continued to amend and adjust themes and subthemes until they were confident the themes accurately captured the coded data and a provisional thematic map was produced (Appendix H).

The second stage of this phase involved ensuring the proposed themes

were valid by reviewing the entire data. Reviewing the entire data set also allowed the researcher to capture any additional data relevant to the themes that had been missed in the earlier coding stages. The researcher ensured the thematic map was coherent before moving onto the next phase. The researcher continued to revise the coding until they were satisfied with the thematic map.

5. Defining themes

The researcher defined the themes to reflect the content of the data within them. Braun and Clarke (2006) recommend organising data sets into a consistent account. Each theme needed to undergo a detailed analysis which considered how the theme relates to the research questions and how they relate to other themes. The researcher was able to identify a number of subthemes within the themes. Subthemes were particularly helpful to provide structure and organisation within large themes.

6. Producing the report

Once the themes and subthemes were finalised, the researcher completed the final analysis of the data by writing up the thematic analysis. This was produced to share themes and provide sufficient data extracts to evidence the researcher's analytic narrative. Themes were identified at a latent level, meaning the analysis aimed to go beyond the semantic content of the data and the researcher shared the ideas, assumptions and conceptualisations which shaped the content of the data (Braun and Clarke, 2006). The researcher endeavored to share the theme's meaning and implications, in addition to analysing what the themes reveal about the role of clinical psychology to prevent homelessness in adult mental health services.

2.6.1. Reviewing the Quality of the Study

Throughout this research, the researcher continued to practice reflexivity, which involved considering their role in the research and the factors which may affect the study (Barrett et al. 2020).

Elliott et al. (1999) offer publishability guidelines for researchers to consider which are specifically relevant to qualitative research. These include (1) owning one's perspective, (2) situating the sample, (3) grounding in examples, (4) providing credibility checks, (5) coherence, (6) accomplishing general versus specific research tasks, (7) resonating with readers. Considering the fourth guideline, Elliott et al. (1999) summarised methods that can be used to review the credibility of themes. These include reviewing understandings with the participants; using a number of qualitative analysts to review the data for inconsistencies or errors; comparing two or more varied qualitative perspectives; or where suitable, 'triangulation' with external factors or quantitative data. The current research will be considered against these guidelines will be discussed further within the *Discussion– Quality of the Research*.

Braun and Clarke (2021) outline a number of questions specifically intended to guide the assessment of thematic analysis research quality and these were used to reflect on this project. These generally aim to ensure the researcher has provided an adequate explanation of the methods and methodology and a well-developed and justified analysis. The current research will be considered against these criteria will be discussed further within the *Discussion – Quality of the Research*.

2.7. Relationship to the Research

As previously stated within this chapter, it is important the researcher shares their relationship to the research as this will be influenced by the ontological position (Bisman, 2010) and have a direct influence on the interpretation of the data (Harper, 2011). I am approaching this topic as someone who was first drawn to work with the homelessness sector through personal experience volunteering in a soup kitchen. It was during these times I was able to get to know some of the attendees, learn their stories and increase my awareness of the extent of the problem with homelessness.

As I began my career in psychology and working clinically with individuals, I found myself at times feeling helpless when I would work with people with housing difficulties with no clear pathway in how to support them. At other times I grew frustrated that people were declined psychological support because “until their housing was addressed, therapy would be ineffective”.

I have been inspired by specialised services, organisations and trusts who work flexibly to support the needs of SUs. I draw upon frameworks such as the Power Threat Meaning Framework (Johnstone & Boyle, 2018) to understand the impact of wider social factors on an individual’s threat response, often viewed instead as symptoms of a mental health difficulty. I believe that as CPs, we have a responsibility to engage in social justice which can contribute to the prevention of homelessness and consequently reduce psychological distress. I believe this can be achieved through direct work with individuals to support their needs and work with systems that perpetuate and maintain injustices which contribute to homelessness. I was drawn to conduct this research with the hope to learn from clinicians who are already working in this way and to formulate new ways of working to reduce homelessness within the UK.

Despite the position I hold, throughout this research I have endeavoured to remain neutral when conducting the interviews and during analysis process. It is important to acknowledge that despite my effort to remain impartial during this research, implicit expectations could have influenced the analysis process.

CHAPTER THREE: RESULTS

In this chapter, the results of the thematic analysis will be presented. The analysis of the interviews identified three main themes: understanding homelessness, system structures and CPs' skills and relevance. Within these three themes, a further 13 sub-themes were constructed. Table 2 below provides a summary of these. These themes and sub-themes will be discussed in depth and will be illustrated with quotes taken from the interviews.

Table 2

A Summary of Themes and Sub-themes Identified from the Analysis.

Theme	Sub-themes
1. Understanding Homelessness	<ol style="list-style-type: none">1. Varied Definitions of Homelessness2. Influence of Societal Narratives on Individual Responsibility3. Structural Causes of Homelessness4. Personal and Professional Influences on Understandings of Homelessness
2. Systemic Barriers and Facilitators on Homelessness Prevention	<ol style="list-style-type: none">1. Barriers within NHS Services2. Good Practice in the Third Sector3. The Need for Professional Bodies to Advocate4. Clinical Psychology Training
3. Clinical Psychologists' Skills and Relevance	<ol style="list-style-type: none">1. Considering Homelessness at Assessment and Individual Advocacy

2. The Power and Status of Clinical Psychology Within Services
 3. Developing and Sharing Formulations
 4. The Need for Clinical Psychologists to Become Politically Active
 5. The Need for Clinical Psychologists to Work with Commissioners and Stakeholders
 6. Not the Role or Responsibility of Clinical Psychology
-

3.1. Theme One: Understanding Homelessness

Participants reflected on their understanding of homelessness; how it comes to be and what impacts this understanding. Many spoke about the systemic and political factors that contribute to the risk of homelessness. Others spoke of societal narratives that suggest homelessness is a 'choice' or an individual responsibility.

3.1.1. Sub-theme One: Varied Definitions of Homelessness

One participant reflected on the importance of having a shared understanding of what is considered to make someone homeless. Four of the participants inferred homelessness was street homelessness whilst two of the participants acknowledged other forms of homelessness such as people living in temporary accommodation or in poor housing conditions:

Anyone of us can become homeless, any one of us are at risk of homelessness if enough circumstances were to coalesce but for most of us it might be a period of sofa surfing, a gap between tenancy, something like that rather than the chronic revolving door.

Participant 8

The impact of different definitions of homelessness on statistics and the implications this might have on funding and support was also reflected upon:

I think the starting point of that for me is how we define homelessness because I know there are some ridiculous things like for councils when they do surveys of homelessness. They only count people on the streets, and I think it's something ridiculous like people have to be lying down to be counted when they do the council headcounts. So, what that means is we have huge proportions of the homeless community that aren't included in the stats. We've got people that sofa surf, rely on good will from family and friends in really unsafe living situations but they wouldn't necessarily be counted as homeless. And I think that's what we see a lot of in services is people living in quite risky situations but probably a lot of statutory services aren't necessarily aware of.

Participant 6

3.1.2. Sub-theme Two: Influence of Societal Narratives on Individual Responsibility

Whilst discussing their understanding of homelessness, four participants spoke of the wider societal narratives around individual responsibility and meritocracy. This can deflect the responsibility from the government and other systems to make structural changes that will reduce the risk of homelessness or provide support to people at risk of homelessness:

It's a neoliberal ideology and I think that contributes a lot actually, because that's not achievable for everybody and people aren't supported. It's kind of like people are left to fend for themselves, and if you succeed, it's seen as you being individually successful. And if you fail it's seen as your individual failure when there's all these systemic issues.

Participant 11

Others challenged the societal narratives around individual responsibility by outlining the complexity around homelessness. For example, it is not as simple as an individual making the 'wrong' choices that lead to homelessness, as an individual's environment and psychological needs will influence the options that

are available to them and this can exacerbate the risk of homelessness. In order for someone to make positive choices, a person's psychological needs need to be met and to be adequately supported. This must be done whilst acknowledging the role of a person's environment in limiting how much a person can avoid the risk of homelessness:

There can be a narrative around people making choices, like a choice to be homeless or a choice to be in an abusive relationship or a choice to use substances and I think that if peoples' psychological needs are met [...] people can be supported to take some responsibility for their individual role in that. But that people can't do that if they are not in an environment where it is possible to make a choice. I guess I would see it as, I hope, people would be able to make choices that would be more helpful for them but often people aren't in a position where they can make that choice, I don't think society sees that.

Participant 2

3.1.3. Sub-theme Three: Structural Causes of Homelessness

Eight participants discussed the broad range of systemic factors including housing, employment and austerity that may contribute to an adult's risk of homelessness:

I think from a structural, societal point of view... you're looking at the increasing instability of employment. Also, the privatisation of housing and rent being decided against so called market valuations and the deconstruction of social housing over the last 30 years as part of the neoliberal capitalist agenda which disadvantages the vast majority of individuals, certainly that are working class or lower end of the socioeconomic scale. [...] I think within that there's racism that plays a role and many other structural factors, but I think those are the main ones.

Participant 4

Factors in our country, especially in the last decade or so, things like the economic policies, government decisions and choices around funding

allocation. I think austerity measures have decimated the services that are around to support people and I don't think we're in a culture in the UK that supports society very well.

Participant 6

Two participants also challenged understandings of homelessness which convey system failures as individual risk factors. When considering risk factors of homelessness such as Attention Deficit Hyperactivity Disorder (ADHD) and learning disabilities, participants critiqued systems for not meeting the individual's needs leading to increased risk of homelessness. They also recognised factors such as alcohol misuse as a coping strategy for systemic oppression and trauma:

The people who are commonly refused are those with drug and alcohol or addiction issues which are really issues around oppression and exploitation of the individual and the individual reacting to that by using drugs and alcohol and then falling into another vicious cycle. So, the research suggests ADHD, one piece of research suggests you are about five times more likely to be homeless. Acquired brain injury often happens before the person is homeless, learning disabilities have higher prevalence rates, around 12% some of the research suggests and autism as well and then these commonly being construed as lifestyle choices of the individual. And the homeless housing system not fully acknowledging the lack of skills or competencies a person will have in order to maintain their home.

Participant 4

This participant went on to discuss other circumstances which can be considered individual factors that contribute to homelessness but can be recognised as systemic failings:

On a local systemic level, and family level what we see is trauma all the time. I mean, trauma is a sanitised word, when we think about trauma, we are actually thinking about childhood violence, children witnessing violence, being victims of violence and torture that we commonly describe as trauma or adverse childhood experiences. Intergenerational trauma as well, and the attachments are then affected by that trauma and then that

trauma then being compounded by a lack of a safety net in society so whether it be schools, NHS mental health, physical health systems or social systems that are there to support an individual just not being there. And certainly, over the past 10 years that's been exacerbated by austerity and cutbacks.

Participant 4

Similarly, four participants discussed relationship or placement breakdown. They gave a common example when an individual has increasing mental health or cognitive impairment needs which services fail to support. This is often seen as due to an individual's challenging behaviour rather than due to inadequate support, which contributes to a residential placement breakdown:

In my older adults' group what we see a lot of is placements breaking down. This might be people living with family and then the family situation becomes unobtainable, it might be older adults who get divorced, or their relationships break down and then for the first time they are trying to look after themselves. It might be that they're in residential placements and for a myriad of different reasons the residential placement breaks down and that can be financial but that could be related to using substances, increasing mental or cognitive needs...not so much increasing physical needs I think it's more the kind of mental health and cognitive impairment that services find quite challenging to manage.

Participant 6

Lastly, one participant considered the emotional impact of systemic protocols during abrupt transitional periods such as leaving the care system, on psychological concepts such as attachment, which increase the risk of homelessness:

I have thought about it quite a lot from an attachment-based perspective and the conversations I've had with people have reinforced that. That they had something that felt like a secure-ish base and they had some relationships with people who might be social workers or other support

workers that they have known for quite a long period of time, and then in the absence of that, even though they may [...] actually have the practical skills required for running a house, they just couldn't maintain the emotional stability that was required. It's just, I think very very lonely and very isolating for people and generally just very difficult for people to feel that cut off and not have any continuity of care. It often wasn't tapered off, it ends quite abruptly I think, arbitrarily when they reach a certain age.

Participant 7

3.1.4. Sub-theme Four: Personal and Professional Influences on Understandings of Homelessness

During the interviews, participants spoke of the range of influences on their understanding of homelessness. Six participants identified their professional experiences such as clinical or research experiences and interactions with colleagues as influential in their understanding of homelessness:

I think my career in mental health, initially I started out in secure hospitals and then prison. And I think about when I worked in a women's prison then it was a remand prison which meant you had people coming in and out. [...] And often they didn't have a sentence yet because they were awaiting court and things that you just didn't know when people would be in or out and that made it really hard to plan for release. But I know what happened for most of the women I worked with [...] was that they were just released homeless... So that I think that was my first thinking of "this is a bit shit, like what? How can they not house?" And we would see the exact same people back again two weeks later. I was there for 18 months and some people I'd see four or five times, so that really got me thinking like "what's the system all about?" and thinking this clearly isn't working.

Participant 11

Actually, I think a lot of the general population are aware of homelessness but perhaps they don't have the face to face of it every day. That actually it has always been something that I have been very aware of and have been

wanting to support but really you don't see the reality of it until you start to actually work in services like mental health services or hospital settings or something, so I would definitely say it's changed since working in mental health services.

Participant 10

Whilst two participants reflected on personal experiences such as volunteering and their faith community as influential on their understanding and attitudes towards homelessness:

I do some volunteering on a Sunday evening in a local soup kitchen and so as part of that I would just go and speak with people about what had led them to become homeless.

Participant 7

I have friends who work in homeless services but also by being connected to a church, there is a lot of attempted work to try and help people in the community that are homeless, so I guess it is informed by lots of different parts of my life really.

Participant 5

3.2. Theme Two: Systemic Barriers and Facilitators on Homelessness Prevention

The second theme encompassed system structures that may prevent CPs from being more active in homelessness prevention whilst participants also suggested solutions to these barriers. Solutions were often recognised as good practice within other organisations, particularly third sector organisations. Furthermore, other disciplines such as nursing and social care, hold attributes participants valued to prevent homelessness.

3.2.1. Sub-theme One: Barriers within NHS Services

Participants reflected on aspects of NHS systems which may act as a barrier to the profession preventing homelessness. These included high caseloads, lack of

resources and long waiting lists identified by six participants, which prevent system change and do not allow time to reflect or evaluate current services:

I think logistical pressure; time, high caseloads, fewer resources, long waiting lists all of those considerations that mean that people are really...I think the prospects of taking on something new is daunting and unrealistic.

Participant 8

Five participants also spoke of how these pressures impacted on additional support such as support letters, particularly as these are often not recognised in job plans:

The letters can be very lengthy, and it can be hard to find time for the report writing and I think seeing that as valid as an hour spent in a therapy session would be useful.

Participant 2

Nine participants described services as inaccessible to many of the SUs. One way in which services were considered inaccessible was due to their rigid Did Not Attend (DNA) policies which often stipulate if an individual misses a number of appointments, they are discharged from the service:

The barriers in other services is a big part of it; you don't attend a number of sessions and then you're excluded for however long or there's a waitlist management system that doesn't have any alternative provision of support or people have comorbid difficulties or drug and alcohol difficulties or there is something about the referral pathway that is complicated and in a lot of the health services, not just specific to mental health there's a real need for people to advocate for themselves and that can be really difficult when one can't.

Participant 8

Whilst considering the limitations of DNA policies, five participants acknowledged some SUs will need time to engage with services. By implementing a DNA policy, this engagement stage cannot be accounted for:

Unfortunately, because services are so stretched you know understandably they don't offer flexibility for people to DNA when they don't feel able to come in there's not the space to take the time to do the work for the engagement to improve. Because obviously you can't help somebody if you aren't seeing them but there's not really any time allowed for that engagement [...]. And I don't think that necessarily has to be psychology led but I think it needs to be psychology informed in recognising maybe some of the psychological formulation that may be why it's happening.

Participant 2

Two participants highlighted some individuals will be unable to access services due to diagnoses and the influence of the medical model which may be used as criteria for exclusion from a service:

The system is very rigid and structured and difficult to access and you know some of that is, to some level structure and those systems are necessary but I think particularly the extremely diagnostic and medical views we have within primary care and inpatients is unhelpful because it definitely creates barriers for people to gain entry. There is a huge amount of assessment that is required before people are deemed to have particular diagnoses and reach thresholds before they can get access to services. And for people who have a lot of complexity that is very difficult to tolerate. Those repeated assessments are very difficult and also because they aren't neatly fitting into any box, their ability to actually access services is reduced.

Participant 9

One participant honestly explained the role of rigid exclusion criteria in the management of waiting lists within their NHS service:

With one hundred people on our waiting list which is what it is now since COVID which is unprecedented, you are kind of almost looking for ways to keep the waiting list down, which is awful but it's the reality.

Participant 1

During conversations about the role of NHS systems in the prevention of homelessness, three participants spoke of the impact of cuts and lack of resources on job roles:

One of the first things that comes to mind is just austerity and our cuts and actually our capacity as CPs becoming more and more limited and that means how our roles are changing, how we work with services is changing; all the time we have so many competing demands to think about that there is a big risk isn't there that homelessness just doesn't sometimes come into our heads. And it's not by fault of the clinician perhaps of not caring or thinking about that but actually the amount of caseloads we hold, the work we have to do, I think that puts it at risk of being able to do what you want to do.

Participant 10

Six participants identified services are separated into specialties which often work independently from one another. This prevents inter-disciplinary learning, limiting the opportunity for service development and employment of good practice:

Referrals to social care often won't end up in ongoing liaison we kind of flag it up and it has to be left to them to some extent but often we don't necessarily see the practice that is happening behind the scenes there, and that's really hard especially because we don't share the same electronic systems, we don't share any of that stuff so we can't actually see what's happening always.

Participant 10

This also means that some people never reach services to receive support due to overlapping exclusionary criteria across the services:

The way services are set up to be very much in silos, separate from each other and to have exclusion criteria that mean there is just a subset of people you would never work with in a lot of services.

Participant 8

This division of services impacts on the quality of communication between services and can also contribute to individual's needs not being met:

Whilst they might have support workers from different organisations involved, I still think there is a lack of co-ordination of all of this so the services aren't necessarily joined up and then they aren't communicating and that leads to somebody perhaps being housed temporarily away from their support network and that doesn't make things better for them at all, actually it makes things worse and isolated and so then they might end up rejecting that placement and then end up sofa surfing.

Participant 12

The division of services can also contribute to some individuals 'slipping through the net' as they don't meet the criteria for any of the services. The example of an individual with mental health needs who misuses substances will often be excluded by mental health services due to substance misuse but will not be able to access substance misuse services due to mental health difficulties was discussed by three participants:

It's a bit of a tricky one [...], and I found this on the homeless placement as well because often people get ping ponged around an awful lot. Drug and alcohol services won't see them if they have what they consider to be a mental health problem and mental health services won't see them if they have a drug and alcohol or substance addiction problem and weirdly the two things are totally separate; the drug and alcohol and mental health services.

Participant 7

Within this context, two participants spoke of the lack of psychology in substance misuse services and the impact this may have on working collaboratively with other mental health services in addition to providing opportunities to prevent homelessness:

When we were talking at the beginning about risk factors for homelessness and we were talking about substance misuse, it makes me think about some of the links between those services and homelessness

and I guess CP jobs are in addiction services, but they are more hard to come by now.

Participant 10

When considering how services may need to work differently to support individuals more broadly, one participant considered the need to reconsider how interventions are measured:

I think it's all about how you set your outcomes. So, I have some people where we have what look like very, very small therapeutic gains but actually for them, I am delighted that I've got them through the door. So, they are small gains but for that person they are very significant gains.

Participant 6

3.2.2. Sub-theme Two: Good Practice in the Third Sector

During the interviews, participants were asked for any good practice they have witnessed within other disciplines clinical psychology could learn from, and seven participants spoke of third sector organisations:

To be honest the people I have been most impressed with in my homelessness work have been people who are outside of the NHS. So, the best work that I have witnessed has been from the charity sector, from the third sector. Often those organisations are staffed by people who have a grounding in social work, or they will be doing it from the basis of religious or moral stance rather than a medical or health perspective.

