

**Being homeless and experiencing mental health-related difficulties:
Listening to and learning from the experiences of service users of a
designated homeless psychology service**

Thesis submitted for the degree of Doctorate in Clinical Psychology
(DClinPsy) at the University of Leicester

by

Helen Taylor

Department of Psychology

University of Leicester

2012

Declaration

I can confirm that this thesis and the research reported within it is my original work. It was written and submitted in part fulfilment of the degree of DClinPsy (i.e. Doctorate in Clinical Psychology). It has not been submitted for any other degree or academic qualification.

**Being homeless and experiencing mental health-related difficulties:
Listening to and learning from the experiences of service users of a designated
homeless psychology service**

Helen Taylor

Abstract

Homeless adults experience high levels of mental health-related difficulties, but experience barriers in accessing mainstream mental health services. To provide more equitable access, a small number of innovative services have developed in the UK. The current literature review explored the research evidence for their therapeutic impact. Based upon the narrative synthesis of 13 heterogeneous research studies, designated services for homeless adults were found to have a therapeutic impact, as measured on a range of outcomes. Methodological flaws however, were identified in all of the research studies reviewed. It was concluded that given the paucity of research in this field, clinical applicability was very limited. In particular, the need for further research into service users' views of existing services was identified.

The research study sought to understand service users' experiences of: homelessness and mental health; psychological needs; a Homeless Psychology Service; and, their ideas regarding service development. Qualitative interviews were conducted with seven adults who had accessed a specialist Homeless Psychology Service in the UK. Analysis using Interpretative Phenomenological Analysis revealed that becoming and being homeless had a detrimental psychological impact on all participants. All but one of the participants benefited from engaging with the service (i.e. through catharsis, gaining insight, overcoming hopelessness, making positive changes). The findings provide insight into how they benefited or not and what makes homeless adults 'different'. The findings support the need for specialist services which meet their needs by providing flexibility and by persistently seeking to combat 'mistrust' by encouraging engagement. The Homeless Psychology Service is promoted as a potential service model for future developments.

The Critical Appraisal offers the Researchers' reflections on conducting this study.

Acknowledgments

I wish to thank the seven participants who shared their experiences with me so openly. It was an absolute honour to be able to hear their stories, and without them this research would not have been possible.

I also wish to thank my academic supervisor, Dr Marilyn Christie at the University of Leicester for her time, support and guidance throughout the research process. I am also particularly grateful to one of the Psychologists within the Homeless Psychology Service¹ for helping with planning and recruitment and for providing endless encouragement. I feel inspired by her passion and enthusiasm for work in this field.

Finally I want to thank my wonderful husband, friends and family for knowing me well enough to somehow strike the perfect balance between leaving me to work, whilst also providing endless fun and distraction whenever I have needed it.

Thank you again, to everyone.

¹ In recognition of the need to protect the anonymity of the service, it is with regret that this Psychologist could not be named.

Word Count

Abstract: 298 words

Part 1: Literature review

Abstract: 292 words

Full text (excluding tables): 6,965 words

Part 2: Research report

Abstract: 297 words

Full text (excluding tables): 11,931 words

Part 3: Critical appraisal

Full text: 2,163 words

Total word count for main text (minus abstracts and tables): 21,059 words

Total word count for appendices (i.e. minus mandatory appendices)²: 7,793 words

Total word count for whole thesis: 28,852 words

² Appendices A, E, G, N, and S are mandatory appendices which total 4145 words.

Contents

Declaration.....	i
Abstract.....	ii
Acknowledgments.....	iii
Word Count.....	iv
Contents	v
List of Tables	viii
List of Figures	ix
Part 1: Literature Review.....	1
Abstract.....	2
1. Introduction	3
2. Method	6
2.1. Data collection.....	6
2.2. Data extraction.....	12
2.3. Description, critical appraisal and synthesis	12
3. Results.....	13
3.1. Quantitative studies and their research findings.....	13
3.2. Qualitative studies and their research findings.....	19
3.3. Methodological synthesis and critical appraisal.....	20
3.4. Summary of findings.....	26
4. Discussion	28
4.1. Limitations of the current review	31
5. Practitioner points.....	32
References	33
Part 2: Research Report	41
Abstract.....	42
1. Introduction	43
1.1. National service developments	44
1.2. Research evidence.....	45
1.3. Research aims and research questions	47
1.4. Implications for Clinical Psychology practice	47
2. Methodology	49

2.1. Design	49
2.2. Position of the Researcher/forestructure	49
2.3. Research context	50
2.4. Participants	50
2.5. Materials	51
2.6. Procedure.....	51
2.7. Quality issues.....	57
3. Results.....	58
3.1. Theme A: The psychological impact of becoming homeless.....	59
3.2. Theme B: The psychological impact of being homeless	62
3.3. Theme C: Traumatic events and mental health difficulties prior to homelessness	69
3.4. Theme D: Personal experiences of using the Homeless Psychology Service ..	70
3.5. Theme E: The national provision of psychology services for homeless adults	83
3.6. Theme F: Personal experience of being interviewed.....	84
4. Discussion	85
4.1. Summary of research findings.....	85
4.2. Implications for clinical psychology practice.....	88
4.3. Strengths and limitations	89
4.4. Recommendations for further research	90
References.....	92
Part 3: Critical Appraisal	99
1. Introduction	100
2. Conducting the research.....	100
3. Limitations	105
4. Future research opportunities	106
5. Reflections on personal and professional development.....	106
References.....	108
Appendices.....	110
Appendix A: Guidelines to authors for journal targeted for literature review	111
Appendix B: Data extraction template	116
Appendix C: A table displaying the aim, setting, intervention, study design, sampling process and characteristics of 13 research studies	117