Participant 9

Five participants identified organisations and disciplines such as social care and nursing who work flexibly to allow an individual to access their service. The interventions provided varies, allowing for engagement and advocacy:

I have worked alongside some charity sector organisations and I think sometimes not even with people who have a titled profession but just amazing at advocating for people and really seeing people. And seeing people in their day to day lives and drawing a conclusion and

understanding on that rather than I think sadly in mental health services, the first contact is a referral usually and I think often people develop a conclusion about somebody based on the fact that they are homeless. So that maybe limits the opportunity to be seen. And charity sector organisations tend to [...] think about such a holistic range of needs that sadly staff in mental health services just don't have the capacity for.

Participant 2

They just have a very solid ethos that runs through the heart of it, you know you hear a lot of tripe about psychologically informed environments which I heard a lot in the hostels, about the importance of psychologically informed environments [...] but you walk in and the place is filthy and there's boxes everywhere and you kind of think "well you can have all the training you want on psychologically informed environments but if you don't have a place that's clean that you'd be happy to live in then no-one's going to show up there". I think that runs through the heart a bit more at [X].

Participant 7

3.2.3. Sub-theme Three: The Need for Professional Bodies to Advocate

During the interviews, four participants spoke about the role of professional and regulatory bodies such as the British Psychological Society (BPS), the BPS Division of Clinical Psychology (DCP), Association of CPs UK (ACP-UK) and the Health and Care Professions Council (HCPC) and how they could be used to support CPs to think more about homelessness:

I was just thinking a bit about our professional bodies. So not necessarily HCPC but more like BPS and DCP and ACP more recently, in terms of them supporting in this aspect. So, as I mentioned like the power threat meaning framework, those organisations have supported them to be rolled out and I wonder if homelessness was brought more to the agenda [...] we have special interest groups don't we but there isn't one for homelessness. So, actually how those organisations can support with that.

Participant 10

Three participants also reflected on the need for such bodies to be more politically active and outspoken on social inequalities and homelessness. No participants reflected on the current BPS policy campaign 'From Poverty to Flourishing' or previous coverage BPS have had on homelessness in the past:

I think the BPS is awful. I don't think they really take a stance. I think they should be as an organisation, so much more outspoken about what's OK and what's not OK and be using that power and the membership and the platform to promote social justice issues and social inequality, you know, social justice stuff. And I just don't think that happens.

Participant 11

Homelessness in a country with the fifth or sixth biggest economy in the world and a very rich country with enough money to solve these issues, and it doesn't do, then we can say these are political decisions that lead to homelessness. Therefore, in my view, homelessness is a form of political murder. And I think psychologists, certainly with the BPS for whatever reason do not wish to get involved in these wider discussions. So, I think as a profession we are let down by the BPS and more recently the ACP UK, who are there to represent and be a bit more politically active, I'm yet to see any specific communications around the psychological aspects of homelessness.

Participant 4

3.2.4. Clinical Psychology Training

During the interviews, the role of clinical psychology training was considered. One participant reflected on the experience of placement rotations during professional training and the skills developed which could be harnessed when advocating for individuals' needs. Interestingly, they provide a contrasting idea about the use of CPs' voices to the previous quote, relaying a confidence to share opinions:

I think the fact that we get 3 years of training in the NHS makes us excellent system navigators. I think we are professionally raised to believe

that our opinion is worth something and that we should be sharing it as broadly as possible makes us very effective advocates. And usually, we are well resourced as individuals and professionals; usually if we need knowledge, we can get it somehow and if we need to make links, we usually can make them.

Participant 6

Whilst six participants explained teaching during clinical training had not considered homelessness or the role clinical psychology could play in prevention. As a result, this was not an issue they held in mind during clinical practice or recognised fell within their responsibilities:

I don't think we pay enough attention because you get trained in mental health [...] we don't get much training in the other bits.

Participant 3

I don't think we ever really had housing or homelessness mentioned particularly, not as a focus, maybe as a tangent. And similar to drug and alcohol use and benefits [...], I just don't think social needs are necessarily at the forefront of training and if it's not in training then I guess people don't think about it as much.

Participant 11

One participant explained they only began considering homelessness as part of their responsibility once they started a new specialised clinical role:

In my main role which is going to work in the community mental health team, I think it is something that we are quite removed from unfortunately because of the way that systems are set up. People have to almost jump through a lot of hoops to get through to CMHT and when we have had people come through to the CMHT who were sofa surfing or in temporary accommodation or hostels for instance, they may then sit on our waiting list for two years and we wouldn't have direct work with them. So, I think, prior to doing the project, I didn't see it necessarily as my responsibility.

Participant 12

Contrary to other participants' experiences, one participant received teaching from the homelessness sector during training and shared how this supported them to be more interested in homelessness within clinical psychology:

I think also during training I was really lucky in that we would have somebody from my current service come and give a talk about this sector during training and that really piqued my interest in it.

Participant 8

3.3. Theme Three: Clinical Psychologists' Skills and Relevance

The third theme identifies the skills and roles of CPs that can contribute to preventing homelessness in adults. Opportunities included during direct clinical work, the utilisation of our position within the NHS and the power that may afford us and utilising the skills we gain during training which include neuropsychology understanding and formulation skills. The majority of this theme suggests prevention of homelessness is a relevant aspect of a CP's role however the final sub-theme explores reasons why CPs may not be a relevant profession in this social issue.

3.3.1. Sub-theme One: Considering Homelessness at Assessment and Individual Advocacy

When looking at the opportunities within direct work, two participants proposed we consider risk of homeless during risk assessments:

I was quite struck by what you were saying [...] what would show me that someone was at risk of homelessness and I think it would be really great if that was thought about more as part of a risk assessment.

Participant 2

When reflecting upon current practice to assess the risk of homelessness, three participants recognised they may assume the individual will inform a clinician if this was a concern. Contrary to this, four participants were curious about the role shame may play in preventing an individual from disclosing such concerns:

Unless a person explicitly said, we were never explicitly asking “do you feel at risk of homelessness?”. Perhaps under the assumption that it would just come out as an issue, but that’s not always the case because there’s a lot of shame about it. I think it would be worth it being explicitly asked or incorporated, particularly in the community mental health team type organisations.

Participant 7

Two participants went on to think how these conversations could be more explicitly welcomed. One participant proposed naming such social factors within assessments or interventions to be considered with SUs:

Maybe it’s about as CPs, being clear with people that thinking and the stuff that goes on internally in our minds is only one aspect that affects our general wellbeing, and all of those social factors are really important as well. And maybe naming that with people so that they feel comfortable to bring it up and so that the conversation can be broadened to other things rather than maybe intra-psycho factors.

Participant 9

Three participants considered how we work directly with these risk factors of homelessness during individual work. An example may be for the intervention to focus on substance misuse or trauma focussed work. By supporting someone to reduce these factors, we may reduce their risks of being homeless either in the immediate or long-term future:

Well, it might be that if you know that they are engaging in a behaviour which is causing them to have arguments with their landlord or in a difficult situation with their family [...] might be looking at prioritising teaching them more skills to control angry outbursts or look more directly at their addictive behaviour that maybe adding to some of that.

Participant 1

Thinking about on an individual level what predicts and maintains homelessness, the opportunity to work around people's individual trauma, to establish more trauma informed care in services, working either directly on substance misuse or closely with those who are working directly with substance misuse. And often one of the clinical interventions are also targeting the reasons why people might be continually homeless as well.

Participant 8

During interviews, four participants spoke about the power of writing supporting letters to organisations such as housing to prevent tenancy breakdown or other risks of homelessness. This was often viewed as the minimal amount of input a psychologist could have in the prevention of homelessness:

I think systemically that's probably the kind of work we do to perhaps advocate on behalf of them for housing, work with other agencies that might be involved... writing letters of support, you could think about writing letters of support for benefits.

Participant 9

I wrote a couple of letters where the person's current accommodation wasn't meeting their psychological needs where there was antisocial behaviour and that triggering PTSD symptoms for example. And my focus was that was damaging their mental health and possibly reducing the likelihood of the treatment being effective. [...] But it is possible that if that wasn't thought about and that was influencing a person's mental health then that tenancy could have fallen through.

Participant 2

Three participants spoke of the value of the neuropsychological understanding CPs have and the important role this can play to support the needs of SUs and prevent homelessness or repeated homelessness:

Neuropsychological testing is something that is not always linked with homelessness, but [...] it's a huge skill that we have to actually use that

evidence to support people. So, bringing that into a formulation because I think that's really powerful data.

Participant 6

With another going on to say:

So, something like 80% of people who are street homeless have been assaulted and present with a head injury and that is a whole additional complexifying factor that we don't necessarily think about and a lot of the specific memory clinics and those sorts of services, people will find really difficult to engage with.

Participant 9

One participant noted the current lack of best practice guidelines when working with someone who is at a risk of homelessness. They go on to suggest CPs need to adapt their psychological understanding and current frameworks so that these can be employed in these circumstances:

That tolerance of uncertainty is what is needed because there are no NICE guidelines as yet. There are no best practice guidelines, we are working off chaos, but we have the skills as a profession to build a sense making framework, whether it be psychologically informed environments or trauma informed care [...] that take into account the context of the individual and their support network in the homeless sector to support all levels of it.

Participant 4

3.3.2. Sub-theme Two: The Power and Status of Clinical Psychology Within Services

During the interviews, seven participants reflected upon the power and status CPs often hold within NHS services and considered this position to facilitate their ability to shape their job roles and the service policies and procedures.

Interestingly three participants reflected that the job role can often be determined by the individual CP. Therefore, the amount of support someone receives may be

dependent on the individual attitude of the clinician. In theory this can allow for more preventative work to take place if a CP recognises this is part of their work:

I think in terms of that authority and what we do with our responsibility, it is often left to us to decide what we do with it. And whilst that's great because in my role I can be like "I'm going off to do a consultation" but equally I can also be like "I'm not going to go and do a consultation and I am still doing my job".

Participant 5

Five participants spoke of the power CPs hold within an NHS team through the 'Doctor' title, often holding roles of a higher banding than the majority of the team. Through reflections, participants felt we could be using this afforded power more effectively to engage in more advocacy and with commissioners:

I have also been quite influenced by [X] in terms of their discussions about clinical psychology's need to be more proactive in [...] the support that we offer people around the benefits system and social services and that article they wrote about asylums [...] have given me confidence to push forward and use the legitimacy and status of being a CP within the NHS and yielding that because it does make a difference.

Participant 9

I think CPs often have quite a bit more power than they're comfortable with, partly because of having the doctor title, and I think people are hesitant to [...] embrace that power. And that could mean they miss out on opportunities to do things like speaking with commissioners or meeting with commissioners or, putting a voice across at a local commissioning level and advocating for the role of psychological factors in things like homelessness and things like drug addiction. But I think that actually psychologists should be quite powerful in that, like a powerful advocate against the... not against the medical model but in addition to the medical model or understanding.

Participant 7

One participant shared their own experiences of increasing accessibility to the NHS service they work in. This required converting the service into a more open access service which allows for engagement:

I took over clinical leadership of it just over two years ago and we completely redeveloped it from a care co-ordination model which excluded about 80% of our referrals to a more open access service with more of an engagement and assessment model which has increased the acceptance of referral rates to last year, it was about 75%.

Participant 4

3.3.3. Sub-theme Three: Developing and Sharing Formulations

Six participants considered formulation as a valuable skill we have that could be used in homelessness prevention. Four participants spoke of the importance of sharing formulations with wider systems to enable a broader understanding about an individual:

A psychologist's role that would be really helpful is formulating the person's multiple needs rather than just seeing it as a housing need and if we fix that we will all be ok and recognising that [...] to fulfil a housing need you also need to think about with a person their psychological and emotional needs in order to maintain the tenancy.

Participant 2

It's not about 'not having a house', it's about not having the capacity to live independently because of emotional strain a lot of the time. Just the difficulties of living alone, that huge emotional strain is a much bigger barrier than some of the practical housing problems.

Participant 7

Another participant concurred and suggested formulations can increase empathy:

Clinical Psychologists could try and instil a sense of psychological thinking in teams and the understanding that homelessness isn't fundamentally about a lack of practical resources. So, it can be working with people

themselves or it can be the systemic working around them, with teams, families, services. You usually are trying to bring in some empathy and not get people written off too quickly. I think that's a huge thing we do.

Participant 6

Two participants reported the value of providing formal consultations to teams for particular individuals to support their understanding and ensure an individual's needs are met:

Just for the psychological understanding of why people may behave the way they behave or why they may struggle to maintain things in the way that they expect. [...] my clinical work where I have done some of those consultations, people don't really know that much about this person in terms of their mental health which I find really shocking when they're there helping them.

Participant 5

Participants recognised the benefits of joint working across services to meet the needs of SUs holistically. An aspect of the role of a CP was understood to be liaising and bringing together various relevant services for a SU, in addition to providing regular formulation sessions to teams. This would support a better understanding of the individuals and their needs that the teams work with. This can avoid outcomes such as accommodation placement breakdown:

There is also something about joining up [...] I'd say a proportion of the people I work with are in supported accommodation or hostel situations and I actually think we try, [...] but it's often hard to get going, to have links to a regular like formulation slot or whatever it is, something we can offer to them because people are obviously at risk of being evicted from supported accommodation. [...] how can you prevent the system from creating the problem for the people that we work with.

Participant 5

Furthermore, two participants spoke about the role of formulation within reflective practice:

Things like reflective practice is a big part of our work and really encouraging the system to understand some of the more formulation driven understandings of the client group. And to other services who maybe are in mental health but don't have an understanding of the sector. It could be doing joint trainings with groups like substance misuse services or other mental health services and inviting them too.

Participant 8

3.3.4. Sub-theme Four: The Need for Clinical Psychologists to Become Politically Active

Six participants spoke about the political role clinical psychology must play in order to contribute to the prevention of homelessness:

I was thinking at a political level and this is definitely something I believe in but not sure how that works in practice but [...] sharing the psychologically informed perspective of the rights of people who are homeless and trying to change the narratives around people who are facing homelessness and use that to use a political platform to inform policy by doing research.

Participant 2

I think we need to get political, it is abhorrent that we're not. I think often, individual psychologists can be quite political, but I think in a public sense we often sit on the fence and keep quiet... I just think as a profession we should be doing a lot more and being much more outspoken and put ourselves out there.

Participant 11

Participant 12 reflected on the difficulty to be politically active if this is not supported within the service you work within:

There has been a lot of unrest and I think that all helps to make you question your own practice and make you question your values; why are you in this job? What are you standing for? And I think if you don't have

that supported within your psychology department then it is very hard to be political, it's very hard to be outspoken if it's not welcomed.

Participant 12

3.3.5. Sub-theme Five: The Need for Clinical Psychologists to Work with Commissioners and Stakeholders

During the interviews, six participants identified the opportunity to work with commissioners and stakeholders to change the systems which continue to contribute to homelessness. They further reflected on how this may look; through reflective practice provision to these audiences and adapting communication style when sharing information:

I would offer reflective practice to the team, advice, consultation across the homeless network and in depth psychologically informed environments training [...] to anyone who has got interest in working with people who are homeless and also managers of organisations and local authority, combined authority and NHS commissioners to develop their knowledge as well.

Participant 4

It's more around having those conversations with stakeholders, having those conversations with management, having those conversations with directorate boards about where our priorities lie and how we can, because essentially, the powers that be are concerned about money. They are concerned about referral rates, waiting list targets etc so unfortunately it's a corporate world and we need to be strategic about our thinking which is selling to the powers that be how something will offset waiting lists, how it will save them money in the long run, we need to sell it so that it becomes an idea that will make their lives easier.

Participant 12

One participant spoke of their experiences working closely with commissioners and the positive impact this may have on meeting the needs of SUs. They also reflected on the role of reflective practice, if this facilitated closer working

relationships between clinical psychology and commissioners or if closer working relationships facilitated reflective practice:

Commissioners have often been quite separate to clinicians whereas we have a very direct line with commissions so we would often potentially approach them directly if there was a client we were concerned about who, for whatever reason it was really difficult to place them on the pathway and we needed input [...] then we might reach commissioners to have their input or involvement. So, it's a much closer working relationship and it does feel that closer working relationship potentially introduces a need for reflective practice but also that it emerges from these reflective practices as well.

Participant 8

3.3.6. Sub-theme Six: Not the Role or Responsibility of Clinical Psychology

Whilst many shared ideas and experiences of how CPs could contribute to the prevention of homelessness, some contending factors were identified which suggested homelessness prevention was not the responsibility of the profession.

Two participants discussed the concept of therapeutic relationships, boundaries and other disciplines who would be better suited to intervene in the prevention of homelessness:

I don't try to prevent, I don't think it's my role to prevent homelessness. I think if I were a social worker I may have been brought up on a different diet of what I need to do.

Participant 3

I think that people get referred through for individual therapy and then there's all this stuff about boundaries and therapeutic relationship and what's OK, what's not OK and all these rules. [...] it doesn't feel like it falls to the psychologists to get involved say in helping with housing applications or talking with somebody about their different options because there's this assumption often that there's other people in the team that will do it if there is a support worker or someone else. [...] I feel like

we get quite limited sometimes in scope and what's allowed or not allowed, and I think the money thing comes into it again and we're expensive and cost a lot and they want us doing these specialist things which are seen as therapy and other bits as well.

Participant 7

Moreover, five participants spoke of the psychological concept; The Hierarchy of Needs (Maslow, 1943). Two participants interpreted this theory to confirm psychological interventions would be unsuitable where basic needs of housing were not met. Therefore, SUs would need to resolve housing difficulties and rerefer to psychology services afterwards:

It's hierarchy of needs. I say that it's very difficult to consider... what you might call reflective higher order stuff when your basic needs aren't met, and it's not really the home that's in question it's the safety that it brings with it. So, if you don't have safety looking at compassion focussed work, all other bets are off.

Participant 3

We are not very good at giving people access to our service, I don't think. Or if housing is an issue, we might say they need to sort that out before they can really engage in our work, but I think that's because of the nature of our work. Maybe IAPT or shorter-term services could play a vital role in managing behaviours that might leave people to be at risk of homelessness. I do think there is a lot that psychology could do but it's finding the service.

Participant 1

One participant shared they had learnt how to consider and support individuals' basic needs from other professions, and this has led them to adapt their own practice:

I hope I've taken a lot from my nursing colleagues in terms of not just sticking on what I consider to be psychology topics, you know thoughts, feelings, behaviour. I think I am much more comfortable now talking about

things like finances, stuff that is the key things, the real sort of hierarchy of needs. There's no point working on anything higher until we get you sorted with the basics.

Participant 6

CHAPTER FOUR: DISCUSSION

This research aimed to explore the role of clinical psychology in the prevention of homelessness within adult mental health services.

Within this chapter the key findings of this study will be summarised and considered in relation to the current theoretical and empirical literature. Using the findings, the research questions set within the *Introduction* will be addressed. The researcher will reflect upon the quality of the research, considering the study's strengths and limitations. Finally, the wider implications of the research upon all levels of the Ecological System's Theory (Bronfenbrenner, 1979) and future research will be discussed.

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

4.1.1. What Can Clinical Psychologists Working in Adult Mental Health Services do to Prevent Homelessness?

Participants spoke of a range of opportunities the profession can utilise to prevent homelessness. This spanned across advocacy and increasing awareness of the social issue, influencing the system structures the profession operate within and direct clinical work. These will be discussed in more detail throughout this section. Within the first theme '*Understanding Homelessness*', participants spoke of the individual and systemic risk factors that make someone more vulnerable to homelessness and indicated ways CPs could reduce these risks. For example, some participants spoke of the profession's role to support teams to understand the SUs' needs through formulation to prevent avoidable placement breakdown or to challenge narratives which may suggest homelessness is a choice made by individuals. Within the second theme '*Systemic Barriers and Facilitators of Homelessness Prevention*', participants reflected upon how service policies such as exclusion criteria and DNA policies can make services inaccessible or unsuitable to meet the needs of people at risk of homelessness. Opportunities for the profession to prevent homelessness were identified throughout the interviews, particularly within the third theme '*Clinical Psychologists' Skills and Relevance*'. These opportunities will be discussed using the prevention

framework (Fitzpatrick et al., 2019) as outlined in *Introduction - Understanding Prevention*. As this research focussed on the prevention of homelessness, responses addressed the first three levels of the framework; universal, targeted and crisis prevention.

4.1.1.1. Universal prevention. It was clear during this research that many were eager for the profession to be more politically active to challenge structural causes of homelessness to reduce future risks of homelessness. This supports previous work conducted by Rahim et al. (2020) who argue that individuals within the profession should be encouraged to recognise work as political. It can be invaluable to appreciate the power and position the profession holds within NHS services and the influence this may have on positively challenging social inequalities upheld within the current political climate. Psychology groups such as 'Psychologists for Social Change' (<http://www.psychchange.org/>) were identified as proactive political groups that CPs have benefitted from engaging with, enabling them to take more political action outside of their employment.

4.1.1.2. Targeted prevention. Within this study, the opportunity to identify risks of homelessness during the assessment process and throughout interventions by reviewing SUs' housing circumstances and considering vulnerability factors during formulations were recognised. The role of advocacy to prevent homelessness was also highlighted throughout the study. Many spoke of the influential impact the profession can have in supporting teams to understand a person's needs through reflective practice and consultation. Participants spoke of offering training to other local services such as supported accommodation to increase awareness of the risk of homelessness, in addition to providing reflective practice. It was hypothesised that increasing the awareness of the risk of homelessness and encouraging reflective practice increased empathy towards SUs. Consequently, this can reduce an individual's risk of homelessness due to placement breakdown and by earlier intervention due to increased awareness by staff.

During conversations, we heard of the benefits that come with working closely with service commissioners and stakeholders. Participants shared the direct impact this can have on improving relationships. By increasing commissioner and stakeholder awareness of the issues SUs may face, including risk and causes of homelessness, these influential bodies can review budget allocation to target these issues, directly impacting on service provision and service policy which benefits those who are more vulnerable to homelessness. The BPS (2012) provided CPs guidance on how to work within the NHS commissioning structure.

Participants acknowledged the importance of providing some SUs with more time to engage with services and with their psychologist. This felt particularly important for people who may have more predisposing factors which place them at higher risk of homelessness, for example, previous trauma, substance misuse, and insecure attachments (Seager, 2011). During this study, participants spoke of how important it was to allow time for SUs to engage. Enabling SUs to build trust with their clinicians and services was a particular focus when considering the impact previous experiences may have had on attachment. This had been witnessed within third sector organisations which were regarded as invaluable for the success of interventions. Participants who practice within specialist homelessness or hostel services reported engagement time was a necessity within the interventions for their client group. Attachment is particularly important to consider within this context. For example, previous research concludes there is a higher prevalence of insecure or weak attachment relationships for children who enter the care system after the age of eleven (The Care Inquiry, 2013; Hannon et al., 2010).

This study has brought attention to the role of formulation skills CPs hold to prevent homelessness. For example, participants acknowledged some individuals who experience drug and/or alcohol difficulties are often excluded from mental health services. Often these are coping strategies for other mental health difficulties such as trauma (Brady, et al., 2004; Ouimette & Brown, 2003). It is estimated that an individual is two to five times more likely to have either mood/anxiety difficulties or a substance misuse difficulty when the other condition

is present (Sareen et al., 2001; Sareen et al., 2006). Khantzian (1985, 1997) proposed the self-medication hypothesis to explain this comorbidity, suggesting substances are used as a coping mechanism to manage difficult experiences connected to mood/anxiety difficulties. Subsequently, substance dependency can develop as this coping strategy is relied upon more over time (Turner et al., 2018). CPs can consider substance misuse as a maladaptive coping strategy for other mental health difficulties within formulations to broaden service inclusionary criteria. CPs could work collaboratively with these individuals to reduce the impact of their mental health difficulties and in turn, reduce substance misuse which could consequently reduce the risk of homelessness.

Participants and the following research identify people with brain injury are more at risk of homelessness, in addition to those who are homeless being at higher risk of acquiring a brain injury. Participants explained this awareness can support the formulation of SU needs and behaviours to avoid placement breakdown or allow for adaptations to be made during psychological interventions.

It is also important to consider the role of clinical psychology in the comorbidity of substance misuse and brain injury. According to Hwang et al. (2013), a history of brain injury is strongly related to poor health conditions among the homeless population. These include seizures, mental health and substance misuse problems. The researchers suggest these conditions are bidirectional; mental health and substance misuse can increase the risk of brain injury and therefore homelessness could be both a cause and consequence of brain injury. Adshead et al. (2019) concede that substance abuse presented with a brain injury can present challenges to recovery and social interactions. Hayes et al. (2001) propose substances are frequently used as a coping mechanism for individuals, to allow individuals to avoid facing the changes that have been made to their functioning and avoid emotional distress. CPs can use this knowledge to develop pathways which provide support for substance misuse and brain injury. It would also be relevant to consider the impact of substance misuse within cognitive assessments to make appropriate adjustments for these individuals, as mentioned by one participant.

Some participants spoke of the risk of homelessness during service transitions such as leaving the care system or prison. Often people leaving these systems can experience a sudden withdrawal of support. Statistics illustrate in the first two years after leaving the care system, a third become homeless and a quarter of homeless people have been in care in their childhood at some point (National Audit Office, 2015). In the UK, the preparation to enter independence begins when young people in the care system are sixteen years old. This is an ambitious task and there is an expectation to achieve this transition into adulthood and carry out the associated activities at a much younger age than their peers who are not within the care system (Hannon et al., 2010). Stein and Morris (2010) highlight the preparation stage provides an opportunity for young people to explore, reflect, take risks and search for their identity however the impact of making mistakes holds higher risks for looked after children. Whalen's (2015) report for the Public Policy Institute for Wales draws attention to the fact that at the age of 18, many young people are moving out of care into a form of independent living. In addition to physical accommodation, the quality of support offered will determine the success of these transitions. Whalen (2015) reiterates the successful transition for care leavers is heavily influenced by the relationships these individuals have with trusted adults and the continuity of support they receive after their transition. Without suitable accommodation and support, there are a range of negative outcomes including poor employment, physical and mental health, offending and homelessness. CPs can build stronger connections with care systems and advocate for more comprehensive support throughout the young person's transition outside of the care system. Many of the participants within this research suggested more flexible support which extends past their move into independent living. This can avoid relationship ruptures for the young person, nurturing secure attachments and offer opportunity to provide support prior to crisis.

Within the interviews, some participants spoke of their experiences working within the judiciary system, witnessing those released with no housing often become repeat offenders. Multiple reports suggest a third of offenders did not have a fixed abode prior to imprisonment (Social Exclusion Unit, 2002; Gojkovic et al., 2012). Furthermore, there is a similar proportion of prison leavers that report being

homeless, which amount to around 30,000 people a year in the UK. It could be hypothesised this may be due to ruptures in relationships, poverty and discrimination. The All-Party Parliamentary Group (APPG) (2017) presented recommendations to prevent homelessness during transitions from institutions of care or prison. As these are recommendations, there is no legal responsibility to fulfil these and so continue to vary throughout the nation. The APPG (2017) acknowledged there is a lack of understanding for the needs of prison leavers or the extent of the problem and there is an uncertainty of who is responsible to meet their housing needs. CPs can conduct research to provide further evidence and advocate for the improvement of transitions from services to reduce the risk of homelessness.

4.1.1.3. Crisis prevention. The researcher heard of the influence CPs can have on housing decisions. Many participants recognised the impact of providing supporting letters which can provide psychological understanding to other organisations such as housing.

4.1.2. What Are Clinical Psychologists' Perceptions of the facilitators and Barriers to Preventing Homelessness?

Participants spoke of the facilitators and barriers that influence the profession's ability to prevent homelessness within adult mental health services.

4.1.2.1. Facilitators. Clinical training has provided CPs with a broad range of skills they can utilise in a range of settings which lend themselves well to this cause. For example, this study emphasised clinical skills such as neuropsychological assessments, formulation and reflective practice and the use these have in preventing homelessness. Participants valued the experiences CPs gained navigating various NHS and third sector organisations during placement rotations, allowing CPs to share and learn ideas with a broad range of people. As stated within the sub-theme The Power and Status of Clinical Psychology Within Services, participants recognised the privileged position the profession holds within NHS services, which affords power that could be used to influence service policy and structures. Some participants recognised the reluctance some

clinicians may have to harness this power, perhaps from being 'conscientious', however this can create a barrier to positive change.

Psychological distress can be understood as developing within social, cultural, historical and political contexts within community psychology (Levine et al., 1997; Orford, 2008). CPs have become increasingly interested in this position as the current economic context impacts the health of the SUs they support (Barr et al., 2015; Harris, 2014; Harper, 2015) as reflected within the results of this study. There is an increase in discussions about how macro-level change and community psychology principles can be used to respond to the psychological distress created by the economic crisis (Carr & Sloan 2003; Psychologists Against Austerity, 2015; Stuckler et al., 2009).

4.1.2.2. Barriers. Despite eleven out of twelve participants considered CPs have a role to prevent homelessness and could suggest a multitude of ways in which this could be done, there was a discrepancy between what could be done, and what participants were currently doing. Many of the participants explained they had not received teaching on the issues of homelessness during clinical training. As a consequence, many reflected the risk of homelessness was not typically considered and therefore they did not have many experiences of providing interventions. The only participant who spoke of receiving teaching on homelessness shared the positive impact this had on their practice, enabling them to consider risks during assessments and intervention. This is supported by previous research by Lucock et al. (2006), who reviewed the strongest influences of clinical practice on psychotherapists and CPs. They surveyed 95 qualified psychotherapists and 69 clinical psychology trainees across four areas of the UK to consider the main influences on their clinical practice. From the results, Lucock et al. (2006), concluded one of the most highly rated factors was professional training for both qualified psychotherapists and trainee CPs in addition to post-qualification training for qualified psychotherapist participants. During the interviews for this current research, participants spoke of homelessness in various ways, for example some spoke of sofa surfing, unstable or unsuitable housing and those seeking asylum, whilst others referred only to street homelessness. This variation of homelessness definition could reflect the lack of

teaching within training and overall awareness of the topic. One participant also reflected CPs could be expected to decide the parameters of their job role, meaning they could decide to offer certain interventions, for example, reflective practice or not. If CPs have received little training about homelessness and prevention, they may be less likely to include preventative interventions in their work. Within this research, many participants expressed the lack of training impacted upon their confidence to support those affected by homelessness. Some participants noted that at the time of the interviews there are no NICE guidelines for working therapeutically with people who are or at risk of homelessness, maintaining CPs low confidence to work with this affected population. Consequently, this can prevent CPs from supporting people at risk of homelessness or may lead to identifying a need for support too late.

As previously stated within the theme *Understanding Homelessness*, CPs within this research identified individual and systemic factors which can increase the risk of homelessness. CPs' understanding of homelessness and their role within the social issue can influence the interventions offered. This may mean some members of the profession see homelessness as a social issue, not a psychological issue. Therefore, do not believe psychology is a relevant resource within the solution of this issue and do not offer interventions. Attribution Theory (Weiner, 1985) proposes the provision of support to disadvantaged groups can be impacted by what factors clinicians consider contribute to the issue and the level of control people have to change this. Research has summarised the Global North hold two dominating explanations for homelessness (Benjaminsen & Bastholm Andrade, 2015; Johnson et al., 2015). The first are 'individualistic' explanations, which emphasises the influence of vulnerabilities and behaviours of an individual such as poor mental health and substance misuse on risk of homelessness. Secondly, there are 'structural' factors, which focus on broader influences of homelessness such as a broken housing market (MHCLG, 2018), poverty and unemployment. Bramley and Fitzpatrick (2018) critique these explanations challenging the idea there are two dichotomous positions and in holding two separate positions there is a risk of conflating individual explanations with personal agency. This is particularly relevant when there are many individual

circumstances an individual has no control over that may leave them vulnerable to homelessness. The narrative of homelessness being a choice was reflected upon during this study's interviews. The participants highlighted the importance to challenge such beliefs as this contributes to stigma in addition to affecting the resources and interventions offered for homelessness. Participants reflected both individual and structural risk factors can contribute to risk of homelessness, complimenting Bramley and Fitzpatrick's critiques. During the interviews, some CPs criticised narratives which place individual responsibility on homelessness, acknowledging these factors are often actually systemic failings. In particular, some participants addressed factors which place individuals at higher risk of homelessness such as ADHD and learning disabilities. It was their view that these are mistakenly categorised as individual factors but only increase risk of homelessness due to systemic failures. For example, the inadequate support for those with learning disabilities or lack of support during service transitions is what contributes to the risk of homelessness. It could be hypothesised that how CPs understand the causes of homelessness may influence the level of support they offer. If risk of homelessness is seen as a social issue, CPs may view social action as the most effective way to address the difficulties or signpost individuals for more practical support, for example to the housing association. On the contrary, if they view the risk of homelessness as an individual difficulty, CPs may be more likely to offer individual psychological interventions but may overlook the systemic structures which maintain their difficulties.

During the interviews many spoke of the barriers to prevent homelessness upheld by the NHS systems in which they work within. For example, many explained there are high demands placed upon services which impact on waiting times. With limited resources resulting in high caseloads, CPs often do not have the remit for 'additional' duties omitted in their job description such as support letters. Due to the increasing demands on services, there is often a limit on the number of sessions an individual will receive, often not accounting for time to engage. However, as mentioned in *Targeted Prevention*, when considering those affected by risk of homelessness, it can be appreciated that many would benefit from time for engagement. To manage long waiting times, services will often employ a DNA policy that discharge SUs if they do not attend a certain number of

sessions. Participants within this study challenged the appropriateness of such policies for those who may be at risk of homelessness. They argue maintaining regular appointments can be a challenge due to housing, financial and relational instability.

Participants reflected upon the barriers encountered due to services working independently of each other, describing services as 'silos'. CPs can use their experiences of consultation and leadership to work alongside other local services to negotiate SU populations to avoid individuals from 'slipping through the net'. Stringfellow et al. (2015) found this is particularly prevalent for those with multiple social needs such as housing in addition to mental, physical, and substance misuse needs. In this research, many participants spoke of the gap across mental health services and substance misuse services, CPs can bring these services together to work collaboratively to ensure SUs access the most suitable support. As outlined within the theme *Developing and Sharing Formulations*, one participant suggested CPs can connect with other services by providing regular formulation sessions to other local service teams. Another example of how this can be achieved is taken from Public Health England's (2017) guidance which includes allocating each SU with co-occurring mental health needs and substance misuse to a key worker who liaises across services. Alternatively, CPs can offer shared training sessions across substance misuse services and mental health services or develop cross-service policies to facilitate joint working. Participants consistently reported substance misuse typically fell within the exclusionary criteria for mental health services. This is despite the previous research described above, which evidences the comorbidity of substance misuse and mental health difficulties and/or brain injuries. Allsopp and Kindermann (2019) conducted research exploring the influence of diagnoses in accessibility to services. The authors recognised diagnoses were typically used as exclusion criteria instead of inclusionary criteria. The diagnoses most commonly named within exclusion criteria were substance misuse, degenerative conditions, such as dementia and learning disability diagnoses. These are closely followed by 'severe and enduring mental illness' for example 'personality disorder', 'schizophrenia' and 'bipolar disorder' diagnoses. It was noted that the differences across service provisions were determined by team competencies instead of by

diagnosis. This reflects the accounts made by participants within this research that they may not feel skilled to support people at risk of homelessness due to limited training. Allsopp and Kindermann (2019) contend variation across services can encourage innovation, providing an opportunity for teams to learn from each other. As a result, services can be better equipped to meet SUs needs and more accurately identify client populations. The researchers noticed support for other psychosocial factors, such as social, financial and trauma-related difficulties were deficient within the services they analysed and suggest services should aspire to improve this support. By addressing these issues, it could positively impact SUs who have clear risk factors of homelessness, such as the psychosocial factors identified above, but who would not meet a psychiatric diagnosis. Allsopp and Kindermann (2019) explain these pathways will need to be non-diagnostic to prevent the progression of an individual's distress into psychiatric disorders. This evidence strongly suggests a change in inclusionary criteria and how service pathways are set up is needed.

This current study also highlighted the role of psychological concepts for example, Maslow's Hierarchy of Needs (1943) and therapeutic boundaries in limiting the role of CPs in the prevention of homelessness. Maslow's Hierarchy of Needs (1943) conceptualises the five hierarchical levels of human needs. This model identifies these levels as physiological needs (e.g. food, water, warmth) and safety needs (e.g. security and safety), psychological needs such as belongingness and love needs (e.g. relationships) and esteem needs (e.g. feeling accomplished) and finally self-fulfilment needs such as self-actualisation (e.g. achieving full potential) (McLeod, 2018). This model posits people need to achieve physiological needs first before moving onto psychological needs and finally reaching self-actualisation. Participants in this study reported a shared clinical experience that many psychological services will exclude SUs with housing difficulties from psychological interventions. The rationalisation is that they will be unable to engage in psychological interventions when their basic needs have not been met. Conversely, some participants used this psychological concept to justify psychological input, proposing CPs can support an individual to achieve physiological needs as part of the psychological intervention. They recognise the physiological instability that may be contributing to the

psychological distress, or to view behaviours such as substance misuse as maladaptive coping strategies for distress. The St. Mungo's LifeWorks project (St. Mungo's, 2011) also challenged this idea that people whose physiological needs aren't met cannot engage with psychological interventions. Within this project SUs were offered psychotherapy sessions, of which 75% experienced improvements in their wellbeing. Similarly, the Crisis Skylight mental health project (Pleace and Bretherton, 2013) offered SUs interventions including counselling sessions. These projects illustrate the ability SUs hold to engage in psychological support, irrespective of their physiological circumstances. This provides evidence to challenge the current rationale for exclusion currently embraced by services. It is also important to consider the broader critiques of Maslow's Hierarchy of Needs (1943). Hanley and Abell (2002) argue this theory is heavily grounded in Western ideals. They propose these ideals are individualistic and under-emphasise the use of relationships in personal growth, viewing these relationships as only helpful to meet love and belonging deficiencies. Neher (1991) highlights this theory undermines the role of an individual's cultural environment in their psychological development, that it is only required for very basic support and nurturance whilst over-emphasising the role of the individual, innate influences on our psychological growth. The Hierarchy of Needs (Maslow, 1943) suggest basic needs cannot be met without others and relationships are a tool to facilitate the journey to self-actualisation. Once someone reaches self-actualisation, relationships become obsolete and the need for connection is no longer sought for. Instead, Hanley and Abell (2002) propose an alternative version of the model which accentuates relationships beyond meeting a deficiency. Hanley and Abell (2002) further critique this model as gendered. Gilligan (1982) argues women may view relationships as an end goal rather than a vehicle to achieve a goal, contrary to Maslow's model. Consequently, Maslow's Hierarchy of Needs inadvertently suggests men are more equipped to reach self-actualisation due to the gender differences on the perception of relationships.

Interestingly, despite a vast range of evidence which identifies a number of factors which make someone more vulnerable to homelessness as outlined within the *Introduction - Social Inequality*, many were not discussed by

participants during the interviews. For example, participants did not discuss the role of disability in exasperating homelessness. This may be a reflection on the sample, as all participants practiced within mainstream adult mental health services rather than physical or learning disability services. As previously discussed, due to services being separated into silo's, those with learning disabilities will often be excluded from adult mental health services and so this sample of CPs may not typically work with this client group, explaining why this client group is not considered in their responses. Lastly, as previous research detailed within the *Introduction - Social Inequality* also highlight, those with disabilities may access mainstream mental health services however disabilities or learning needs may go undetected and therefore needs are unmet.

Despite the identified role of CPs with policy development, only one participant was noted to have practiced in this way. Hosticka et al. (1983) proposed the term 'policy-knowledge gap' which describes the lack of knowledge about policy within psychology. Furthermore, Burton et al. (2007) recognise the lack of career structure to support those who do work at a macro-level. Despite professional training emphasising leadership competences and placements entailing policy level work, Peacock-Brennan et al. (2018) state professional training has not attended to developing the skills required to influence policy enough. Browne et al. (2020) also recommended skills to strategise policy change during training to fill this 'policy-knowledge gap' (Hosticka et al., 1983).