Appendix D: A table displaying the data collected, analysis, key findings, reflexivity and key limitations of each of 13 research studies	121
Appendix E: Statement of epistemological position	126
Appendix F: Brief Information Leaflet	127
Appendix G: Participant Information Sheet	130
Appendix H: Poster advertising the research study.....	135
Appendix I: Consent Form.....	137
Appendix J: Topic Guide	138
Appendix K: Voucher Receipt Form.....	139
Appendix L: Summary Report Request Form	140
Appendix M: List of Local Support Agencies	141
Appendix N: Letters to and from ethics committees.....	143
Appendix O: Additional ethical considerations	154
Appendix P: Transcription notation and list of pseudonyms.....	156
Appendix Q: Detailed description of analytic process	157
Appendix R: Example of initial noting on a transcript excerpt	159
Appendix S: Chronology of research progress	160
Appendix T: A diagrammatic representation of key emergent themes	161
Appendix U: A table to show the frequency of ‘super-ordinate’ and ‘sub-ordinate’ themes	162
Appendix V: Traumatic events and mental health-related difficulties prior to becoming homeless as interpreted by the Researcher	164
Appendix W: Ideas for the dissemination of the research findings.	165
Appendix X: Ideas for further analysis of current data set	166

Addenda: Transcripts have been separately presented as an Addendum

Transcript 1: ‘Jon’

Transcript 2: ‘Jen’

Transcript 3: ‘Daniel’

Transcript 4: ‘Ruby’

Transcript 5: ‘Eve’

Transcript 6: ‘Mike’

Transcript 7: ‘Denise’

List of Tables

	Page number
<u>Part 1: Literature review</u>	
Table 1: List of search terms used and search outcomes	7
Table 2: Summary of preliminary search findings	8
Table 3: Inclusion and exclusion criteria	9
 <u>Part 2: Research report</u>	
Table 1: Super-ordinate themes	58

List of Figures

	Page number
<u>Part 1: Literature review</u>	
Figure 1: A PRISMA flow diagram to summarise the literature review search process.	11

Part 1: Literature Review

What is the evidence for the therapeutic impact of providing mental health-related services for homeless adults? A systematic review of the UK research literature

Helen Taylor

Abstract

Prepared inline with the British Journal of Clinical Psychology guidelines³

Purpose

Homeless adults who experience mental health problems find it difficult to access traditional mental health services. Designated services have recently been developed in the UK to meet the needs of this particularly vulnerable group. The aim of the current study was to conduct a systematic review to determine what is currently known about the evidence for the therapeutic impact of these services in the UK.

Methods

Literature searches were conducted using three search engines to retrieve potentially relevant articles. Of the 4305 articles found, 13 met the inclusion criteria for the review (i.e. original research findings from evaluations of UK services published within peer reviewed journals). Following data extraction, the research papers were summarised and synthesised using both tabulation and descriptive and evaluative narrative.

Results

Despite the complex needs of homeless adults, the current review found that designated mental health services can have a therapeutic impact, as measured on a range of outcomes. This finding was drawn from a small evidence base consisting of a heterogeneous group of research studies, all of which contained methodological weaknesses.

Conclusions

The current UK research literature provides very limited ‘snap shots’ into mental health service provision for adults who are homeless. Clinical application of this knowledge base will remain limited until further research is conducted in the areas of service outcomes, longitudinal effectiveness and service users’ views.

³ Guidelines for authors can be seen in Appendix A. This literature review has been written in line with the DClinPsy thesis requirements (i.e. maximum 7000 words, 300 words for the abstract).

What is the evidence for the therapeutic impact of providing mental health-related services for homeless adults? A systematic review of the UK research literature

1. Introduction

An extensive knowledge base has identified that homeless adults experience high levels of mental health problems, with prevalence estimates for mental illness ranging from 30 to 50 percent (Scott, 1993). Homeless adults are twice more likely than housed adults to experience mental health difficulties (Victor, 1992), with this raised prevalence being associated with stressful life events and lack of social support (Sims & Victor, 1999).

Despite being in very high need of psychological services, homeless adults face significant problems gaining equitable access to traditional mental health care (The Marmot Review, 2010). Reasons for this include: the lack of responsibility placed on services to seek out vulnerable non-attendees (Crane & Warnes, 2001); low levels of GP (i.e. General Practitioner) registration and high levels of mobility (Owen & Khalil, 2007); lack of flexibility in appointment systems and discharge procedures (Spence, 2009); and stigma (O'Reilly et al., 2009). For these reasons, gateways to mental health services for homeless adults have traditionally only opened at the point of crisis via Accident and Emergency departments or in-patient services (Holland, 1996; Symington, 2010; Timms & Borrell, 2001). Without treatment, mental health difficulties in this population are unlikely to improve (Craig & Hodson, 2000) and are further compounded by co-occurring difficulties with housing, physical health, drug and alcohol use, previous trauma and lack of social support (Kershaw et al., 2003; Taylor et al., 2006).

Following substantial charitable and government investment (Crane & Warnes, 2005), designated services have developed across the UK in recent years (Shelter, 2008). These services are often only anecdotally described in the research literature (e.g. Shepherd et al., 1998; Spence, 2009), and the reasons behind their development and their theoretical underpinnings are not well understood. In addition to this, it is unfortunate that little attention has been paid to their evaluation (Philappot et al., 2007).

With current Government policy committing to reduce inequitable access to health care for homeless adults (HM Government, 2009), and calls for further funding to 'roll-out' psychological therapies for homeless populations in the UK (Shelter, 2008), a coherent understanding of the evidence of treatment effectiveness is required. Making broad recommendations for service delivery based on limited evidence negates the principles of evidence based practice and risks the development of ineffective services, which may waste both valuable resources and breach the ethical duty of care (Ciliska et al., 2007).