Throughout the interviews, participants spoke about the role of professional bodies to support and encourage CPs to take a more political stance on social inequalities. These comments were made despite the progress the BPS have been making to take a more active role in politics. For example, there has been an expansion of the BPS policy team to encompass the 'Psychological Workforce', 'Psychological Government' and 'From Poverty to Flourishing'. Additionally, they have taken an active role to respond to the Department of Health and Social Care Advancing our health: preventions in the 2020s (British Psychological Society, 2019). None of the participants of this study spoke of these progressions, which leads to considerations of how CPs become aware of BPS action. It can be hypothesised that if more CPs were aware of these actions,

they may feel more able to take individual action too. Browne et al. (2020) also suggest moving from individual to macro-level working may require CPs to become more engaged with professional bodies.

4.2. Critical Review and Reflections

4.2.1. Quality of the Research

As mentioned within the *Methodology - Reviewing the Quality of the Study*, Elliott et al. (1999) offer publishability guidelines which are particularly relevant to qualitative research. These include (1) owning one's perspective, (2) situating the sample, (3) grounding in examples, (4) providing credibility checks, (5) coherence, (6) accomplishing general versus specific research tasks, (7) resonating with readers. Braun and Clarke (2021) also emphasise the importance of owning one's perspective. The researcher created various opportunities within *Methodology - Relationship to the Research* and *Discussion - Reflexivity* to state and explain their perspective. As discussed within *Methodology - Data Analysis*, Braun & Clarke's (2006) six phases of analysis were used by the researcher to develop themes from the data gained. Initially, transcripts were individually coded, and latent codes were generated (Braun and Clarke, 2006). Themes were developed through a thorough coding process. The researcher then used spreadsheet software to cluster related codes together and following this, clusters were used to differentiate potential themes. The analysis was inductive; therefore codes and themes were rooted in the data gained in the research instead of being driven by previous theory (Braun and Clarke, 2006). Elliott et al. (1999) also offer methods to review the credibility of themes. These include reviewing understanding with the participants; using a number of qualitative analysts to review the data for inconsistencies or errors; comparing two or more varied qualitative perspectives; or where suitable, 'triangulation' with external factors or quantitative data. For this research, emerging themes were shared and discussed with peers and the research supervisor reviewed the generated themes and provided feedback and suggestions for improvements. This allowed the researcher to avoid mistakes such as confusing codes and themes and confusing themes and topics as warned by Braun and Clarke (2021). The

researcher also considered the way themes were presented within *Results*, paying attention to the number of quotes presented by each participant. Additionally, the researcher compared the different perspectives which arose in the interviews.

Braun and Clarke (2021) encourage researchers to specify the type of thematic analysis they are undertaking. In this research, reflexive thematic analysis has been employed and specified within *Thematic Analysis*. The use of this approach means multiple analysts are not desirable for the quality of the research (Braun and Clarke, 2021). Within *Methods*, the researcher aimed to provide details and rationale for the analytical process. Additionally, Williams and Morrow (2009) suggest researchers should provide evidence illustrating the quality and quantity of data gathered is sufficient. This goes beyond sample size (Yeh and Inman, 2007) and should reflect a wide range of perspectives which are likely to provide rich data and sample diversity can facilitate the range of perspectives. By advertising the research on national social platforms with minimal exclusionary criteria, the researcher aimed to interview a range of CPs. The final sample was made up of participants with a diversity of experience, service setting, number of years practicing and level of authority. To address the final principle, within the *Results Chapter*, the researcher identified a range of themes which were believed to be comprehensive reflections of the interviews taken place. Evidence of how the interpretations fit the data were presented, for example through use of quotes to illustrate the interpretations made by the researcher. Throughout the *Results Chapter* the researcher endeavoured to provide a broad range of quotes to inform the interpretations made. Additionally, to support the claims made, the findings have been offered within the context of existing theoretical literature to build upon the current understanding of homelessness prevention which can be found within *Research Questions: The findings in the Context of the Literature*. Lincoln and Guba (1985) also recommend 'member checking' whereby the researcher seeks the participant's feedback at various points during the research process to ensure the researcher's interpretations honour the meanings held by the participants. During this piece of research, the researcher checked for mutual understanding throughout the interviews, however, due to the nature of the thesis

did not have the opportunity to conduct further checks as the research progressed.

Braun and Clarke (2006; 2021) outline a number of questions to guide the assessment of thematic analysis research quality which were used to reflect on this project. Within *Methods - Thematic Analysis*, the researcher clearly outlined the epistemological assumptions and recognised the different approaches to use in thematic analysis. The researcher provided a rationale for the approach chosen and ensured this approach was used consistently with a critical realist position. Braun and Clarke (2021) also argue data does not need to be limited to descriptive analysis as thematic analysis has the potential to provide interpretative analysis. Throughout the analysis process, the researcher has provided interpretations which can be found in the *Results* and explored within the *Discussion*.

4.2.2. Reflexivity

Williams and Morrow (2009) discuss the balance between participant meaning and the researcher's interpretation, emphasising this balance is strongly related to subjectivity. Barrett et al. (2020) posit reflexivity as a constant process of reviewing the researcher's position within the context of the research and requires acknowledging and challenging the social and cultural influences that may affect this context. Verdonk (2015) emphasises the role of questioning, examining, accepting, and articulating our attitudes, assumptions, perspectives and roles in the process of reflexivity. These processes were imperative to undertake in this research as qualitative researcher views and beliefs contribute to the analytic process (Braun et al., 2006).

4.2.2.1. Personal reflexivity: Throughout the research process, the researcher used reflective logs and conversations with their supervisor to remain conscious of their biases and assumptions, allowing these experiences to remain separate from the participants' narratives (Barrett et al., 2020). Within these opportunities for reflection, the researcher held in mind their beliefs on the role of CPs, their political alignment, epistemological perspective and personal experiences as outlined in *Methodology– Relationship to the Research*. It was also important to

recognise the dynamics the researcher faced as a trainee whilst completing this study. For example, during the write up of this study it was important to reflect the findings without being drawn to take the position of neutrality, in order for the findings to be more accepted or 'softened' or fear of damaging professional relationships. Although neutrality may support the researcher gain professional status, this would have little to no impact on homelessness. Thompson (2007) discussed the discomfort which arises from many trainee CPs when considering a socio-political approach within the profession. Thompson (2007) highlighted that when socio-political aspects are not attended to, this is not because the clinicians view them as irrelevant but rather, they did not know how the profession could participate at this level. This was a particular hesitation within the NHS system and they summarised some may view the socio-political approach as too idealistic, or that these were personal values which may be difficult to apply within a professional context. Thompson (2007) was also able to distinguish three attitudes towards the profession's political involvement: pro, anti or unsure. Those who were against professional political involvement generally considered this to risk damaging the integrity of the profession and the neutral stance currently taken. It was important for the researcher to consider these positions, particularly resisting the pull to remain neutral to fit the science-practitioner model previous research may endorse (Kennedy & Llewelyn, 2001) which ignores the culture, context and history (Cox and Kelly, 2000).

4.2.2.2. Epistemological reflexivity: Willig (2013) explained epistemological reflexivity entails the factors that initially influence the development of the research questions and how these may guide the outcomes of the research. Epistemological reflexivity also recognises the impact the methodology has on the findings of a study. As outlined in *Ontology and Epistemology*, the researcher adopted a critical realist position which assumes there can be multiple perspectives despite an 'objective reality' (Healy et al., 2000). Therefore, the data gained from the interviews require the researcher's reality and the participants' realities to come together to develop an understanding of the results. In order to truly evaluate the trustworthiness in qualitative research the researcher needs to acknowledge and understand the world views and premises (Williams and Morrow, 2009). Ponterotto (2005) described these world views and premises as

'paradigms' which encapsulate the researcher's views of reality, the researcher-participant relationship, the researcher's position on subjectivity or objectivity, the researcher's values, the process and procedures of the research and how the research is communicated.

4.2.3. Limitations of the Research

When reviewing this research, there have been a number of limitations including the limitations within the sample, social desirability of responses and thematic analysis methodology.

Firstly, it is important to consider the CPs who volunteered to participate in this research. The researcher was mindful that by using a snowball sampling strategy, there was a risk of driving a biased sample. By recruiting two CPs already known to the researcher and three others who heard about the research through other participants, there was the possibility of recruiting a sample of participants with similar mind-sets who do not reflect the broader views of CPs working across the UK. This could also be the case for individuals who were recruited through social media platforms who may have a particular interest in homelessness. Consequently, the results should be considered tentatively.

It is also important to consider the influence of the one-to-one interviews. The researcher acknowledged that some responses may have been impacted by participants trying to provide more desirable response to the interviewer or may have felt their personal role in the prevention of homelessness under the spotlight (Edwards, 1953). The researcher attempted to manage this with a clear introduction to the interview which emphasised there were no right or wrong responses.

When using thematic analysis, it is recommended for coding to be undertaken by two coders (Terry et al., 2017). Unfortunately, this was not possible for this research. Codes and themes were discussed with the researcher's supervisor to provide the opportunity to reflect on the analytic process. It was also not possible to review themes with the participants due to the nature of the thesis which would

have given an additional opportunity to validate the findings (Lincoln and Guba, 1985).

4.2.4. Strengths of the Research

To the researcher's knowledge, this is the first study to explore the role of CPs in the prevention of homelessness within adult mental health services. This allows for initial conclusions to be drawn about the profession's role within adult mental health services in the prevention of homelessness and to begin understanding what supports and hinders the profession in this task.

The sample of participants consisted of a range of professionals with a breadth of professional and personal experience spanning from newly qualified to 28 years of service. Participants came from various areas across the UK, working in a range of adult mental health services. Consequently, the sample cumulatively held a broad range of knowledge which was reflected in the interviews and the results of this research.

4.3. Implications of the Research

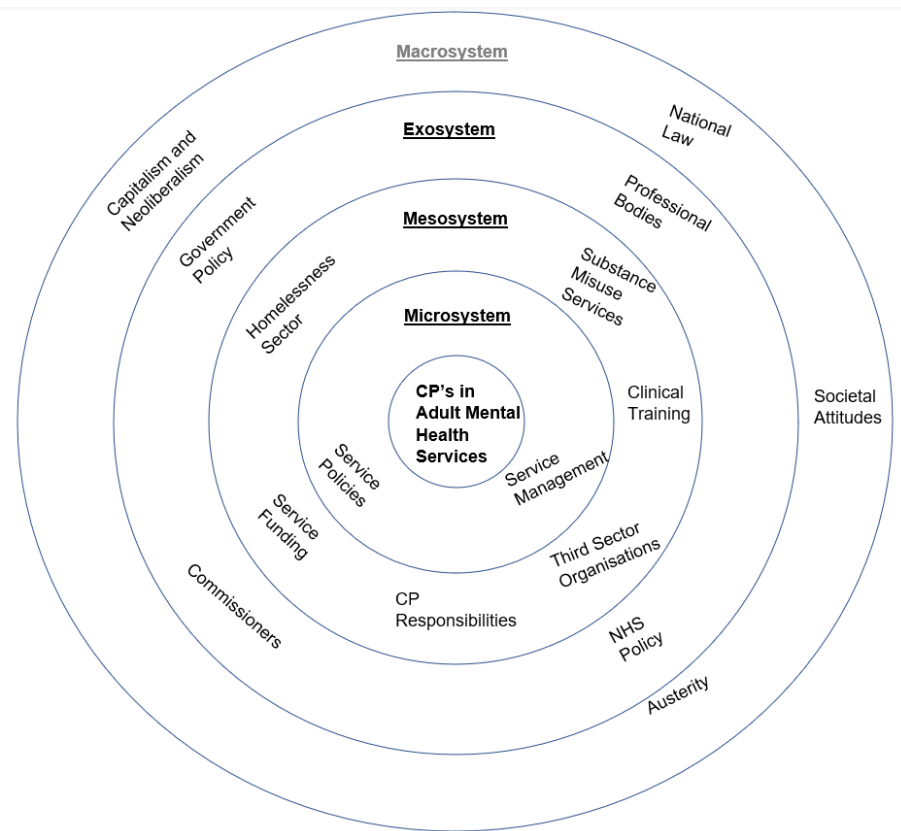
The Ecological System's Theory (Bronfenbrenner, 1979) has become increasingly used as a conceptual tool for guiding public mental health interventions (Eriksson et al., 2018). This section explores how this model can be used to generate and map developments within the wider systems to positively improve the profession's practice to prevent the risk of homelessness within the UK.

This model can highlight where developments can be made at each system level to utilise the role of clinical psychology in the prevention of homelessness within adult mental health services. This framework recognises that each level is influenced by all others, therefore only addressing an intervention identified within one system is unlikely to bear great impact. In order for substantial changes to be made, the profession must embrace a holistic approach, implementing change at each system level to positively impact this social need. As this research focussed

on the role of CPs in the prevention of homelessness within adult mental health services, they have been placed centrally within the formulation (Figure 1). The homelessness prevention framework proposed by Fitzpatrick et al. (2019) outlined in the *Introduction* of this research complements this system's theory well and will be referred to throughout the reference of this model. It is important to ensure each level of the prevention framework is addressed as we consider the implications of this research to maximise the impact of this work, contributing to the universal prevention of homelessness.

Figure 1.

The Application of Bronfenbrenner's (1979) Ecological System's Theory to Conceptualise the Wider Implications of the Research on the Role of Clinical Psychology in the Prevention of Homelessness.



4.3.1. The Microsystem

The microsystem is the first level which has direct contact with the CPs working within adult mental health services. These can include the service management and service policies which outline the boundaries of clinical practice. The relationship within this level is bidirectional and so the microsystem can influence the CP, however the CP can influence the microsystem. For example during this research, it has been said that service policies such as exclusion criteria, allowing for engagement within clinical interventions or asking about housing circumstances as standard practice during assessments influence how much a CP can prevent homelessness within adult services. The results of this research show CPs should involve themselves in service policy development to positively influence protocols to improve access to services for this population. Despite this majority perspective, only two participants spoke of their personal experiences of influencing service policy. This may reflect a clinician's level of responsibility and banding within a service, whereby those in leadership positions are more able to address service policy issues.

All services should prioritise improving access to their services. Hewett and Halligan (2010) posited due to systems' limited inclusion criteria, homeless peoples' needs are being discriminated against as they struggle to access the appropriate services. This study heard participants speak of the barriers people at risk of homelessness face when attempting to access services. These included the rigid exclusionary criteria and the division of services into specialties. In order to address this, CPs could work collaboratively with experts by experience to understand the barriers that prevent access to services to those at risk of homelessness. A main aspect of social justice work is advocating together with marginalised and disempowered communities rather than for these communities. Therefore, it is important for CPs to seek representatives from these communities to provide an insight into needs which can assist and inform clinicians in the development of interventions (Marshall-Lee et. al., 2020). Another example could be for CPs to present supporting evidence to change service policies to increase access for disadvantaged populations such as those at risk of homelessness. These changes can take the form of changing existing service policies which exclude certain individuals from services and extending interventions to allow

SUs time to engage with the service. This would enable affected individuals to access and engage with services and therefore increase the opportunities for the profession to intervene prior to a person becoming homeless. CPs can utilise their skills in audit to evaluate the impact of changes to ensure these changes have contributed to an increase in access to services. This can stimulate further work to remove these barriers.

During the interviews, CPs voiced a range of experiences in how services address issues revolving around the risk of homelessness suggesting it is often service-dependent, potentially to manage the consequences of service cuts on service demand with reduced resources. However, many reflected the rationale that someone may be excluded from psychological interventions due to risk of homelessness and how this is rationalised by the psychological concept, the Hierarchy of Needs (Maslow, 1948). Within this context, psychological teams and services argue a SU will not benefit from a psychological intervention if their basic needs of secure housing are not met. This rationale can shape individual service policies and protocols. CPs should use research skills to explore this further whilst drawing upon current research or examples that contradict this. They can then use their position to influence service policies to ensure people aren't excluded unnecessarily.

Additionally, Lucock et al. (2006) identified current supervision and psychological formulation were some of the highest influencing factors on practice. CPs are often expected to provide supervision to clinicians pre-training, trainee CPs and less senior CPs within their services. The use of supervision was not discussed by the participants of this research, perhaps indicating homelessness is often not a consideration within services. CPs should bring conversations about homelessness prevention into supervision and formulation to encourage other clinicians within the profession to also consider this risk with those they work with.

CPs can utilise their experiences and positions to exhibit leadership roles, seeking opportunities to work collaboratively with commissioners and other stakeholders. This was discussed by multiple participants, however only two participants had personal experience of working in this way. This study heard of the unique relationships CPs may have with commissioners for example,

providing reflective practice. There are also opportunities for CPs to sit within commissioning structures as 'experts' within a certain area. CPs can foster positive relationships, provide evidence and broaden the commissioner's understanding of homelessness risk and the financial implications of this social need. Consequently, this can lead to budget reviews which can positively impact this population for example, by broadening inclusion criteria, allowing for advocacy, or allowing time to engage with services.

Overall, these changes can contribute to the targeted and crisis levels of prevention (Fitzpatrick et al., 2019) as we will come into more contact with those who are at higher risk of homelessness or those in imminent risk of homelessness.

4.3.2. The Mesosystem

The Mesosystem encompasses the agencies CPs may work with or have worked alongside. The effectiveness of these relationships will have an impact upon the work CPs can do to prevent homelessness. During the interviews, participants reflected that despite some having experience of social inequality teaching, homelessness was not generally discussed or considered during their core professional training. As a result, many suspected this shaped their understanding of what is considered to fall within the clinical psychology role. The BPS (2019) advise clinical training should prepare trainee CPs to work holistically and integratively, holding in mind all factors which may influence an individual's circumstances, using psychological knowledge to guide practice and interventions. Therefore, a focus on social factors which can contribute to the risk of homelessness and the role of clinical psychology should be considered explicitly throughout training.

In addition to providing space during teaching to consider such factors, training should provide more placement opportunities that encourage SU advocacy and policy development. Many participants looked at experiences working within third sector and charity organisations to learn best practice. By seeking more placements in charity sectors, training programmes will provide further opportunity for trainees to practice in a wide range of settings, providing a

broader range of interventions within services not necessarily bound to the same structural limitations of the NHS. Consequently, trainees can carry new ways of working into future job roles, positively impacting the SUs they work with. It is important to acknowledge there are already opportunities for third sector organisation placements during training, however opportunities are not consistent and available to all trainees. During clinical training, CPs are required to become adept in cognitive assessments and could use these skills to provide neuropsychological assessments for those with suspected brain injury. This would allow SUs and services to understand their cognitive strengths and limitations. By doing this, an appropriate care package of support can be put in place for the individual and provide context for behaviours which can reduce the risk of homelessness or repeated homelessness.

By making these changes, the profession will be contributing to targeted prevention (e.g. those who are usually excluded across services due to 'dual diagnosis') and crisis prevention (e.g. being more aware of factors which indicate someone may be at risk within the next 56 days) according to the homelessness prevention framework (Fitzpatrick et al., 2019).

4.3.3. The Exosystem

The exosystem is understood as the ways in which the relationships between the mesosystem and microsystem affect the CPs work within adult mental health services.

Rahim et al. (2020) posit psychological work is political and CPs should be encouraged to engage at this level. As stated in the previous section addressing the research question '*What can CPs do to prevent homelessness?*', the power and position they hold should be utilised to promote social justice and address inequalities maintained by wider systems. Furthermore, this can also include the promotion and provision of proactive preventative interventions (Harper, 2016). By undergoing such work, the psychological distress experienced by the affected populations will reduce.

Additionally, CPs can work collaboratively with professional bodies such as the BPS to amplify the development of professional body structures to engage the profession more in social issues such as homelessness prevention. The BPS houses a range of special interest groups, however there is not a homelessness special interest group. It would be valuable for such a group to be created to allow opportunities for individual CPs to engage in this work.

As a government policy, the Homelessness Reduction Act (2017) falls within the exosystem of this system's model. This Act has set out new duties which require certain clinicians that are employed by public authorities to identify when a peoples' housing situation is at risk within the next 56 days and, if consent is given, refer the individual or family to their local housing authorities for preventative support. These public authorities include prisons, youth offender institutions, social services, hospital in-patient, emergency departments and urgent treatment centres, probation services and Jobcentre plus (Homeless Link, 2018). Unfortunately, this list does not include many of the settings in which CPs' practice, such as primary and secondary care which may contribute to the dominant narrative that CP's do not have a role in homelessness prevention. Despite this, this study has highlighted the multitude of opportunities CPs can intervene in an individual's experience of homelessness. This evidences the relevance and appropriateness of CPs contribution and that the profession should employ the standards set by the Homelessness Reduction Act. It would be beneficial for these oversights to be considered during any review of the Act so that it applies to all health services. With government attending to the rising need to reduce homelessness, and the introduction of policies such as the Homelessness Reduction Act (2017) and Rough Sleeping Strategy (MHCLG, 2018), it is a time where CPs may have an audience to contribute to further policy developments.

CPs can hold an active role in policy development to provide a psychological perspective of social issues. They can use their knowledge in systemic processes which perpetuate social inequality and negatively impact people who have been marginalised and ensure these are considered during policy development. CPs can continue to undertake research and service audits to build up evidence which

can be presented to commissioners and stakeholders who can bring about change in policy and advocate for social inclusion. As a result, this can allow people who are at risk of homelessness access to psychological services and provide more opportunities to intervene before someone reaches a 'crisis' point. Browne et al. (2020) emphasise CPs will need to be supported to be involved in this work by the organisations and services in which they work. Due to service cuts, CPs may not feel able to contribute to policy development due to the lack of time and resources they have.

Furthermore, experts by experience should be present within teams and positions of leadership to advise what support should be offered to those affected by risk of homelessness. Having team members who have lived experience provides more potential for services to challenge the macro level factors that influence SU's mental health problems (Chu et al., 2012). Working with SUs in this way is often included in professional training and a skill CPs should feel experienced in. Overall, these changes can contribute to the universal and targeted levels of prevention (Fitzpatrick et al., 2019) as policies reduce the risk of homelessness to the overall population as well as reducing social inequalities which make people more vulnerable to homelessness.

4.3.4. The Macrosystem

The macrosystem surrounding CPs who work within adult mental health services include more distant influences such as austerity, the national law, and societal attitudes. These may have an indirect influence on the abilities the profession has to contribute to the prevention of homelessness. Nelson and Prillethensky (2005) identify two key strategies for macro-level intervention, ameliorative interventions and transformative interventions. Ameliorative interventions aspire to transform policies related to the treatment of individual SUs, whilst transformative interventions aim to transform policies related to wider social determinants which contribute to psychological distress (Nelson, 2013). Both of which CPs can intervene.

Societal attitudes towards homelessness need to change by challenging the narratives of homelessness being an individual's responsibility. This can increase

community empathy with the affected population and can have an impact on funding allocation and research interest.

The cuts to funding which were implemented under the UK government's austerity agenda have an ongoing impact upon the ability for the profession to provide high quality interventions to SUs who may be at risk of homelessness. Due to ongoing increased demand leading to higher caseloads with limited resources, CPs may continue to report reduced capacity to offer individual interventions, opportunity for engagement or advocacy amongst the affected population. It is imperative that law and policies recognise the impact these cuts have made, often providing short-term solutions but requiring SUs to repeatedly use services in the long-term. CPs can contribute to policy development and political activism to bring about these changes. CPs can be involved at a policy level by uniting relevant expertise from across the discipline to develop policy reports and position papers, responding to a consultation or holding events in Parliament to disseminate psychological evidence directly to those who are in positions to make change (BPS, 2019). Bullock (2019) emphasised the influence of psychological research on policy by allowing us to understand factors that contribute to poverty, in addition to understanding and challenging societal attitudes towards those in poverty. Crowley et al. (2019) summarised poverty-related bills were 65.6% more likely to be enacted when they directly cited psychology. Citing psychology could be used to support policy, define an investment such as a new training program or training funding, to protect the well-being of individuals or to reflect upon a psychologist's expertise in the area (Crowley et al., 2019). Foscarinis (1991) calls for action to apply public pressure onto elected officials to stimulate legislative action. Examples of how CPs can do this include educating others with up-to-date legislative proposals to enable the public to apply effective pressure on political leaders, to contact representatives in governments (e.g., Members of Parliament) to raise concerns and for groups to take part in lobbying for change to apply organisational pressure. This could include individual CPs becoming more involved within the BPS or their local Psychologists for Social Change (<http://www.psychchange.org/>) group.

As discussed within the *Introduction* and *Results* chapters, the current market and lack of social housing has made housing unaffordable to many, contributing to elevated stress (Gibson et al., 2011) and placing them at risk of homelessness (McGuinness, 2019). Within the *Introduction* one of the themes outlined within 'A New Deal for Social Housing' (MHCLG, 2018) aimed to increase social housing. CPs could be involved in the evaluation of this initiative and be involved in any consequential policy developments. By CPs advocating for both more social housing and affordable housing, this risk of homelessness and source of psychological distress which impacts disadvantaged families the most can be eliminated.

Macro-level interventions intend to make social and political change. There will be a positive impact across all levels within the homelessness prevention framework by making changes within the macrosystem (Fitzpatrick et al., 2019). Not only will policy and societal attitude change contribute to reducing the risk of homelessness by addressing austerity (universal prevention), but it will also have a positive impact on those who are at risk of repeat homelessness (recovery prevention), those at higher risk of homelessness (targeted prevention), those who may be at risk of homelessness within the next 56 days (crisis prevention) and those who are in immediate risk of homelessness (emergency prevention).

4.3.5. Implications for Future Research

Throughout the interviews there was a discourse around the role of commissioners, it would be highly valuable to conduct further research to gain an understanding of commissioner perspectives on homelessness prevention within psychological services and the potential roles of CPs in preventing homelessness.

Participants reflected on the role of their clinical training on their awareness of the social issue of homelessness and to what extent preventative work resonates with their job roles. Further research could explore the influence of homelessness teaching during core professional training on practice.

Throughout the interviews, Maslow's Hierarchy of Needs (1943) was often the foundation for services to withhold psychological interventions from people at risk of homelessness. Future research could attempt to gain insight into the experience of psychological intervention from the perspective of SUs who may be at risk of homelessness. This could gain an understanding into the subjective experiences people have and if psychological intervention is experienced as inappropriate or helpful by the people we work with.

As outlined within *Social Inequalities*, the Rough Sleeping Strategy (MHCLG, 2018) identified there is limited research which explore the particular risks of homelessness to the LGBT community and what their needs are when they are homeless. It would be helpful to undertake research to understand the risks and needs of homelessness faced by this community. These findings could better inform particular homelessness preventative measures for this community.

Finally, this study explored the role of clinical psychology within adult mental health services. To expand such research across the broad range of the professional roles in different settings to encapsulate clinical psychology within other services such as physical health, children's services and forensic services would be valuable. Subsequently, a vast amount of evidence supporting the role of clinical psychology in the prevention of homelessness can be collected, which can be applied in any setting, amplifying the overall positive impact this profession can have on this social crisis.

4.4. Conclusion

This is the first study to provide an initial overview of the role of clinical psychology in the prevention of homelessness from the perspective of CPs working in adult mental health services. Results found clinical psychologists can contribute to the prevention of homelessness at a clinical, policy and political level. Clinical interventions included: reviewing housing circumstances during assessments and interventions, conducting cognitive assessments where appropriate, providing consultation and reflective practice for clinicians and advocating for SU needs to be considered (e.g. providing support letters). It was also identified the profession can contribute to improving this social issue within policy development, utilising leadership and research knowledge to advocate for change in processes. Participants also highlighted the importance for CPs to be politically active to challenge the wider contexts which perpetuate homelessness. Following the analysis of data gathered from the interviews, there was often a discrepancy between what CPs reported could be actioned by the profession and what CPs do in practice. A number of facilitating factors were noted to support CPs to engage in this work, including the skills gained during professional training and the position the profession holds within NHS structures. Barriers to engage in this work were also identified which included the lack of training in homelessness and skills to influence policy within professional training. Barriers within NHS structures were also recognised including; how rigid NHS structures can be, policies that may limit CPs remit and access to services, and that services are divided into specialities, encouraging silo working. Lastly, how CPs understand homelessness and psychological concepts such as Maslow's hierarchy of needs (1943) were recognised as potential barriers to the profession engaging in this preventative work.

This study identified the opportunities the profession, or individual CPs, have to intervene at all levels of the ecological system and how to address the perceived barriers. CPs are encouraged to build relationships with commissioners and other local services and to change service policies to prevent homelessness at a broader level. Institutions of professional training need to incorporate discussions around homelessness and develop trainee CPs' knowledge on how to influence

policy. This should be incorporated into teaching to provide CPs with skills to provide interventions for the affected population.

Future research to understand the experience of psychological intervention from the perspective of SUs who may be at risk of homelessness would also strengthen the proposal for the profession to take a more active role addressing this social issue. Furthermore, exploring commissioner perspectives on homelessness prevention within psychological services should be addressed. These can provide an idea of any other barriers that prevent the profession engaging in this work.

REFERENCES

- Adshead, C. D., Norman, A., & Holloway, M. (2019). The inter-relationship between acquired brain injury, substance use and homelessness; the impact of adverse childhood experiences: an interpretative phenomenological analysis study. *Disability and Rehabilitation*, 1–13. <https://doi.org/10.1080/09638288.2019.1700565>
- Aiden, H., & McCarthy, A. (2014). Current attitudes towards disabled people. *Scope*. <https://www.scope.org.uk/Scope/media/Images/Publication%20Directory/Current-attitudes-towards-disabled-people.pdf?ext=.pdf>.
- Aldridge, R. W., Story, A., Hwang, S. W., Nordentoft, M., Luchenski, S. A., Hartwell, G., Tweed, E. J., Lewer, D., Vittal Katikireddi, S., & Hayward, A. C. (2018). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *The Lancet*, 391(10117), 241–250. [https://doi.org/10.1016/s0140-6736\(17\)31869-x](https://doi.org/10.1016/s0140-6736(17)31869-x)
- Ali, A., & Lees, K. E. (2013). The therapist as advocate: Anti-oppression advocacy in psychological practice. *Journal of Clinical Psychology*, 69(2), 162-171. <https://doi.org/10.1002/jclp.21955>
- Alley, D. E., Lloyd, J., Pagán, J. A., Pollack, C. E., Shardell, M., & Cannuscio, C. (2011). Mortgage delinquency and changes in access to health resources and depressive symptoms in a nationally representative cohort of Americans older than 50 years. *American Journal of Public Health*, 101(12), 2293–2298. <https://doi.org/10.2105/ajph.2011.300245>
- All-Party Parliament Group for Ending Homelessness. (2017). *Homelessness Prevention for Care Leavers, Prison Leavers and Survivors of Domestic Violence*. Crisis.

https://www.crisis.org.uk/media/237534/appg_for_ending_homelessness_report_2017_pdf.pdf

- Allsopp, K., & Kinderman, P. (2019). The use of diagnoses in mental health service eligibility and exclusion criteria. *Journal of Mental Health, 30*(1), 97–103. <https://doi.org/10.1080/09638237.2019.1677875>
- Amore, K., Baker, M., & Howden-Chapman, P. (2011). The ETHOS definition and classification of homelessness: An analysis. *European Journal of Homelessness, 5*(2), 19-37. <https://www.feantsa.org/download/article-1-33278065727831823087.pdf>
- Anfara, V. A., & Mertz, N. T. (2006). *Theoretical frameworks in qualitative research* (1st ed.). SAGE Publications, Inc.
- Astbury, J. (2010). The social causes of women's depression: A question of rights violated. In D. C. Jack & A. Ali (Eds.), *Silencing the self across cultures: Depression and gender in the social world*. Oxford University Press.
- Backer, T. E., & Howard, E. A. (2007). Cognitive impairments and the prevention of homelessness: Research and practice review. *Journal of Primary Prevention, 28*(3–4), 375–388. <https://doi.org/10.1007/s10935-007-0100-1>
- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Open University Press.
- Barnes-Holmes, Y., Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2002). Relational frame theory: A post skinnerian account of human language and cognition. *Advances in Child Development and Behaviour, 28*, 101-138. [https://doi.org/10.1016/s0065-2407\(02\)80063-5](https://doi.org/10.1016/s0065-2407(02)80063-5)
- Barr, B., Kinderman, P., & Whitehead, M. (2015). Trends in mental health inequalities in England during a period of recession, austerity and welfare

- reform 2004 to 2013. *Social Science & Medicine*, 147, 324–331.
<https://doi.org/10.1016/j.socscimed.2015.11.009>
- Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to . . . be reflexive when conducting qualitative research. *The Clinical Teacher*, 17(1), 9–12.
<https://doi.org/10.1111/tct.13133>
- Barton, C., & Wilson, W. (2021). *Social rented housing (England): Past trends and prospects*. House of Commons Library.
<https://commonslibrary.parliament.uk/research-briefings/cbp-8963/>
- Braubach, M. (2011). Key challenges of housing and health from WHO perspective. *International Journal of Public Health*, 56(6), 579 – 580.
<https://doi.org/10.1007/s00038-011-0296-y>
- Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly*, 27(2), 101–113. <https://doi.org/10.1111/1471-6402.00090>
- Benjaminsen, L., & Bastholm Andrade, S. (2015). Testing a typology of homelessness across welfare regimes: Shelter use in Denmark and the USA. *Housing Studies*, 30(6), 858–876.
<https://doi.org/10.1080/02673037.2014.982517>
- Bennett, G. G., Scharoun-Lee, M., & Tucker-Seeley, R. (2009). Will the public's health fall victim to the home foreclosure epidemic? *PLoS Medicine*, 6(6).
<https://doi.org/10.1371/journal.pmed.1000087>
- Bisman, J. (2010). Postpositivism and accounting research: A (personal) primer on critical realism. *Australasian Accounting, Business and Finance Journal*, 4(4), 3–25. <https://ro.uow.edu.au/aabfj/vol4/iss4/2/>
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development* (1st ed.). SAGE Publications, Inc.
- Brady, K. T., Back, S. E., & Coffey, S. F. (2004). Substance abuse and

- posttraumatic stress disorder. *Current Directions in Psychological Science*, 13(5), 206-209. <https://doi.org/10.1111/j.0963-7214.2004.00309.x>
- Bramley, G., & Fitzpatrick, S. (2018). Homelessness in the UK: Who is most at risk? *Housing Studies*, 33(1), 96–116.
<https://doi.org/10.1080/02673037.2017.1344957>
- Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard edges: Mapping severe and multiple disadvantage in England*. Lankelly Chase Foundation.
<https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
<https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2021). One size fits all? What counts as (reflexive) thematic analysis? *Qualitative Research in Psychology*, 18(3), 328-352.
<https://doi.org/10.1080/14780887.2020.1769238>
- Brewin, C. R. (1984). Perceived controllability of life events and willingness to prescribe psychotropic drugs. *British Journal of Social Psychology*, 23(3), 285-287. <https://doi.org/10.1111/j.2044-8309.1984.tb00642.x>
- British Psychological Society. (2012). *Introductory guide to commissioning*.
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Introductory%20Guide%20to%20Commissioning.pdf>
- British Psychological Society. (2019). *How can we embed psychology in public policy?* <https://thepsychologist.bps.org.uk/volume-32/may-2019/how-can-we-embed-psychology-public-policy>
- British Psychological Society. (2019). *Standards for the accreditation of doctoral programmes in clinical psychology*.

<https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf>

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Browne, N., Zlotowitz, S., Alcock, K., & Barker, C. (2020). Practice to policy: Clinical psychologists' experiences of macrolevel work. *Professional Psychology: Research and Practice*, 51(4), 371–382.
<https://doi.org/10.1037/pro0000301>

Bullock, H. E. (2004). Diagnosis of low-income women. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 115–120). Jason Aronson.

Bullock, H. E. (2019). Psychology's contributions to understanding and alleviating poverty and economic inequality: Introduction to the special section. *American Psychologist*, 74(6), 635-640.
<http://dx.doi.org/10.1037/amp0000532>

Buhrich, N., & Teesson, M. (1996). Impact of a psychiatric outreach service for homeless persons with schizophrenia. *Psychiatric Services*, 47(6), 644-646.
<https://doi.org/10.1176/ps.47.6.644>

Burgard, S. A., Seefeldt, K. S., & Zelner, S. (2012). Housing instability and health: Findings from the Michigan recession and recovery study. *Social Science & Medicine*, 75(12), 2215–2224.
<https://doi.org/10.1016/j.socscimed.2012.08.020>

Burton, M., Kagan, C., Boyle, S., & Harris, C. (2007). *History of community psychology in the UK*. Palgrave.

Caci, H., Doepfner, M., Asherson, P., Donfrancesco, R., Faravone, S. V., Herbas, A., & Fitzgerald, M. (2014). Daily life impairments associated with self-reported childhood/ adolescent attention-deficit/hyperactivity disorder and experiences of diagnosis and treatment: Results from the European

Lifetime Impairment Survey. *European Psychiatry*, 29(5), 316-323.
<https://doi.org/10.1016/j.eurpsy.2013.10.007>.