Systematic reviews that identify primary research, appraise quality and synthesise their results (Glaziou et al., 2001; Khan et al., 2003) provide a reliable basis on which evidence based practice and policy can be informed (Dixon-Woods et al., 2006; Webb & Roe, 2007). Existing reviews of the literature on treatment for homeless adults have focussed upon: the prevalence of mental health-related difficulties (e.g. Crisis, 2009); generic healthcare provision (Wright & Tomkins, 2006); assertive outreach services (Coldwell & Bender, 2007; O'Campo et al., 2009); and service users' views (Bhui et al., 2006). Of the reviews that have focussed upon evidence for service effectiveness (i.e. Coldwell & Bender, 2007; O'Campo et al., 2009) which found evidence for the effectiveness of assertive community treatment approaches for homeless adults, both relied solely upon literature from the United States. This trend

was also reflected in a review of service users' views, which included only one UK-based study (i.e. Bhui et al., 2006). Differences have been identified between the characteristics and engagement with services by homeless populations in the UK and other countries (e.g. Crane et al., 2005; Forchuck et al., 2008). Combined with inevitable differences in culture, socio-economic climate, welfare policy and service provision, the applicability of these previous findings to the UK context are limited. The aim of the current study therefore, was to conduct a systematic review of the UK research literature to assess what is known about the therapeutic impact of providing mental health-related services for adult homeless populations.

2. Method

To increase methodological rigour and objectivity, the process of data collection, extraction, critical appraisal and synthesis was determined prior to the conduct of the current review (Khan et al., 2003). Each of these stages is described below.

2.1. Data collection

In line with the current review's aim, three groups of search terms were developed reflecting the population (i.e. homeless*), needs (i.e. psycholog*, mental health) and services under investigation (i.e. service*, therap*, counsel*, suppor*). An asterisk (*) was used to represent truncation which enabled the retrieval of all forms of a word. Combining one search term from each group created eight different permutations.

Research literature published between January 1990 and December 2011 in the fields of nursing, psychology and psychiatry was searched in January 2012 using EBSCO (to access PsycARTICLES, PsycEXTRA and PsycINFO), Ovid (to access Medline(R) and Embase) and ISI Web of Science. As it can be seen in Table 1 below, 24 searches were conducted which resulted in the retrieval of 4305 articles. Initial screening of titles and abstracts identified 78 articles, which potentially addressed the question posed by the review (see Table 2).

Search term permutations	Results			
	SEARCH A	SEARCH B	SEARCH C	Total results
	PsycARTICLES, PsycEXTRA & PsycINFO (via EBSCO)	Medline(R) & Embase (via Ovid)	ISI Web of Science	
1. Homeles* & Psycholog* & Servic*	168	120	95	383
2. Homeles* & Psycholog* & Therap*	68	55	36	159
3. Homeles* & Psycholog* & Counsell*	4	9	4	17
4. Homeles* & Psycholog* & Suppor*	133	101	94	328
5. Homeles* & Mental health & Servic*	655	530	871	2056
6. Homeles* & Mental health & Therap*	78	85	128	291
7. Homeles* & Mental health & Counsell*	6	11	5	22
8. Homeles* & Mental health & Suppor*	286	335	428	1049
Total:	1398	1246	1661	4305

Table 1: List of search terms used and search outcomes

Search	Total articles retrieved	Articles screened as being of potential relevance
A	1398	45
B	1246	21
C	1661	12
Total:	4305	78

Table 2: Summary of preliminary search findings

The abstracts of the 78 articles were then further screened using the inclusion and exclusion criteria listed in Table 3 below. Although traditionally, qualitative research has been under-utilised in systematic reviews (Sandelowki & Barroso, 2002), it provides an additional dimension which can bolster a review's validity (Evans, 2007; Whitemore, 2007). For this reason, any paper reporting original research findings (i.e. qualitative or quantitative) on mental health services for adult homeless populations were included in the current review.

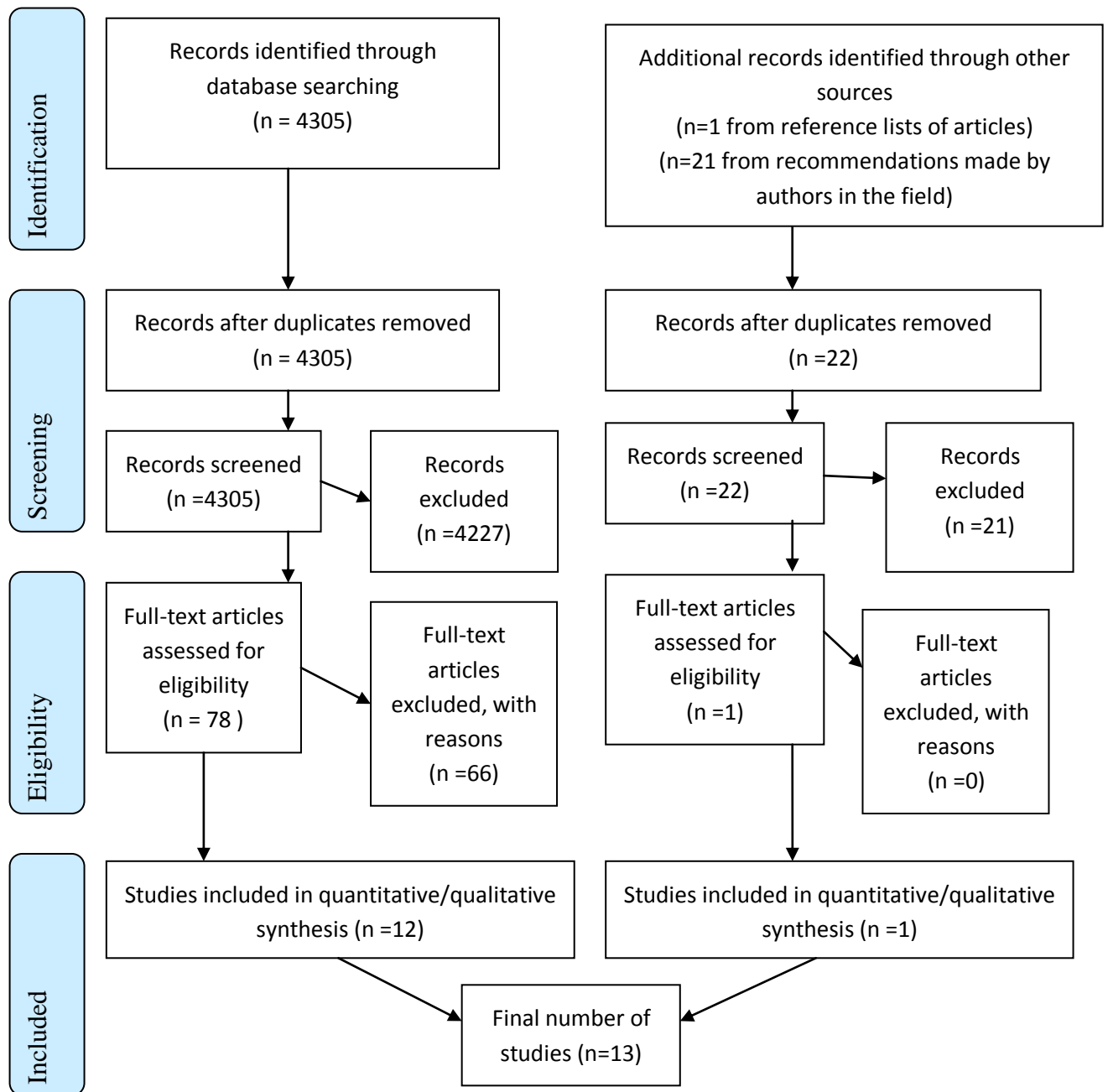
Category	Inclusion	Exclusion
1. Type of publication.	<ul style="list-style-type: none"> - Published in English. - Peer reviewed Journal. - Full text accessible. 	<ul style="list-style-type: none"> -Not published in English. -Not a peer reviewed journal. -Not full text accessible.
2. Type of research study.	<ul style="list-style-type: none"> - Papers reporting original empirical findings using qualitative, quantitative or mixed methods designs. -Research describing and evaluating mental health related services for adult homeless populations. 	<ul style="list-style-type: none"> -Papers not reporting original empirical findings. -Research not describing and evaluating mental health related services for adult homeless populations.
3. Location of research.	UK.	Non-UK.

Table 3: Inclusion and exclusion criteria

Sixty-six papers were excluded according the criteria as follows: did not collect primary research data (n=8); only described the characteristics of homeless populations rather than evaluating services (n=49); were not published in a peer reviewed journal (n=2); or collected data from outside of the UK (n=7).

The reference lists of the 12 remaining articles were screened, resulting in one further article being identified which met the inclusion criteria. This resulted in 11 quantitative and two qualitative articles being accepted for the current review, and these are identified within the Reference list by an asterisk (*). The primary author of each of these articles was contacted directly (i.e. via email or postal address) to request their assistance in identifying any further articles that might have been missed. Out of those contacted, six responded and between them suggested a further 21 documents, all of which were interesting in terms of the area of research, but none of which met the inclusion criteria as previously defined (i.e. they did not evaluate UK-based mental health services for homeless adults). The adapted PRISMA diagram (Moher et al., 2009) below in Figure 1 offers a full summary of the search process from identification to inclusion.

Figure 1: A PRISMA flow diagram to summarise the literature review search process



2.2. Data extraction

To ensure consistency (Glasziou et al., 2001), data extraction was guided by the use of a data extraction template (see Appendix B).

2.3. Description, critical appraisal and synthesis

Using ‘descriptive data synthesis’ (Evans, 2007), each study was summarised to present the results using tabulation, descriptive and evaluative narrative. Care was taken not to critique qualitative research using quantitative criteria (Dixon-Woods et al., 2006) and in order to respect the differences in methodology and epistemology, no attempts were made to combine qualitative and quantitative findings (Sandelowski & Barroso, 2002). Due to the small number of studies, quality appraisal was not used to exclude any articles and the critical appraisal process was guided by the headings in the data extraction template.

3. Results

This results section begins by providing a descriptive summary of each of the 11 quantitative research studies and their findings, in the chronological order in which their contribution to the field was published. These studies evaluated a range of specialist services for homeless adults which included: psychiatric and mental health drop-in clinics; in-patient wards; community mental health teams; outreach services and specific therapeutic interventions (i.e. cognitive behavioural therapy and individual psychotherapy). Descriptive summaries are then provided of the two qualitative research studies which interviewed homeless adults. The first of these studies attempted to understand service users' views in regard to a range of services for homeless adults (e.g. mental health, physical health and housing), whilst the other focussed specifically upon evaluating a hostel-based mental health service. To aide comparison, all 13 of the selected research studies have been summarised in Appendix C. Brief descriptions of the data collected, analysis, key findings, ethical considerations, reflexivity and key limitations can be seen in Appendix D.

The second part of this result section presents a methodological synthesis and critical appraisal of the 13 research studies included in this review. This was to assess the strength of the evidence on which any current findings can be drawn.