Cannuscio, C. C., Alley, D. E., Pagán, J. A., Soldo, B., Krasny, S., Shardell, M., Asch, D. A., & Lipman, T. H. (2012). Housing strain, mortgage foreclosure, and health. *Nursing Outlook*, 60(3), 134–142.e1.
<https://doi.org/10.1016/j.outlook.2011.08.004>

Caplan, N. (1979). The two-communities theory and knowledge utilization. *American Behavioral Scientist*, 22(3), 459–470.
<https://doi.org/10.1177/000276427902200308>

The Care Inquiry. (2013). *Making not breaking: Building relationships for our most vulnerable children*.
https://www.becomecharity.org.uk/media/1129/care_inquiry_-_full_report_april_2013.pdf

Carr, S. C., & Sloan, T. S. (2003). *Poverty and psychology: From global perspective to local practice*. Springer. <https://doi.org/10.1007/978-1-4615-0029-2>

CHAIN. (2020). *Annual report: Greater London April 2019 – March 2020*.
https://airdrive-secure.s3-eu-west-1.amazonaws.com/london/dataset/chain-reports/2020-09-09T09%3A03%3A58/Greater%20London%20full%202019-20.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAJJDIMAIVZJDICKHA%2F20210528%2F%2F%2Faws4_request&X-Amz-Date=20210528T145411Z&X-Amz-Expires=300&X-Amz-Signature=f4916c0fea6eca024449123ad33980681ecee54fc4f1ea11398d4c2a156fe593&X-Amz-SignedHeaders=host

Choudhuri, D., Glauser, A., & Peregoy, J. (2004). Guidelines for writing a qualitative manuscript for the journal of counselling & development. *Journal of Counselling & Development*, 82(4), 443–446.
<https://doi.org/10.1002/j.1556-6678.2004.tb00332.x>

- Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). The public psychology doctoral training model: Training clinical psychologists in community mental health competencies and leadership. *Training and Education in Professional Psychology, 6*(2), 76–83. <https://doi.org/10.1037/a0028834>
- Churchard, A., Ryder, M., Greenhill, A., & Mandy, W. (2018). The prevalence of autistic traits in a homeless population. *Autism, 23*(3), 665-676. <https://doi.org/10.1177/1362361318768484>
- Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy, 47*(11), 910–920. <https://doi.org/10.1016/j.brat.2009.07.010>
- Clarke, V., & Braun, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.
- Conway, K. P., Compton, W., Stinson, F. S., & Grant, B. F. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders. *The Journal of Clinical Psychiatry, 67*(02), 247–258. <https://doi.org/10.4088/jcp.v67n0211>
- Corrigan, J. D. (1995). Substance abuse as a mediating factor in outcome from traumatic brain injury. *Archives of Physical Medicine and Rehabilitation, 76*(4), 302–309. [https://doi.org/10.1016/s0003-9993\(95\)80654-7](https://doi.org/10.1016/s0003-9993(95)80654-7)
- Costello, E. J. (2016). Early detection and prevention of mental health problems: Developmental epidemiology and systems of support. *Journal of Clinical Child & Adolescent Psychology, 45*(6), 710–717. <https://doi.org/10.1080/15374416.2016.1236728>
- Cox, R., & Kelly, P. (2000). From anti-psychiatry to critical psychology. *The Journal of Critical Psychology, Counselling and Psychotherapy, 2*, 3–5. <https://doi.org/10.1080/1606635081324>

- Cromarty, H. (2021). *Coronavirus: Support for rough sleepers (England)*. House of Commons. <https://researchbriefings.files.parliament.uk/documents/CBP-9057/CBP-9057.pdf>
- Cromarty, H. (2021). *Social housing reform in England: What next?* House of Commons. <https://researchbriefings.files.parliament.uk/documents/CBP-9227/CBP-9227.pdf>
- Crowley, M., Supplee, L., Scott, T., & Brooks-Gunn, J. (2019). The role of psychology in evidence-based policymaking: Mapping opportunities for strategic investment in poverty reduction. *American Psychologist*, 74(6), 685–697. <https://doi.org/10.1037/amp0000466>
- Daly, S., & Allen, J. (2017). *Voluntary sector action on the social determinants of health*. Institute of Health Equity. <https://www.instituteofhealthequity.org/resources-reports/voluntary-sector-action-on-the-social-determinants-of-health/voluntary-sector-action-on-the-sdoh-evidence-review.pdf>
- Demetrovics, Z. (2009). Co-morbidity of drug addiction: An analysis of epidemiological data and possible etiological models. *Addiction Research & Theory*, 17(4), 420–431. <https://doi.org/10.1080/16066350802601324>
- Department of Education. (2018). National implementation adviser for care leavers' first year report: October 2017 to October 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/916016/National_Implementation_Adviser_for_Care_Leavers_Annual_Report.pdf
- De Vries, R., Reeves, A., & Geiger, B. (2017). *Inequalities in the application of welfare sanctions in Britain*. The International Inequalities Institute. <https://osf.io/preprints/socarxiv/exn68/>
- Edgar, B. (2009). *European review of statistics on homelessness*. European

Observatory on Homelessness.
<https://www.feantsaresearch.org/download/6-20098376003316223505933.pdf>

Edwards, A. L. (1953). The relationship between the judged desirability of a trait and the probability that the trait will be endorsed. *Journal of applied Psychology*, 37(2), 90-93. <https://doi.org/10.1037/h0058073>

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229. <https://doi.org/10.1348/014466599162782>

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, 16(4), 414–433. <https://doi.org/10.1057/s41285-018-0065-6>

Equality and Human Rights Committee. (2015). *Is Britain fairer? The state of equality and human rights 2015*. www.equalityhumanrights.com/sites/default/files/is-britain-fairer-2015.pdf

Fahmy, E., Williamson, E., & Pantazis, C. (2016). *Evidence and policy review: Domestic violence and poverty*. Joseph Rowntree Foundation. https://research-information.bris.ac.uk/ws/files/80376377/JRF_DV_POVERTY_REPORT_FINAL_COPY_.pdf

Ferguson, K. T., Cassells, R. C., MacAllister, J. W., & Evans, G. W. (2013). The physical environment and child development: An international review. *International Journal of Psychology*, 48(4), 437–468. <https://doi.org/10.1080/00207594.2013.804190>

- Fitzpatrick, S. (2005). Explaining homelessness: A critical realist perspective. *Housing, Theory and Society*, 22(1), 1–17.
<https://doi.org/10.1080/14036090510034563>
- Fitzpatrick, S., Bramley, G., & Johnsen, S. (2013). Pathways into multiple exclusion homelessness in seven UK cities. *Urban Studies*, 50(1), 148-168. <https://doi:10.1177/0042098012452329>
- Fitzpatrick, S., Mackie, P., & Wood, J. (2019). *Homelessness prevention in the UK: Policy briefing*. UK Collaborative Centre for Housing Evidence.
<https://housingevidence.ac.uk/wp-content/uploads/2019/07/Homelessness-Prevention-in-the-UK-Policy-Brief-July-2019-final.pdf>
- Fitzpatrick, S., Pawson, H., Bramley, G. & Wilcox, S. (2018). *The homelessness monitor*. England 2011. Crisis.
<https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/homelessness-monitor/england/the-homelessness-monitor-england-2011/>
- Foscarinis, M. (1991). The politics of homelessness: A call to action. *American Psychologist*, 46(11), 1232–1238. <https://doi.org/10.1037/0003-066X.46.11.1232>
- Freitas, H., Oliveira, M., Jenkins, M., & Popjoy, O. (1998). The focus group, a qualitative research method. *Journal of Education*. 1-22.
https://www.researchgate.net/profile/Henrique-Freitas-8/publication/241399754_THE_FOCUS_GROUP_A_QUALITATIVE_RESEARCH_METHOD/links/541af4990cf25ebee988d6e6/THE-FOCUS-GROUP-A-QUALITATIVE-RESEARCH-METHOD.pdf
- Gaetz, F., & Dej, E. (2017). A new direction: A framework for homelessness prevention. Canadian Observatory on Homelessness.

https://www.homelesshub.ca/smites/default/files/attachments/COHPreventionFramework_1.pdf

Garvie, D. (2017). *Homelessness Reduction Act 2017: Policy and practice briefing*.

https://assets.ctfassets.net/6sxvmndnnpn0s/ZhIMP1aeh1mOBzBDX2z1H/58b3122b8d18585a6b57c7cd693601ad/Homelessness_HRA17_Implementation_Briefing_FINAL.pdf

Gibson, M., Petticrew, M., Bamba, C., Sowden, A. J., Wright, K. E., & Whitehead, M. (2011). Housing and health inequalities: A synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. *Health & Place*, 17(1), 175–184.

<https://doi.org/10.1016/j.healthplace.2010.09.011>

Gill, A., & Daw, E. (2017). *From care to where? Care leavers access to accommodation*. Centrepoin. <https://centrepoin.org.uk/media/2035/from-care-to-where-centrepoin-report.pdf>

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Harvard University Press.

Gojkovic, D., Mills, A., & Meek, R. (2012). *Accommodation for ex-offenders: Third sector housing advice and provision*.

<https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/tsrc/working-papers/working-paper-77.pdf>

Goodman, L. A., Smyth, K. F., & Banyard, V. (2010). Beyond the 50-minute hour: Increasing control, choice, and connections in the lives of low-income women. *American Journal of Orthopsychiatry*, 80(1), 3–11.

<https://doi.org/10.1111/j.1939-0025.2010.01002.x>

Gould, T. J. (2010). Addiction and cognition. *Addiction Science and Clinical Practice*, 5(2), 4-14.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3120118/>

- Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, S. P., Dufour, M. C., Compton, W., Pickering, R. P., & Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry*, *61*(8), 807.
<https://doi.org/10.1001/archpsyc.61.8.807>
- Guba, G. E., & Lincoln, S. Y. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105–117). Sage.
- Gulliver, K. (2016). *Forty years of struggle a window on race and housing, disadvantage and exclusion*. Human City Institute.
<https://hqnetwork.co.uk/download.cfm?doc=docm93jjjm4n2932.pdf&ver=5697#:~:text='Forty%20Years%20of%20Struggle'%20is,the%20Race%20Relations%20Act%201976>.
- Hage, S. M., & Kenny, M. E. (2009). Promoting a social justice approach to prevention: Future directions for training, practice, and research. *The Journal of Primary Prevention*, *30*(1), 75–87.
<https://doi.org/10.1007/s10935-008-0165-5>
- Hanley, S.J. & Abell, S.C. (2002). Maslow and relatedness: Creating an interpersonal model of self-actualization. *Journal of Humanistic Psychology*. *42*(4):37-57. <https://doi.org/10.1177/002216702237123>
- Hannon, C., Wood, C., & Bazalgette, L. (2010). In loco parentis. Demos.
https://www.demos.co.uk/files/In_Loco_Parentis_-_web.pdf
- Harker, L. (2006). *Chance of a lifetime: The impact of bad housing on children's lives*. Shelter.
https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/chance_of_a_lifetime_-_the_impact_of_bad_housing_on_childrens_lives
- Harker, L. (2006). *Delivering on child poverty: What would it take?* Department for Work and Pensions.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272371/6951.pdf

Harper, D. (2011). Choosing a qualitative research method. In D. Harper & A. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 83–97). Chichester: John Wiley & Sons Ltd.
<https://doi.org/10.1002/9781119973249.ch7>

Harper, D. (2015). Psychologists against austerity. *The Psychologist*, 28(5), 172.
https://thepsychologist.s3.eu-west-2.amazonaws.com/articles/pdfs/0315lett.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIA3JJOMCSR35UA6UU%2F20210522%2F%2F%2Fs3%2Faws4_request&X-Amz-Date=20210522T182213Z&X-Amz-SignedHeaders=Host&X-Amz-Expires=10&X-Amz-Signature=225fb9c50ecb041470c637d21b06af751df2a7ed2176b985550d259a99a9b132

Harper, D. (2016). Beyond individual therapy. *The Psychologist*, 26(6), 440-445.
<https://thepsychologist.bps.org.uk/volume-29/june/beyond-individual-therapy>

Harris, C. (2014). The impact of austerity on a British council estate. *The Psychologist*, 27(4), 40-43. <https://thepsychologist.bps.org.uk/volume-27/edition-4/impact-austerity-british-council-estate>

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (Eds.). (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. Plenum Press.

Headway. (2018). *Communication problems after brain injury*.
<https://www.headway.org.uk/about-brain-injury/individuals/effects-of-brain-injury/communication-problems/>

- Healy, M., & Perry, C. (2000). Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research: An International Journal*, 3(3), 118–126.
<https://doi.org/10.1108/13522750010333861>
- Heirene, R., John, B., & Roderique-Davies, G. (2018). Identification and evaluation of neuropsychological tools used in the assessment of alcohol-related cognitive impairment: A systematic review. *Frontiers in Psychology*, 9, 2618. <https://doi.org/10.3389/fpsyg.2018.02618>
- Henwood, B. F., Derejko, K. S., Couture, J., & Padgett, D. (2015). Maslow and mental health recovery: A comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(2), 220–228.
<https://doi.org/10.1007/s10488-014-0542-8>.Maslow
- Hesdorffer, D. C., Rauch, S. L., & Tamminga, C. A. (2009). Long-term psychiatric outcomes following traumatic brain injury. *Journal of Head Trauma Rehabilitation*, 24(6), 452–459.
<https://doi.org/10.1097/htr.0b013e3181c133fd>
- Hewett, N., & Halligan, A. (2010). Homelessness is a healthcare issue. *Journal of the Royal Society of Medicine*, 103(8), 306-307.
<https://doi.org/10.1258/jrsm.2010.10k028>
- Hewson, A. (2016). Bromley briefings prison factfile. Prison Reform Trust.
<http://www.prisonreformtrust.org.uk/Publications/Factfile>
- HM Treasury. (2013). *Budget 2013*.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/221885/budget2013_complete.pdf
- Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345–357.
<https://doi.org/10.1177/1468794103033004>

Homeless Link. (2018). *Who is supporting people now? Experiences of local authority commissioning after supporting people*.
https://www.homeless.org.uk/sites/default/files/site-attachments/Who%20is%20supporting%20people%20now%20Report%20Jan13_0.pdf

Homeless Link. (2018). *Young & homeless 2018*.
<https://www.homeless.org.uk/sites/default/files/site-attachments/Young%20and%20Homeless%202018.pdf>

Homeless Link. (2020). *Young & homeless: Executive summary*.
<https://www.homeless.org.uk/sites/default/files/site-attachments/Young%20and%20Homeless%202020%20Executive%20Summary.pdf>

Homelessness Reduction Act 2017.
<http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted>

Hopkins, P. (2017). Social geography I: Intersectionality. *Progress in Human Geography*, 43(5), 937-947. <https://doi.org/10.1177/0309132517743677>

Hosticka, C. J., Hibbard, M., & Sundberg, N. D. (1983). Improving psychologists' contributions to the policymaking process. *Professional Psychology: Research and Practice*, 14(3), 374–385. <https://doi.org/10.1037/0735-7028.14.3.374>

Housing Act 1988. <https://www.legislation.gov.uk/ukpga/1988/50/contents>

Housing Act 1996 s.175-177.
<https://www.legislation.gov.uk/ukpga/1996/52/section/175>

Hoyt, W. T., & Bhati, K. S. (2007). Principles and practices: An empirical examination of qualitative research in the journal of counseling psychology. *Journal of Counseling Psychology*, 54(2), 201–210.
<https://doi.org/10.1037/0022-0167.54.2.201>

- Hu, Xiaoti. (2018). Methodological implications of critical realism for entrepreneurship research. *Journal of Critical Realism*, 17(2), 118-139. <https://doi.org/10.1080/14767430.2018.1454705>
- Hulse, K., & Saugeres, L. (2008). *Housing insecurity and precarious living: An Australian exploration*. Australian Housing and Urban Research Institute. <https://apo.org.au/node/3189>
- Hutchinson, S., Page, A., & Sample, E. (2014). *Rebuilding shattered lives*. St. Mungos. <https://www.mungos.org/publication/rebuilding-shattered-lives-final-report/>
- Hwang, S. W., Chambers, C., Chiu, S., Katic, M., Kiss, A., Redelmeier, D. A., & Levinson, W. (2013). A comprehensive assessment of health care utilization among homeless adults under a system of universal health insurance. *American Journal of Public Health*, 103(S2), S294–S301. <https://doi.org/10.2105/ajph.2013.301369>
- Johnsen, S., & Watts, B. (2014). *Homelessness and poverty: Reviewing the links*. Heriot-Watt University.
- Johnson, G., Scutella, R., Tseng, Y. P., & Wood, G. (2015). *Entries and exits from homelessness: A dynamic analysis of the relationship between structural conditions and individual characteristics* (248). Australian Housing and Urban Research Institute Limited. https://www.ahuri.edu.au/__data/assets/pdf_file/0013/2155/AHURI_Final_Report_No248_Entries-and-exits-from-homelessness.pdf
- Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society. <https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/PTM%20Main.pdf>

- Jones, J. M., Levine, I. S., & Rosenberg, A. A. (1991). Homelessness research, services, and social policy: Introduction to the special issue. *American Psychologist*, 46(11), 1109–1111. <https://doi.org/10.1037/0003-066X.46.11.1109>
- Joseph Rowntree Foundation. (2018). *Non-decent housing and overcrowding*. <https://www.jrf.org.uk/data/non-decent-housing-and-overcrowding>
- Jumisko, E., Lexell, J., & Söderberg, S. (2005). The meaning of living with traumatic brain injury in people with moderate or severe traumatic brain injury. *Journal of Neuroscience Nursing*, 37(1), 42–50. <https://doi.org/10.1097/01376517-200502000-00007>
- Kennedy, P., & Llewelyn, S. (2001). Does the future belong to the scientist practitioner? *The Psychologist*, 14, 74–78. https://thepsychologist.s3.eu-west-2.amazonaws.com/articles/pdfs/kennedy.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIA3JJOMCSR35UA6UU%2F20210820%2Feu-west-2%2Fs3%2Faws4_request&X-Amz-Date=20210820T194159Z&X-Amz-SignedHeaders=Host&X-Amz-Expires=10&X-Amz-Signature=4cc0b71558896566bff1fbc8d35c43c24caa26c7a7c0c5b85df5e0b5105c8bbe
- Keohane, N., & Broughton, N. (2013). *The politics of housing*. Social Marketing Foundation. <https://www.smf.co.uk/publications/the-politics-of-housing/>
- Kerbo, H. R. (2003). *Social stratification and inequality: Class conflict in historical and global perspective*. McGraw-Hill.
- Khan, Z., Koehne, S., Haine, P., & Dorney-Smith, S. (2018). Improving outcomes for homeless inpatients in mental health. *Housing, Care and Support*, 22(1), 77-90. <https://doi.org/10.1108/HCS-07-2018-0016>
- Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *American Journal of Psychiatry*, 142(11), 1259–1264. <https://doi.org/10.1176/ajp.142.11.1259>

- Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry*, 4(5), 231–244. <https://doi.org/10.3109/10673229709030550>
- Kiesler, C. A. (1991). Homelessness and public policy priorities. *American Psychologist*, 46(11), 1245–1252. <https://doi.org/10.1037/0003-066X.46.11.1245>
- Krieger, J., & Higgins, D. L. (2002). Housing and health: Time again for public health action. *American Journal of Public Health*, 92(5), 758–768. <https://doi.org/10.2105/ajph.92.5.758>
- Lai, H. M. X., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990-2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, 154, 1-13. <https://doi.org/10.1016/j.drugalcdep.2015.05.031>
- Lemos, G. (2000). *Homelessness and loneliness. The want of conviviality*. Crisis.
- Levine, M., Perkins, D. V., & Levine, M. (1997). *Principles of community psychology: Perspectives and applications* (2nd ed.). Oxford University Press New York.
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic Inquiry* (1st ed.). SAGE Publications.
- London Assembly Housing Committee. (2017). *Hidden homeless in London*. https://www.london.gov.uk/sites/default/files/london_assembly_-_hidden_homelessness_report.pdf
- Lorant, V., Deliege, D., Eaton, W., Robert, A., Philippot, P., & Annseau, M. (2003). Socioeconomic inequalities in depression: A meta-analysis. *American Journal of Epidemiology*, 157(2), 98–112. <https://doi.org/10.1093/aje/kwf182>

- Lucock, M. P., Hall, P., & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology & Psychotherapy*, 13(2), 123–130.
<https://doi.org/10.1002/cpp.483>
- Lund, B. (2006). *Understanding housing policy*. (3rd ed.) Policy Press.
- Lupton, R., Burchardt, T., Fitzgerald, A., Hills, J, McKnight, A., Obolenskaya, P., Stewart, K., Thomson, S., Turnstall, R., & Vizard, P. (2015). *The coalition's social policy record: Policy, spending and outcomes 2010-2015* (4). Centre for Analysis of Social Exclusion.
<https://sticerd.lse.ac.uk/dps/case/spcc/RR04.pdf>
- Maas, A. I., Menon, D. K., Adelson, P.D., Andelic, N., Bell, M. J., Belli, A., Bragge, P., Brazinova, A., Büki, A., Chesnut, R. M., Citerio, G., Coburn, M., Cooper, D. J., Crowder, A. T., Czeiter, E., Czosnyka, M., Diaz-Arrastia, R., Dreier, J. P., Duhaime, A., Ercole, A.,...Yaffe, K. (2017). Traumatic brain injury: integrated approaches to improve prevention. *The Lancet Neurology Commission*, 16(12). 987-1048. [https://doi.org/10.1016/S1474-4422\(17\)30371-X](https://doi.org/10.1016/S1474-4422(17)30371-X)
- MacInnes, T., Tinson, A., Hughes, C., Born, T. B., & Aldridge, H. (2015). *Monitoring poverty and social exclusion 2015*. Joseph Rowntree Foundation. www.jrf.org.uk/mpse-2015
- Mackie, P.K., Johnsen, S. and Wood, J. (2017). *Ending rough sleeping: What works? An international evidence review*. Crisis.
https://www.crisis.org.uk/media/238368/ending_rough_sleeping_what_works_2017.pdf
- MacReady, N. (2009). Neurological deficits in the homeless: A downward spiral. *The Lancet*, 8(3), 228-229. [https://doi.org/10.1016/S1474-4422\(09\)70033-x](https://doi.org/10.1016/S1474-4422(09)70033-x)
- Madoc-Jones, I., Ahmed, A., Hughes, C., Dubberley, S., Gorden, C.,