3.1. Quantitative studies and their research findings

In an attempt to assess the effectiveness of a weekly, three-hour psychiatric drop in clinic at a central London General Practice surgery for homeless adults, Joseph et al. (1990) collected data on psychiatric diagnosis and attendance rates. For three years, all new clients were included in the sample (N=260). The study found that clients who

were diagnosed with schizophrenia were significantly more likely to be ‘long attenders’ (i.e. attend at least five times), than those who did not have the diagnosis. The authors concluded that clients diagnosed with schizophrenia appeared to have benefited most from the clinic and subsequently explained that the mental state of ‘many’ of these clients was also found to have either ‘stabilised’ or ‘improved’.

Bhugra et al. (1997) sought to evaluate the ‘Baron’s Court Project’, a voluntary sector drop-in that offered therapeutic and group work to adults who were homeless and vulnerable due to mental health problems. An independent researcher asked service users to take part in a structured interview using questionnaires that measured: socio-demographic factors, psychiatric history and user satisfaction (N=70). All service users described the project as being ‘safe’ and ‘welcoming’. Out of those clients who had used the project for ‘support’ and ‘advice’ (N=36), 86% felt that it was ‘good’ or ‘excellent’, whilst 6% described it as ‘average’ and 8% as ‘poor’.

Commander et al. (1997) explored the impact of a Birmingham-based specialist community mental health team for homeless people (CMHT) on in-patient admissions for patients of ‘no fixed abode’. Over a one year period, weekly telephone calls were made to all local psychiatric wards to collect data on the number and characteristics of admissions and their discharge pathways (n=91). This case group was compared to a control group drawn retrospectively from hospital records prior to the team’s development (n=87). It was found that the CMHT did not reduce the need for in-patient care for homeless adults because it failed to have an effect on psychiatric admissions, but it did have a significant impact on aftercare, with 72% of patients receiving follow-up, in comparison to 46% in the control group.

With the aim of describing outcomes for rough sleepers following admittance to an acute psychiatric ward between 1991 and 1995, Graham et al. (1999) collected

information from ward staff. This specialist ward in London provided on-the-street assessments and in-patient treatment for rough sleepers and worked closely with the local East London Homeless Healthcare Team (HHELP), which provided an outreach service. The sample consisted of 22 rough sleepers and their outcomes were defined as either 'good' (n=11), or 'average' (n=7) by staff. These positive outcomes were identified as being due to specific factors which included: staff qualities (n=9); service continuity (n=6); treatment during admission (n=6); joint working between agencies (n=5); treatment of physical health problems (n=3); and a social worker's involvement (n=2). Clients who experienced psychosis on admission were found to be significantly more likely than non-psychotic clients to be in touch with 'generic' services at follow-up and have confirmed accommodation.

In a follow-up study, Odell & Commander (1999) examined the impact of the Birmingham specialist Community Mental Health Team (CMHTH), which provided 'patient-led' interventions for homeless people, by focussing on outcomes for clients experiencing psychosis. Data on accommodation status, risk, and mental health symptoms was collected at assessment and end of contact on all new clients diagnosed with a psychotic disorder and treated by the CMHTM over a two year period (N=82). Although risk remained prevalent (i.e. substance misuse and criminality) and reductions in depressed mood were not found to be significant, significantly fewer clients were found to experience psychotic symptoms (i.e. delusions and psychosis) and be rough sleeping following contact with the team.

An Aberdeen-based mental health drop-in service for homeless clients that operated at a variety of locations (e.g. hostels) was evaluated by Wood et al. (2001). Psychiatric symptoms and the number of service contacts were recorded as outcome measures for three years on all new clients. Out of the sample (N=86), half were

diagnosed as presenting with a 'serious and enduring mental illness' (n=42). Out of the total sample, 50 of these clients were found to receive 'assessment' only, 25 had 'brief contact' (i.e. a maximum of five sessions) and 11 received 'ongoing care' (i.e. six sessions or more) from the service.

Power and Attenborough (2003) evaluated the START (South Thames Assessment Resource and Training) project's success at helping homeless clients with mental health problems achieve a 'more settled lifestyle'. START was an outreach service that aimed to integrate homeless clients back into their communities and establish contacts between them and local statutory and voluntary mental health services. Follow-up data was collected from current clients who had been consecutively referred to START in 1994 (N=100). At follow up, 49% were living within more permanent accommodation and 55% remained in contact with services. It was therefore reported that clients of the service had achieved a more settled existence.

Killaspy et al. (2004) investigated whether admission to a designated 12 bed in-patient ward for homeless clients in London, who were already engaged with the Focus Homeless Outreach Team, had improved outcomes (i.e. accommodation status and service engagement) after 12 months. The sample included all Focus Team clients who were admitted to any in-patient facility during a one year period (N=50). Over half were admitted to the designated ward for homeless adults (n=29), and the remaining clients were admitted elsewhere, thus forming a control group. One year after discharge, no statistical differences were found between the two groups in regard to accommodation status. Levels of engagement with services, as rated by care co-ordinators' pre-admission and at twelve month follow-up using the 'Homeless Engagement and Acceptance Schedule', were however found to be significantly higher for those adults referred to the designated ward.

A pilot Cognitive Behavioural Therapy (CBT) intervention operating within a therapeutic housing environment in Southampton was evaluated by Maguire (2006). Delivered by a Clinical Psychologist, this included weekly sessions with clients and CBT training for support staff combined with ongoing supervision for their day-to-day work. The sample, which comprised four male rough sleepers who had experienced tenancy breakdowns and had recently attended a detoxification programme for alcohol and/or substance misuse problems were identified on the basis of need. Outcome data was collected at assessment, entry to the project and at ten weeks follow-up. At follow-up, all four men self-reported reduced levels of theft, violence, alcohol consumption and risk to self and others. Perceived self efficacy as measured by the 'Generalised Self-Efficacy Scale' increased slightly for all of the men, but overall functioning as measured by CORE (Clinical Outcomes in Routine Evaluation) increased for half, but decreased for the other half of the sample. In addition to these clinical outcomes, 15 support staff identified feeling significantly less stressed and more self efficacious in influencing change in their client group following training in CBT, as identified by a pre-post questionnaire measure.