- Washington-Dyer, K., Lockwood, K., & Wilding, M. (2019). Imaginary homelessness prevention with prison leavers in Wales. *Social Policy and Society*, 19(1), 145-155. <https://doi.org/10.1017/S1474746419000356>
- Malpass, P. (2003). The wobbly pillar? Housing and the British postwar welfare state. *Journal of Social Policy*, 32(4), 589-606. <https://doi.org/10.1017/S0047279403007177>
- Manese, J., Douse, L., Croteau, J., Helms, J. E., Horwatt, S., Boggs, K., & Stone, G. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58(5), 377–402. <https://doi.org/10.1037/0003-066x.58.5.377>
- Mannuzza, S., Klein, R. G., Bonagura, N., Malloy, P., Giampino, T. L., & Addalli, K. A. (1989). Hyperactive boys almost grown up. V. Replication of psychiatric status. *Archives of General Psychiatry*, 46(12): 1073-1079. <https://doi.org/10.1001/archpsyc.1991.01810250079012>.
- Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot review 10 years on*. Institute of Health Equity.
file:///C:/Users/hanna/Downloads/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report%20(1).pdf
- Marmot, M., Friel, S., Bell, R., Houweling, T. A. J., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, 372(9650), 1661–1669. [https://doi.org/10.1016/s0140-6736\(08\)61690-6](https://doi.org/10.1016/s0140-6736(08)61690-6)
- Marshall-Lee, E. D., Hinger, C., Popovic, R., Miller Roberts, T. C., & Prempeh, L. (2020). Social justice advocacy in mental health services: Consumer, community, training and policy perspectives. *Psychological Services*, 17(1), 12-21. <https://doi.org/10.1037/ser0000349>

- Marteau, T. M., & Riordan, D. C. (1992). Staff attitudes towards patients: The influence of causal attributions for illness. *British Journal of Clinical Psychology*, 31(1), 107–110. <https://doi.org/10.1111/j.2044-8260.1992.tb00974.x>
- Maslow, A. H. (1943). Conflict, frustration, and the theory of threat. *The Journal of Abnormal and Social Psychology*, 38(1), 81–86. <https://doi.org/10.1037/h0054634>
- Mason, K., Cornes, M., Dobson, R., (2017). Multiple exclusion homelessness and adult social care in England: Exploring the challenges through a researcher practitioner partnership. *Research, Policy and Planning*, 33(1), 3-14. <http://eprints.bbk.ac.uk/id/eprint/20621/>
- McGorry, P. D., Ratheesh, A., & O'Donoghue, B. (2018). Early intervention—an implementation challenge for 21st century mental health care. *JAMA Psychiatry*, 75(6), 545. <https://doi.org/10.1001/jamapsychiatry.2018.0621>
- McGuinness, F., Booth, L., & Francis-Devine, B. (2019). *Poverty in the UK: Statistics (7096)*. UK Parliament. <https://commonslibrary.parliament.uk/research-briefings/sn07096/#:~:text=How%20many%20people%20are%20in,level%20to%20the%20year%20before.>
- McLeod, J. D. (2013). Social stratification and inequality. In C. S. Anehensel, J. C. Phelan, & A. Bierman (eds). *Handbook of the Sociology of Mental Health. Handbooks of Sociology and Social Research*. Springer. https://doi.org/10.1007/978-94-007-4276-5_12
- McLeod, S. (2018). *Maslow's hierarchy of needs*. Simply Psychology. <https://canadacollege.edu/dreamers/docs/Maslows-Hierarchy-of-Needs.pdf>
- McMillan, T. M., Laurie, M., Oddy, M., Menzies, M., Stewart, E., & Wainman-Lefley, J. (2015). Head injury and mortality in the homeless. *Journal of Neurotrauma*, 32(2), 116–119. <https://doi.org/10.1089/neu.2014.3387>

- McNeil, C., Hochlaf, D., & Quilter-Pinner, H. (2019). *Social (in)security: Reforming the UK's social safety net*. IPPR.
<https://www.ippr.org/research/publications/social-insecurity>
- Ministry of Housing, Communities and Local Government. (2013). *Homelessness data: Notes and definitions: Information and guidance for local authorities compiling the P1E quarterly data returns on homelessness*. <https://www.gov.uk/guidance/homelessness-data-notes-and-definitions>
- Ministry of Housing, Communities and Local Government. (2018). *A new deal for social housing*.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733605/A_new_deal_for_social_housing_web_accessible.pdf
- Ministry of Housing, Communities and Local Government. (2018). *Rough sleeping strategy*.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733421/Rough-Sleeping-Strategy_WEB.pdf
- Ministry of Housing, Communities and Local Government. (2019). *English housing survey data on dwelling condition and safety*.
<https://www.gov.uk/government/collections/english-housing-survey>
- Ministry of Housing, Communities and Local Government. (2019). *Official statistics rough sleeping snapshot in England: Autumn 2019*.
<https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2019/rough-sleeping-snapshot-in-england-autumn-2019>
- Ministry of Housing, Communities and Local Government. (2020). *The Charter for social housing residents: Social housing white paper*.
<https://www.gov.uk/government/publications/the-charter-for-social-housing-residents-social-housing-white-paper>

- Ministry of Housing, Communities and Local Government. (2020). *Rough sleeping snapshot in England: August 2019*.
<https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2019/rough-sleeping-snapshot-in-england-autumn-2019>
- Ministry of Housing, Communities and Local Government. (2021). *Coronavirus (COVID-19) emergency accommodation survey data: January 2021*.
<https://www.gov.uk/government/publications/coronavirus-covid-19-emergency-accommodation-survey-data-january-2021>
- Mojtabai, R., Olfson, M., & Mechanic, D. (2002). Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Archives of General Psychiatry*, *59*(1), 77. <https://doi.org/10.1001/archpsyc.59.1.77>
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology*, *52*(2), 250–260. <https://doi.org/10.1037/0022-0167.52.2.250>
- Murali, V., & Oyeboode, F. (2004). Poverty, social inequality and mental health. *Advances in Psychiatric Treatment*, *10*, 216-224.
- National Audit Office. (2015). *Care leavers' transition to adulthood*.
<https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood.pdf>
- National Housing Federation. (2019). *Briefing: How many people need a socially rented home?* https://www.housing.org.uk/globalassets/files/resource-files/nhf_briefing_how_many_people_need_a_social_rented_home_final.pdf
- Navarro, L. V., & Benach, J. (1996). Scientific commission for the study of social inequities of health in Spain. *Revista Española de Salud Pública*, *70*(5):503-504. <https://pubmed.ncbi.nlm.nih.gov/9011370/>
- Neale, J. (1997). Homelessness and theory reconsidered. *Housing Studies*, *12*(1), 47–61. <https://doi.org/10.1080/02673039708720882>

- Neher, A. (1991). Maslow's theory of motivation: A critique. *Journal of Humanistic Psychology*, 31(3), 89-112. <https://doi.org/10.1177/0022167891313010>
- Nelson, G. (2013). Community psychology and transformative policy change in the neo-liberal era. *American Journal of Community Psychology*, 52(3-4), 211-223. <https://doi.org/10.1007/s10464-013-9591-5>
- Nelson, G., Lord, J., & Ochocka, J. (2001). Empowerment and mental health in community: Narratives of psychiatric consumer/survivors. *Journal of Community & Applied Social Psychology*, 11(2), 125-142. <https://doi.org/10.1002/casp.619>
- Nelson, G., & Prilleltensky, I. (2005). *Community psychology: In pursuit of liberation and well-being*. Palgrave Macmillan.
- NHS England. (2019). *The NHS long term plan*. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>
- Nilsson, J. E., & Schmidt, C. K. (2005). Social justice advocacy among graduate students in counseling: An initial exploration. *Journal of College Student Development*, 46(3), 267-279. <https://doi.org/10.1353/csd.2005.0030>
- Norman, A. (2016). A preventable death? A family's perspective on an adult safeguarding review regarding an adult with traumatic brain injury. *Journal of Adult Protection*, 18(6), 341-352. <https://doi.org/10.1108/JAP-08-2016-0017>
- Novoa, A. M., Bosch, J., Díaz, F., Malmusi, D., Darnell, M., & Trilla, C. (2014). Impact of the crisis on the relationship between housing and health. Policies for good practice to reduce inequalities in health related to housing conditions. *Gaceta Sanitaria*, 28(1), 44-50. <http://dx.doi.org/10.1016/j.gaceta.2014.02.018>.
- Oakes, P. M., & Davies, R. C. (2008). Intellectual disability in homeless adults: A prevalence study. *Journal of Intellectual Disabilities*, 12, 325-334. <https://doi.org/10.1177/1744629508100496>

- Oddy, M., Moir, J. F., Fortescue, D., & Chadwick, S. (2012). The prevalence of traumatic brain injury in the homeless community in a UK city. *Brain Injury*, 26(9), 1058–1064. <https://doi.org/10.3109/02699052.2012.667595>
- Office for Budget Responsibility. (2019). *Economic and fiscal outlook*. http://cdn.obr.uk/March-2019_EFO_Web-Accessible.pdf
- Office for the Deputy Prime Minister. (2005). *Sustainable communities: Homes for all*. https://www.books.google.co.uk/books?id=i57-PIS7YDUC&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false
- Office for National Statistics. (2017). *Housing summary measures analysis: 2016*. <https://www.ons.gov.uk/peoplepopulationandcommunity/housing/articles/housingsummarymeasuresanalysis/2016>.
- Office for National Statistics. (2020). *Deaths of homeless people in England and Wales 2019 registrations*. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations#causes-of-death-among-homeless-people>
- Office for National Statistics. (2020). *Domestic abuse victim characteristics, England and Wales: year ending in March 2020*. <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2020>
- Olson-Madden, J. H., Brenner, L. A., Corrigan, J. D., Emrick, C. D., & Britton, P. C. (2012). Substance use and mild traumatic brain injury risk reduction and prevention: A novel model for treatment. *Rehabilitation Research and Practice*, 2012, 1–6. <https://doi.org/10.1155/2012/174579>

- Oppenheim, A. N. (2000). *Questionnaire design, interviewing and attitude measurement* (2nd ed.). Continuum.
- O'Regan, F., Logan, P. E., Lloyd, T., & McConkey, M. (2017). *A lifetime lost, or a lifetime saved. Born to be ADHD*.
<https://www.addni.net/uploads/ADHD%20DIR%20report%20version%2018%20-%20no%20watermark.pdf>
- Orford, J. (2008). *Community psychology: Challenges, controversies and emerging consensus*. John Wiley & Sons Ltd.
[https://books.google.co.uk/books?hl=en&lr=&id=ZJkxokvr75wC&oi=fnd&pg=PR5&dq=Orford,+J.+\(2008\).+Community+psychology:+Challenges,+controversies+and+emerging+consensus&ots=gWZ9CN95U5&sig=juaL0n3j2j0aOCFXkzgVQp8Vgs#v=onepage&q=Orford%2C%20J.%20\(2008\).%20Community%20psychology%3A%20Challenges%2C%20controversies%20and%20emerging%20consensus&f=false](https://books.google.co.uk/books?hl=en&lr=&id=ZJkxokvr75wC&oi=fnd&pg=PR5&dq=Orford,+J.+(2008).+Community+psychology:+Challenges,+controversies+and+emerging+consensus&ots=gWZ9CN95U5&sig=juaL0n3j2j0aOCFXkzgVQp8Vgs#v=onepage&q=Orford%2C%20J.%20(2008).%20Community%20psychology%3A%20Challenges%2C%20controversies%20and%20emerging%20consensus&f=false)
- Orne, M. T. (1962). On the social psychology of the psychological experiment: With particular reference to demand characteristics and their implications. *American Psychologist*, 17(11), 776–783.
<https://doi.org/10.1037/h0043424>
- Ouimette, P., Moos, R. H., & Brown, P. J. (2003). Substance use disorder-posttraumatic stress disorder comorbidity: A survey of treatments and proposed practice guidelines. In P. Ouimette & P. J. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (p. 91–110). American Psychological Association.
<https://doi.org/10.1037/10460-005>
- Patton, M. Q. (2001). *Qualitative research & evaluation methods* (3rd ed.). SAGE Publications, Inc.
- Pawson, H., Netto, G., Wager, F., Fancy, C., & Lomax, D. (2007). *Evaluating*

homelessness prevention. Department for Communities and Local Government. <https://lemonsandcrane.co.uk/resources/CLG%20-%20Evaluating%20Homelessness%20Prevention.pdf>

Peacock-Brennan, S., Harper, D., & Patel, N. (2018). Developing policy-relevant skills in clinical psychology training. *Clinical Psychology Forum*, 301, 9-14. https://www.researchgate.net/publication/322196150_Developing_policy-relevant_skills_in_clinical_psychology_training

Pennington, J., Rich, H. (2020). *Homeless and forgotten: Surviving lockdown in temporary accommodation*. Shelter. https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/report_homeless_and_forgotten_surviving_lockdown_in_temporary_accommodation

Pickover, A. M., Bhimji, J., Sun, S., Evans, A., Allbaugh, L. J., Dunn, S. E., & Kaslow, N. J. (2018). Neighborhood disorder, social support, and outcomes among violence-exposed African American women. *Journal of Interpersonal Violence*, 36(7–8), NP3716–NP3737. <https://doi.org/10.1177/0886260518779599>

Pinder-Amaker, S., & Bell, C. (2012). A bioecological systems approach for navigating the college mental health crisis. *Harvard Review of Psychiatry*, 20(4), 174–188. <https://doi.org/10.3109/10673229.2012.712842>

Pinderhughes, E. E., Nix, R., Foster, E. M., Jones, D., & Group, C. P. P. R. (2007). Parenting in context: Impact of neighborhood poverty, residential stability, public services, social networks, and danger on parental behaviors. *Journal of Marriage and the Family*, 63(4), 941-953. <https://doi.org/10.1111/j.1741-3737.2001.00941.x>

Pitts, M., Mangle, L., & Asherson, P. (2015). Impairments, diagnosis and treatments associated with Attention-Deficit/Hyperactivity Disorder (ADHD) in UK adults: Results from the lifetime impairment survey. *Archives of Psychiatric Nursing*, 29, 56–63. <https://doi.org/10.1016/j.apnu.2014.10.001>

- Pleace, N., & Bretherton, J. (2013). *A review of Crisis Skylight's mental health services*. Centre of Housing Policy. <https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/services-and-interventions/review-of-crisis-skylight-s-mental-health-services-2013/>
- Pollack, C. E., & Lynch, J. (2009). Health status of people undergoing foreclosure in the Philadelphia region. *American Journal of Public Health, 99*(10), 1833–1839. <https://doi.org/10.2105/ajph.2009.161380>
- Ponsford, J., Whelan-Goodinson, R., & Bahar-Fuchs, A. (2007). Alcohol and drug use following traumatic brain injury: A prospective study. *Brain Injury, 21*(13–14), 1385–1392. <https://doi.org/10.1080/02699050701796960>
- Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52*(2), 126–136. <https://doi.org/10.1037/0022-0167.52.2.126>
- Prestwich, J. (2020). *The social housing white paper is an important realignment of the landlord/tenant relationship*. Inside housing. <https://www.insidehousing.co.uk/comment/comment/the-social-housing-white-paper-is-an-important-realignment-of-the-landlordtenant-relationship-68689>
- Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. Palgrave Macmillan.
- Prior, K., Mills, K., Ross, J., & Teesson, M. (2016). Substance use disorders comorbid with mood and anxiety disorders in the Australian general population. *Drug and Alcohol Review, 36*(3), 317–324. <https://doi.org/10.1111/dar.12419>
- Psychologists Against Austerity. (2015). *The psychological impact of austerity: A briefing paper*. <https://psychagainstausterity.wordpress.com/psychological-impact-of-austerity-briefing-paper/>

- Public Health England. (2015). *All our health: Personalised care and population health*. <https://www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health>
- Public Health England. (2017). *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers*.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf
- Public Health England. (2019). *Homelessness: Applying All Our Health*.
<https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health>
- Rahim, M., & Cooke, A. (2020). Should clinical psychologists be political? In W. Curvis (Ed.), *Professional Issues in Clinical Psychology: Developing a Professional Identity Through Training and Beyond* (pp. 81–91). Oxon: Routledge.
- Reeves, A., Clair, A., McKee, M., & Stuckler, D. (2016). Reductions in the United Kingdom's government housing benefit and symptoms of depression in low-income households. *American Journal of Epidemiology*, 184(6), 421–429. <https://doi.org/10.1093/aje/kww055>
- Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the epidemiologic catchment area (ECA) study. *JAMA: The Journal of the American Medical Association*, 264(19), 2511–2518. <https://doi.org/10.1001/jama.264.19.2511>
- Riessman, C. K. (1993). *Narrative analysis (Qualitative research methods)* (1st ed.). SAGE Publications, Inc.
- Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. Sage.

- Rojas, Y., & Stenberg, S.-Å. (2015). Evictions and suicide: A follow-up study of almost 22 000 Swedish households in the wake of the global financial crisis. *Journal of Epidemiology and Community Health*, 70(4), 409–413. <https://doi.org/10.1136/jech-2015-206419>
- Rose, G., & Marmot, M. G. (1981). Social class and coronary heart disease. *Heart*, 45(1), 13–19. <https://doi.org/10.1136/hrt.45.1.13>
- Rosenheck, R., Kasprow, W., Frisman, L., & Liu-Mares, W. (2003). Cost-effectiveness of supported housing for homeless persons with mental illness. *General Psychiatry*, 60(9), 940-951. <https://doi.org/10.1001/acrchpsyc.60.9.940>
- Sanabria, J. J. (2006). Youth homelessness: Prevention and intervention efforts in psychology. *Universitas Psychologica*, 5(1), 51-67. <http://www.scielo.org.co/pdf/rups/v5n1/v5n1a05.pdf>
- Sanders, B., & Albanese, F. (2016). *'It's no life at all: Rough sleepers' experiences of violence and abuse on the streets of England and Wales'*. Crisis. https://www.crisis.org.uk/media/20502/crisis_its_no_life_at_all2016.pdf
- Sandhu, K. (2017). *Universal credit and impact on black and minority ethnic communities: A race equality foundation briefing paper (27)*. Race Equality Foundation. <http://raceequalityfoundation.org.uk/wp-content/uploads/2017/11/Better-Housing-27-Universal-Credit.pdf>
- Sareen, J., Chartier, M., Kjernisted, K. D., & Stein, M. B. (2001). Comorbidity of phobic disorders with alcoholism in a Canadian community sample. *The Canadian Journal of Psychiatry*, 46(8), 733–740. <https://doi.org/10.1177/070674370104600806>
- Sareen, J., Chartier, M., Paulus, M. P., Stein, M. B., Leib, R., Wittchen, H, U.,...Kupfer, D. J. (2006). Illicit drug use and anxiety disorders: Findings from two community surveys. *Psychiatry Research*, 142(1), 11-17. <https://doi.org/10.1016/j.psychres.2006.01.009>

- Seager, M. (2011). Homelessness is more than houselessness: A psychologically-minded approach to inclusion and rough sleeping. *Mental Health and Social Inclusion*, 15(4), 183-189.
<https://doi.org/10.1108/20428301111186822>
- Shelter. (2016). *Research report: Survey of private landlords*.
https://assets.ctfassets.net/6sxvmndnnpn0s/1kE9HpyjQKk962Sks6uni1/5bec83d2b9627a96f2afb9e66fea1b4/Landlord_survey_18_Feb_publish.pdf
- Shelter. (2017). *The impact of housing problems on mental health*.
https://assets.ctfassets.net/6sxvmndnnpn0s/6vm40RFZhnrlLDU7RxcgwL/0862bc6071c421f7a001da53359dd0b3/2017_04_19_Research_Report_-_The_impact_of_housing_problems_on_mental_health.pdf
- Shelter. (2018). *Stop DSS discrimination: Ending prejudice against renters on housing benefit*.
https://assets.ctfassets.net/6sxvmndnnpn0s/5ta6BCI8NPeWv2I8VSdFET/b20f1e444c28a0c380f712767e720984/Stop_DSS_Discrimination_-_Ending_prejudice_against_renters_on_housing_benefit.pdf
- Shelter. (2021). *The story of social housing*.
https://england.shelter.org.uk/support_us/campaigns/story_of_social_housing
- Shelter & National Housing Federation. (2017). *Stop DSS discrimination: Ending prejudice against renters on housing benefit*.
https://england.shelter.org.uk/__data/assets/pdf_file/0009/1581687/Stop_DSS_Discrimination_-_Ending_prejudice_against_renters_on_housing_benefit.pdf
- Shinn, M. (2007). Waltzing with a monster: Bringing research to bear on public policy. *Journal of Social Issues*, 63(1), 215–231.
<https://doi.org/10.1111/j.1540-4560.2007.00505.x>
- Silver, J., McAllister, T., & Yudofsky, S. (2005). *Textbook of traumatic brain injury*. American Psychiatric Publishing.
<https://doi.org/10.1176/appi.books.9781585624201>

- Singh, S. P. (2009). Transition of care from child to adult mental health services: The great divide. *Current Opinion in Psychiatry*, 22(4), 386–390. <https://doi.org/10.1097/YCO.0b013e32832c9221>.
- Singh, A., Lyrian, D., Baker, E., & Bentley, R. (2019). Housing disadvantage and poor mental health: A systemic review. *American Journal of Preventative Medicine*, 57(2), 262-272. <https://doi.org/10.1016/j.amepre.2019.03.018>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE Publications Ltd.
- Social Exclusion Unit. (2002). *Reducing re-offending by ex-prisoners*. https://www.prisonstudies.org/sites/default/files/resources/downloads/reducing_report20pdf.pdf
- Spencer, S., Ruhs, M., Anderson, B., & Rogaly, B. (2007). *Migrants' lives beyond the workplace: The experience of central and eastern Europeans in the UK*. Joseph Rowntree Foundation. <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2045-migrants-experiences-uk.pdf>
- Stansfield, J. (2015). Confidence, competence and commitment: Public health England's leadership and workforce development framework for public mental health. *Journal of Public Mental Health*, 14(4), 180–184. <https://doi.org/10.1108/jpmh-07-2015-0033>
- Stein, M. (2006) Research review: young people leaving care. *Child and Family Social Work*, 11(3), 273–279. <https://doi.org/10.1111/j.1365-2206.2006.00439.x>
- Stein, M. (2019). Supporting young people from care to adulthood: International practice. *Child & Family Social Work*, 24(3), 400-405. <https://doi.org/10.1111/cfs.12473>
- Stein, M., & Morris, M. (2010). *Increasing the numbers of care leavers in*

“settled, safe” accommodation. C4EO.