Taylor et al. (2007a) evaluated a voluntary sector mental health service for homeless young people aged 16 to 25 years old, that operated in 18 homeless shelters across England and offered a variety of interventions (e.g. counselling skills, CBT, substance use interventions, psycho-education). To assess the clinical outcomes of the service, pre-post risk assessments and Health of the Nation Outcome Scales (HoNOS) were completed on all young people referred in one year by service staff (N=150). Young people who accessed the service more than once (n=74), were found to improve significantly as measured by total HoNOS scores and most sub-scale scores (i.e. aggressive behaviour, self injury, alcohol/drugs, cognitive problems,

hallucinations/delusions, depressed mood, other mental health problems, relationships, daily living activities and occupation and activities).

In his 2011 paper, Cockersell described a pilot project by St Mungo's (i.e. a UK organisation that provides accommodation and support to homeless people), that added clinical mental health interventions (i.e. access to individual psychotherapy) to existing social care services for homeless adults in London. The aim of the project was based upon the hypothesis that chronically excluded adults were excluded because they experienced psychological disorders. It sought to examine whether a psychotherapeutic intervention would reduce levels of exclusion as measured by attendance rates, outcome measures (i.e. the Wellbeing Impact Assessment Measure, the Outcomes Star) and 'hard' outcomes (i.e. changes in accommodation status, take up of training or employment opportunities). The sample included all referrals to the psychotherapy service who had attended their first appointment (n=247) and a comparison group of St Mungo's residents who had not attended psychotherapy. It was found that 80% of clients continued to attend the specialist service four or more times after their initial assessment and overall attendance rates for sessions was high (i.e. 76%). Many clients who attended psychotherapy (i.e. 76%) were found to 'positively improve' on a range of outcomes as measured by the Wellbeing Assessment Measure. When compared to the control group, clients of the psychotherapy service showed greater outcomes on all areas of the Outcomes Star, with the largest improvement being in the domain of 'meaningful occupation.' Data collected via the Outcomes Star was mapped onto the Cycle of Change (Prochaska & DiClemente, 1982), and clients of the service were three times more likely to progress through 'the Cycle of Change' (i.e. from 'pre-contemplation' to 'action') than the control group. By the end of their sessions, 42% of

clients were in employment, education, voluntary placements or training, in comparison to 21% of the control group.

3.1.1. Summary of findings from quantitative research studies.

In summary, the 11 quantitative research studies in the current review provided evidence that the specialist services that they described did have a positive therapeutic impact on their homeless clients, as measured using a range of outcomes. The studies that used control groups (i.e. Cockersell, 2011; Commander et al., 2007; Killaspy et al., 2004), also identified that homeless clients who had used a designated service showed more positive outcomes than those who did not use the service (e.g. increased engagement with services, progress through the cycle of change, and greater likelihood of being engaged in ‘meaningful occupation’).

3.2. Qualitative studies and their research findings

Rather than evaluating a single intervention, Bhui et al. (2006) interviewed 10 homeless adults in London with mental health problems to ascertain their general views on the adequacy of homeless services to meet their needs (e.g. hostels, health centres). Thematic analysis revealed seven broad themes: ‘health and biography’; ‘stigma’; ‘service provision’; ‘coping’; ‘finances’; ‘hostels and homelessness’; and ‘recommendations to improve services’. Mental health services were rarely mentioned leading the authors to conclude that physical health and social problems were of more importance to the interviewees.

Taylor et al. (2007b) conducted a qualitative evaluation of the hostel-based mental health service described above in their earlier study. Five out of the 18 homeless shelters were selected as being representative due to their size and geographical

location. All clients currently engaged with the mental health service at these five locations were asked to participate in a semi-structured interview with an independent researcher (N=19). Thematic analysis identified that all young people felt that they had benefited from their contact with the service. Also identified were themes that reflected specific aspects of the mental health service that were perceived as contributing to its effectiveness (i.e. confidentiality, staff being separate from shelter staff, offering in-house services, telephone contact, meeting outside of the homeless shelter, supporting referral to other agencies and outreach work).

3.2.1. Summary of findings from qualitative research studies.

The two UK-based qualitative research studies included in the current review produced some interesting findings. The first concluded that mental health services were of less importance to their interviewees than other services (i.e. Bhui et al., 2006). This was thought to reflect the immediacy of this client group's basic needs (i.e. of housing and health care). The second study (i.e. Taylor et al., 2007b), highlighted both the therapeutic impact of a hostel-based mental health service and how it was experienced positively by the service users who used it.

3.3. Methodological synthesis and critical appraisal

The 13 research papers described above sought to directly evaluate 11 different approaches to providing mental health-related services to adult homeless populations. Most of these services were based in London (n=6), with the others being based in Aberdeen, Birmingham, and Southampton and one being based nationally in various locations across England. Only one study neglected to detail the location of their research (Bhugra et al., 1997). Although there was little clinical homogeneity,

similarities between the services enabled them to be categorised roughly into being either: out-reach services providing community-based drop-in (n=4); specialist in-patient psychiatric wards (n=2); a specialist community mental health team (n=1); a psychiatric drop-in clinic within primary care (n=1); a psychotherapy service (n=1); a CBT intervention delivered within a therapeutic housing environment (n=1); and multiple homelessness services (n=1). The staffing for the services ranged from one Community Psychiatric Nurse (CPN) or Clinical Psychologist (i.e. Maguire, 2006; Wood et al., 2001) to larger multi-disciplinary teams (see Appendix C for further information). It was unclear how many staff worked for one of the services (i.e. Cockersell, 2011) and no staffing details were provided by four of the studies, making it difficult to ascertain the size of the services being evaluated (i.e. Bhugra et al., 1997; Graham et al., 1999; Joseph et al., 1990; Killaspy et al., 2004).

Most studies, even within the strict journal word count, provided fairly detailed information on the services themselves, with a good example being found in Wood et al. (2001). Cockersell (2011) also provided insight into how the theoretical and psychotherapeutic research literature, combined with an understanding of the needs of the client group, shaped the development of the service. Three studies provided particularly poor descriptions, describing only that the service provided either ‘one three hour session a week’ (Joseph et al., 1990), ‘individual and group therapeutic work’ (Bhugra et al., 1997), or that it offered ‘in-patient treatment’ (Graham et al., 1999). Such descriptive shortcomings made it difficult to understand what was provided and therefore virtually impossible for the described interventions to be compared with others or replicated elsewhere.

Classification of the research design of the studies in the current review in line with categories suggested by Glasziou et al. (2001), revealed that ‘pre-test post-test’

(n=4) or 'post-test' (n=3) designs were the most common, with other approaches including 'case series' (n=2), 'cohort' (n=1) and 'historical control' (n=1). Both of the qualitative research papers used semi-structured interviews to collect data. Coherence between the aims of the research studies and their chosen design was apparent in all 13 papers.

Although none of the studies used random sampling methods, most of the quantitative studies sampled all service users accessing a service across a designated time frame (n=9). Only one of the studies excluded any eligible participants, and this was achieved by restricting their sample to service users who had been in contact with the service on at least six occasions (Power & Attenborough, 2003). Although their use was understandable, convenience samples nonetheless limit the generalisability of the findings to the adult homeless population as a whole and therefore negates one of the key strengths of quantitative approaches to research.

Only four of the research papers monitored pre-and-post intervention change in their sample (Cockersell, 2011; Maguire, 2006; Odell & Commander, 1999; Taylor et al., 2007a). Three studies described a control group by which their case group's outcomes could be compared, but unfortunately, two were not directly comparable. Killaspy et al. (2004) discovered in hindsight that their control group was significantly less likely to be rough sleeping at the time of admission, thus highlighting selection bias. Commander et al. (1997), compared data collected directly from staff at four Birmingham hospitals over a one year period, with data drawn from a search of medical records at one hospital over a four year period. Even though these authors ascertained that there were no significant differences found between the demographics of their two groups, it is still questionable as to whether or not the data drawn from them could be directly compared. In Cockersell's (2011) research, the progress of hostel residents who

had attended psychotherapy was compared with those who had not, and although it was identified that the two samples were similar in terms of age, ethnicity and 'baselines', the numbers in each group and how these comparisons had been made were unclear. In attempts to provide a control group, it appears that these studies might have increased the potential for bias to affect their findings.

Response bias was only found in one of the quantitative studies (i.e. Bhugra et al., 1997), where eleven service users had refused to participate. This was mitigated by the author's demonstration that there were no significant demographic differences found between those that refused and those who formed the final sample. Attrition was only identified in two of the quantitative studies, resulting in two adults being lost from one sample (Graham et al., 1999) and 27% being lost from another due to difficulties in tracing individual service users (Power & Attenborough, 2003). Information pertaining to response rate and attrition rate was missing for one study (Maguire, 2006).

In regard to the qualitative studies, drop-out was fairly high in one study, which interviewed 19 participants (i.e. Taylor et al., 2007b), with two young people being unavailable at the time of interview and a further seven choosing not to participate. The other qualitative study failed to identify whether or not any of their sample had withdrawn from participating (i.e. Bhui et al., 2006).

The final sample sizes across the studies varied from four (i.e. Maguire, 2006) to 260 homeless adults (Joseph et al., 1990). Small sample sizes within quantitative research studies limit the external validity of the findings, but are of much less importance to qualitative studies. As it can be seen in Appendix C, in almost all of the reviewed studies, the samples were predominantly male, with females predominating in only three papers (i.e. Graham et al., 1999; Taylor et al., 2007a; Taylor et al., 2007b). In regard to age range, the samples in most papers represented a diverse age group with the

youngest participant overall being 14 and the oldest being 71 years of age. In contrast, two studies that evaluated a service aimed at young people (i.e. Taylor et al., 2007a; Taylor et al., 2007b) sampled a younger age group ranging between 16 and 23. Three studies did not identify the age range of their population (i.e. Bhugra et al., 1997; Cockersell, 2011; Maguire, 2006). When considering external validity, it is also important to note that one study (i.e. Bhugra et al., 1997) recruited a sample that was only 35% 'homeless'. Due to the heterogeneous nature of the services and the outcome measures used to evaluate them, it was not possible to differentiate outcomes relating to age or gender.