<https://bettercarenetwork.org/sites/default/files/disability%20differentiated%20needs%206%20feb.pdf>

St. Mungo’s. (2011). Lifeworks: How an innovative psychotherapy project is helping homeless people in their recovery.

<https://www.mungos.org/publication/lifeworks-innovative-psychotherapy-project-helping-homeless-people-recovery/>

Stone, B., Dowling, S., & Cameron, A. (2018). Cognitive impairment and homelessness: A scoping review. *Health and Social Care in the Community*, 27(4), 125-142. <https://doi.org/10.1111/hsc.12682>

Strategic Review of Health Inequalities in England. (2010). Fair society, healthy lives: The Marmot review.

<https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf>

Stringfellow, E., J., Kim, T., W., Pollio, D., E., & Kertesz, S. (2015). Primary care provider experience and social support among homeless-experienced persons with tri-morbidity. *Addiction Science & Clinical Practice*, 10(1).

<https://doi.org/10.1186/1940-0640-10-S1-A64>

Stubbs, J. L., Thornton, A. E., Sevick, J. M., Silverberg, N. D., Barr, A. M., Honer, W. G., & Panenka, W. J. (2019). Traumatic brain injury in homeless and marginally housed individuals: A systemic review and meta-analysis.

Lancet Public Health, 5(1) 19-32. [https://doi.org/10.1016/S2468-2667\(19\)30188-4](https://doi.org/10.1016/S2468-2667(19)30188-4)

Stuckler, D., Basu, S., Suhrcke, M., Coutts, A., & McKee, M. (2009). The public health effect of economic crises and alternative policy responses in Europe: An empirical analysis. *The Lancet*, 374(9686), 315–323.

[https://doi.org/10.1016/s0140-6736\(09\)61124-7](https://doi.org/10.1016/s0140-6736(09)61124-7)

Tabner, K. (2010). *Beyond homelessness: Developing positive social networks*. Rock Trust.

- Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & S. W. Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (Second ed., pp. 17–37). SAGE Publications Ltd. <https://www.doi.org/10.4135/9781526405555>
- Thomas, B. (2011). *Homelessness: A silent killer – A research briefing on mortality amongst homeless people*. Crisis. https://www.crisis.org.uk/media/237321/crisis_homelessness_a_silent_killer_2011.pdf
- Thomas, B. (2012). *Homelessness kills: An analysis of the mortality of homeless people in the early twenty-first century in England*. Crisis. https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf
- Thompson, M. (2007), Exploring the trainees' view of a socio-political approach within UK clinical psychology. *Journal of Community & Applied Social Psychology*, 17, 67- 83. <https://doi.org/10.1002/casp.878>
- Thomson, H., Thomas, S., Sellstrom, E., & Petticrew, M. (2013). Housing improvements for health and associated socio-economic outcomes. *Cochrane Database of Systematic Reviews*, 1–376. <https://doi.org/10.1002/14651858.cd008657.pub2>
- Toporek, R. L., & Williams, R. A. (2006). Ethics and professional issues related to the practice of social justice in counseling psychology. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology: Leadership, vision, and action* (pp. 17–34). Sage. <https://doi.org/10.4135/9781412976220.n2>
- Townsend, P. (1979). *Poverty in the United Kingdom: A survey of household resources and standards of living* (0 ed.). University of California Press.
- Turner, S., Mota, N., Bolton, J., & Sareen, J. (2018). Self-medication with alcohol or drugs for mood and anxiety disorders: A narrative review of the epidemiological literature. *Depression and Anxiety*, 35(9), 851–860. <https://doi.org/10.1002/da.22771>

- Van Straaten, B., Rodenburg, G., Van der Laan, J., Boersma, S. N., Wolf, J. R. L. M., & Van de Mheen, D. (2017). Self-reported care needs of Dutch homeless people with and without a suspected intellectual disability: A 1.5-year follow-up study. *Health and Social Care in the Community*, *25*, 123-136. <https://doi.org/10.1111/hsc.12287>
- Vasquez-Vera, H., Palencia, L., Magna, I., Mena, C., Neira, J., Borrell, C. (2017). The threat of home eviction and its effects on health through the equity lens: A systematic review. *Social Science and Medicine*, *175*, 199-208. <https://doi.org/10.1016/j.socscimed.2017.01.010>
- Velikonja, D., Warriner, E., & Brum, C. (2009). Profiles of emotional and behavioural sequelae following acquired brain injury: Cluster analysis of the personality assessment inventory. *Journal of Clinical and Experimental Neuropsychology*, *32*(6), 610–621. <https://doi.org/10.1080/13803390903401302>
- Verdonk, P. (2015). When I say...reflexivity. *Medical Education*, *49*(2), 147–148. <https://doi.org/10.1111/medu.12534>
- Walker, N. (2021). Work focussed psychotherapy, job retention and political literacy. *Journal of Critical Psychology, Counselling and Psychotherapy*, *21*(1), 49-63.
- Warwick-Booth, L. (2019). *Social inequality* (2nd ed.). Sage.
- Watson, M. (2008). Constituting monetary conservatives via the ‘savings habit’: New labour and the British housing market bubble. *Comparative European Politics*, *6*, 285-304. <https://doi.org/10.1057/cep.2008.12>
- Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review*, *92*(4), 548–573. <https://doi.org/10.1037/0033-295X.92.4.548>
- Whalen, A. (2015). *Provision for young care leavers at risk of homelessness*.

Public Policy Institute for Wales. <https://www.wcpp.org.uk/wp-content/uploads/2018/04/Report-Provision-for-young-care-leavers-at-risk-of-homelessness-FINAL.pdf>

Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, 19(4–5), 576–582. <https://doi.org/10.1080/10503300802702113>

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (Ed.), *The handbook of research methods in psychology* (pp. 5- 21). American Psychological Association. <https://doi.org/10.1037/13619-002>

Willig, C. (2013). *Introducing qualitative research in psychology: Adventures in theory and method* (3rd ed.). Open University Press.

Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Therapists and Knowledge*, 19(3), 186-194. <https://doi.org/10.1002/capr.12204>

Witmer, L. (1907). The psychological clinic. *The American Journal of Psychology*, 18(3), 382. <https://doi.org/10.2307/1412615>

Wollin, D. (1996). 'Rigor in theory-building from cases', presented at ANZAM '96 Conference, Wollongong, NSW, 6-8 December 1996

Yeh, C. J., & Inman, A. G. (2007). Qualitative data analysis and interpretation in counseling psychology: Strategies for best practices. *The Counseling Psychologist*, 35(3), 369–403. <https://doi.org/10.1177/0011000006292596>

Young, S., Fitzgerald, M., & Postma, M. J. (2016). *ADHD: Making the invisible visible*. http://www.russellbarkley.org/factsheets/ADHD_MakingTheInvisibleVisible.pdf

APPENDIX A: 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 Doctoral student in the School of Psychology at the University of East London and am studying for a Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into what Clinical Psychologists can do to contribute to the prevention of homelessness when working in adult mental health services.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my 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 qualified Clinical Psychologists who are currently practicing within adult mental health services.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to meet with the researcher on an online video platform to complete a one-hour interview about potential roles for Clinical Psychology in homelessness prevention within adult mental health services. These interviews will be conducted online via the Microsoft Teams Platform. The discussions had within the interviews will be recorded using the Microsoft Teams recording facility to allow the researcher to transcribe discussions for analysis purposes.

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

Your taking part will be safe and confidential

Your privacy and safety will always be respected, this will be achieved by the following:

- You will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.

- You do not have to answer all questions I ask you and you can stop participating in the interview at any time.
- Interviews will be recorded through the Microsoft Teams platform.
- The interview will then only be transcribed by the researcher (Hanna Yousefzadeh) and these transcripts will remove all identifiable information and will be stored on a password-protected computer.

What will happen to the information that you provide?

- Only the researcher, researcher's supervisor and the examiners will be able to view your anonymised transcript, only where necessary.
- The audio recording of our interview will only be kept until it has been transcribed.
- The transcript of our interview will be destroyed after 5 years.
- You have the right to withdraw the data you provide up to 3 weeks after data collection. To do this, please see below for details. After 3 weeks it will not be possible to withdraw it, as data analysis will likely to have begun.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. You may also request to withdraw your data after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

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

Hanna Yousefzadeh, u1826660@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 B: Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Exploring Clinical Psychologists' roles in the prevention of homelessness within adult mental health services.

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 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

.....

Date:

APPENDIX C: Interview Schedule

INTERVIEW SCHEDULE

As part of this interview we will discuss your views and experiences as a clinical psychologist working in adult mental health services in the UK. There are no right or wrong answers; your honest views and experiences are highly valued, and it is hoped that they will contribute to developing better knowledge and practices to prevent homelessness. I appreciate some of your responses may be directly influenced by this current pandemic and I'd be interested to hear about this in addition to thinking about your previous practice.

1. What do you consider to be factors that may increase risk of homelessness for adults?

a. What influences your views?

2. What if at all, do you see as your role in preventing homelessness for adults?

a. What influences your views on the role of Clinical Psychologists in preventing homelessness for adults?

3. How would you know if homelessness was an issue? What would you be looking for?

4. Thinking about your work in adult mental health services, are there things that you are currently doing/have done to prevent homelessness for adults?

a. What enables you to do that/What prevents you?

b. You have mentioned 'x/y/z', are there any other things you currently do outside of this, perhaps within Supervision, Training, Consultation or outside of clinical work that you do?

5. As a profession, what can clinical psychologists do to help prevent homelessness for adults within the UK?

6. What do you perceive to be getting in the way of clinical psychologist's preventing homelessness?

7. What do you think might enable clinical psychologists to support adults at risk of homelessness?

8. Are there any other things that you expected me to ask that I have not asked about? or are there other things that you feel important to mention that I have not asked about?

Prompts: Please, tell me more. What do you mean? What was that like for you? How does that make you feel? How do you think about that? Can you give me an example?

APPENDIX D: Ethics Approval Letters

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: Mary Spiller

SUPERVISOR: Lorna Farquharson

STUDENT: Hanna Yousefzadeh

Course: Doctorate in Clinical Psychology

Title of proposed study: Exploring Clinical Psychologists' roles in the prevention of homelessness within adult mental health services

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)

1

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

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)

LOW

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

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

Mary Spiller

Date: 15/07/20

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

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk

5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Hanna Yousefzadeh

Programme of study: Professional Doctorate In Clinical Psychology

Title of research: Exploring Clinical Psychologists' roles in the prevention of homelessness within adult mental health services.

Name of supervisor: Dr. Lorna Farquharson

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
I would like to use a poster for participant recruitment (poster attached to this corresponding email and included in the amended ethics application). There is no new information included in this poster but provides key information taken from the information sheet.	This will allow me to advertise my research in an alternative format which may be easier for people to access all relevant information and potentially improve the recruitment process.

Please tick	YES	NO
-------------	-----	----

Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
---	---	--

Student's signature (please type your name): Hanna Yousefzadeh

Date: 02/10/2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	Yes	
Comments		

Reviewer: Tim Lomas

Date: 2.10.20



University of East London
Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

A copy of the approval of your initial ethics application.

Name of applicant: Hanna Yousefzadeh
 Programme of study: DClInPsy – Prof Doc
 Name of supervisor: Dr. Lorna Farquharson

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Exploring Clinical Psychologists' Role in the Prevention of Homelessness within Adult Services	To give more clarity of the project.
New Title: Preventing Homelessness: Exploring the Role of Clinical Psychology in Adult Mental Health Services	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Hanna Yousefzadeh

Date: 24/03/2021

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments		

Reviewer: Glen Rooney

Date: 26/03/2021

APPENDIX E: Debrief Letter

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study exploring Clinical Psychologists' roles in the prevention of homelessness within adult mental health services. This letter offers information that may be relevant following your involvement in this research project.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- You will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.
- The interview has been recorded through the Microsoft Teams platform.
- This recording will now be transcribed solely by the researcher (Hanna Yousefzadeh) and the researcher will remove all identifiable information. The recording will be deleted after it has been transcribed.
- This transcript will then be stored on a password-protected computer.
- Only the researcher, researcher's supervisor and the examiners will be able to view your anonymised transcript, only where necessary and appropriate.
- The transcript of our interview will be destroyed after 5 years.
- You have the right to withdraw the data you provide up to 3 weeks after data collection. To do this, please see below for details. After 3 weeks it will not be possible to withdraw it, as data analysis will likely to have begun.

To find out more information on homelessness, and organisations who are working towards improving healthcare provision for this group you could visit:

<https://www.pathway.org.uk/faculty/>

<https://www.mungos.org/>

<https://www.crisis.org.uk/>

<https://www.homeless.org.uk/>

Additionally, if you would like to learn more about the obligations of NHS staff under the Homelessness Reduction Act please visit:

<https://www.gov.uk/government/publications/homelessnessduty-to-refer-for-nhs-staff>

Contact Details

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

Hanna Yousefzadeh, U1826660@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 F: Transcription Extract

INITIAL CODES

Interviewer: So, I wondered, what do you consider to be factors that might increase the risk of homelessness for adults?

Participant: I think from a structure, societal point of view... you're looking at the increasing instability of employment. Also the privatisation of housing and rent being, I guess rent being decided against so called market valuations and the deconstruction of social housing over that last 30 years as part of the neoliberal capitalist agenda which disadvantages the vast majority of individuals, certainly that are kind of working class or lower end of the socioeconomic scale. So, I think those two, housing and employment from a structural point of view. I think within that there's racism that plays a role and many many other structural factors, but I think those are the main ones. On a local level? A Local systemic level, and family level what we see is trauma all the time. I mean, trauma is a sanitised word, when we think about trauma, we are actually thinking about childhood violence, children witnessing violence, being victims of violence and torture that we commonly describe as trauma or adverse childhood experiences. Intergenerational trauma as well, and the attachments are then affected by that trauma and then that trauma then being compounded by a lack of a safety net in society so whether it be schools, NHS mental health, physical health systems or social systems that are there to support an individual just not being there. And certainly, over the past 10 years that's been exasperated by austerity and cutbacks. The person what's commonly refused is drug and alcohol or addiction issues which are really issues around oppression and exploitation of the individuals and the individual reacting to that by using drugs and alcohol and then falling into another viscous cycle. Although the research suggests ADHD, one piece of research suggests you are about 5 times more likely to be homeless. Acquired brain injury often happen before the person is homeless, learning

Systemic

Trauma

Lack of support systems
Attachment

Substance Misuse

Austerity

ADHD/Brain Injury/Learning
Disability

System Failings

disabilities have higher prevalence rates, around 12% some of the research suggests and autism as well and then these commonly being construed as lifestyle choices of the individual and that system, homeless housing system not fully acknowledging the lack of skills or competencies a person will have in order to maintain their home. That'll be some of the factors.

Interviewer: Thank you. One thing I wondered, you mentioned it's sometimes viewed as lifestyle choices by councils and things like that. I wondered if you could tell me a little more about that in terms of what that looks like or what is that narrative that may be going around about it being a choice?

Participant: That what is offered to individuals by society, yes councils but also NHS services and Drug and Alcohol services what's being offered is considered good and therefore if it's declined the person has made a free and fair choice and therefore those organisations don't take into account those psychological factors which affect that person's choice. So from a psychodynamic point of view the suggestion that the homeless individual's experiences, claustrophobia and agoraphobia nowhere is safe, is not known to lack of psychological awareness of attachment of complex trauma and the effects of that, all point to an individualised self-blaming model or blaming on their understanding or their judgement and understanding of individuals reason and rationale.

Individualising

Individual responsibility

Interviewer: Thank you. And you referred to some research that might show certain people might be more vulnerable to being homeless or might be at higher risk of being homeless, I wondered what else might influence your views on what you have just commented on ways that you may understand increase risk of homelessness?

Participant: Not to get into the party politics but if you look at the trends of certainly rough sleeping up until around 2008, 2009, 2010, they were going down, the trends were lowering and it was only then 2010 and since then through austerity

Political

that it's actually exploded. At that time I was working in [X], [X] homeless psychology service. Or a place in the [X] that offer homeless mental health support to protect confidentiality. And at that time, that was 2012 and services, councils were being cut back, hostels were being closed and key working staff were being...the type of working moved from a more relational basis to transactional. So the councils were decimated at a time where homelessness was then increasing because of the effects of the economy of the austerity agenda and we're seeing the repercussions of that, certainly where I'm at now, in the [X] or [X] of England we are still suffering the consequences of that and it contains a certain level of uncertainty now with COVID we are experiencing masses of increase in homelessness. The economy, which is not sustainable with the resources, we are at capacity with what we do have so we are expecting things to get a lot worse, particularly over the winter time. The government, this government over the last 10 years and again and again despite them knowing and being informed that homelessness isn't a housing issue, or isn't just a housing issue or isn't just a medical issue, they still put out these very small, short term contracts for a year or two years or three years...or even at the minute, 3 months to deal with the most entrenched rough sleepers, the most difficult to engage and to expect services to do something different when a lot that's needed is a long term approach. Working with the person and where they are at and their motivation, so basically the whole system sets up the homeless sector and other services to fail because the only option with short term contracts is that transactional, so called, transactional engagement; "you do X, I'll give you Y". When the person is living day to day and just wants to survive, who doesn't trust services because they've been let down again and again and again and it's just another person or people who are coming saying the same things that they've heard before and the trust isn't there. The shame and the guilt and other emotional impacts of trauma all affect that engagement with frontline homeless staff. As brilliant as they are, not all have that understanding or not all are allowed to have that understanding or time or

Short term contracts

Working where people are at

Engagement

Shame/guilt

flexibility to work in a relational for a long term view of the needs and values of the homeless individual.

APPENDIX G: Transcription Conventions

Minor changes were made to the transcripts to enable the quotes used in the analysis to be read easily.

Repetitive or filler words (e.g. 'I guess', 'you know', 'kind of') were removed.

Conventions informed by Banister et al. (1994) were added within the transcripts:

... omitted words or sections

[text] addition of content for clarity

[X] to replace identifying names or locations to preserve anonymity

APPENDIX H: Thematic Map