The quantitative studies used diverse and multiple measures of outcome, ranging from questionnaire or other outcome measures (i.e. Bhugra et al., 1997; Cockersell, 2011; Killaspy et al., 2004; Maguire, 2006; Taylor et al., 2007a), level of engagement with external services (i.e. Commander et al., 2007; Killaspy et al., 2004; Power & Attenborough, 2003), housing status (i.e. Cockersell, 2011; Killaspy et al., 2004; Odell & Commander, 1999; Power & Attenborough, 2003), mental state (i.e. Joseph et al., 1900; Odell & Commander, 1999), take up of employment or training opportunities (i.e. Cockersell, 2011), risk (i.e. Odell & Commander, 1999; Taylor et al., 2007a), service engagement or attendance (i.e. Cockersell, 2011; Joseph et al., 1999; Wood et al., 2001) and generic outcome ratings (i.e. Graham et al., 1999). Where questionnaire measures were used, they were often poorly described (e.g. Bhugra et al., 1997; Cockersell, 2011; Killaspy et al., 2004) with only one paper providing description of their measure's development, previous use and potential to detect change within the context of adult mental health services (i.e. Taylor et al., 2007a). One further problem with the outcome measures chosen by some of the quantitative studies (i.e. Joseph et al., 1990; Killaspy et al., 2004; Power & Attenborough, 2003; Wood et al., 2001) is that they did not directly

quantify changes in mental health and wellbeing. Instead, what they did show was that the therapeutic impact of the mental health services they evaluated resulted in increased attendance rates, engagement with services and permanency of accommodation.

As with all research, it is possible that the findings of the quantitative studies were influenced by further biases during the data collection procedure. Only one of the quantitative evaluations was described as being ‘independent’ from the service that they evaluated (i.e. Bhugra et al., 1997). The impact of further biases are likely to be increased in those studies that included self report measures (e.g. Bhugra et al., 1997) and those that relied on staff members who have a vested interest in the success of a project to complete the outcome measures (e.g. Odell & Commander, 1999; Taylor et al., 2007a).

In a similar way, the findings from the qualitative research studies could also be influenced by the researchers and the process through which the data was collected and analysed. Although one of these studies was described as being ‘independent’ (Taylor et al., 2007b), reflexive accounts of potential influences were not provided by either of the qualitative studies included in this review (i.e. Bhui et al., 2006; Taylor et al., 2007b).

Only three of the 13 studies reviewed provided any information in regard to the ethical considerations that underpinned their research and reported undergoing an ethical review process (i.e. Bhui et al., 2006; Killaspy et al., 2004; Taylor et al., 2007b). This lack of information across most of the studies was surprising considering the vulnerable nature of the research population.

Out of the 11 quantitative studies, only four described how they had analysed their data. In these cases, either a brief description was given in regard to the use of computerised analysis software (e.g. Bhugra et al., 1997), or of the specific statistical tests used (i.e. Killaspy et al., 2004; Odell & Commander et al., 1999; Taylor et al.,

2007a). Generally, the findings sections of these papers were found to display a combination of descriptive (n=11), non-parametric (n=5) and parametric statistics (n=3). These findings were reported adequately, except within papers written by Commander et al., (1997) where ‘statistical differences’ were referred to without any accompanying statistical output and in Cockersell (2011), where ‘greater outcomes’ were referred to, but no raw data was presented to enable closer examination of these findings. Furthermore, in the Cockersell paper, findings in regard to ‘changes in accommodation status’ (i.e. a named area of data collection), were not reported. In regard to the qualitative studies, both described how the interviews conducted had been transcribed and analysed using a thematic approach. Overall, there were no problems identified in the coherence between any of the studies methods, results and findings.

3.4. Summary of findings

The current systematic review has identified that the quality of evidence from a circumscribed database is impoverished and little is known about the therapeutic impact of mental health-related services for homeless populations in the UK. Due to the identification of methodological weaknesses within all 13 of the articles reviewed, it was not possible to conclude which studies provided ‘stronger’ or ‘weaker’ evidence (e.g. to decide whether or not a study with an incomparable control group, is any better or worse than a study without a control group). It was also not possible to make comparisons between services because of the diverse nature of the samples, settings, interventions and measured outcomes across the research studies.

Despite this, based upon the 13 studies reviewed, it can be tentatively concluded that designated services that address the mental health needs of homeless adults (i.e. specialist outreach services, in-patient psychiatric wards, community mental health

teams, cognitive behavioural and psychotherapy interventions and generic homeless services), can have a positive therapeutic impact, as measured on a variety of outcomes. Some evidence was also found that related to the specific components of these services which contributed to their effectiveness (i.e. Graham et al., 1999; Taylor et al., 2007b). There was no evidence that any of the service innovations made their clients worse in terms of measured outcomes.

The findings of this current review must be interpreted with care and viewed only within the context of the methodological flaws highlighted within all of the individual research studies (e.g. limited information on the service being evaluated, small samples, incomparable control groups, high attrition rates and reliance on research data which is likely to be influenced by those who collect it).

4. Discussion

By focussing upon UK-based research literature, the current review aimed to understand the evidence for the therapeutic impact of providing mental health-related services for homeless adults. By taking a systematic, transparent and replicable approach, the current review has attempted to minimise the potential for bias (Khan et al., 2003; Whitemore, 2007). The inclusion of qualitative and quantitative research studies has also encouraged a comprehensive approach to the review process (Dixon-Woods et al., 2006; Evans, 2007), enabling a holistic overview of the UK research literature in this field.

The aim of the current literature review has been achieved by sourcing what is currently known about the therapeutic impact of mental health-related services for homeless adults, and by evaluating the quality of the current evidence base. The current review found that adult homeless populations, despite their complex needs, can both engage and benefit when specialist services are provided for them. It was identified that, following contact with specialist services, homeless adults were found to show improved outcomes on a range of areas (e.g. increased wellbeing and self efficacy). It also found evidence that designated services can contribute towards what have been described as ‘hard outcomes’ (e.g. gaining more settled housing, engaging in training or education). Cockersell (2011) has argued that homelessness is a manifestation of psychological disturbances and is as much a mental health issue, as it is a social one. The findings from the current review supported this opinion by highlighting how mental health-based interventions do not just have a therapeutic impact on mental health and wellbeing. They also serve to tackle the root causes of homelessness and by doing so,

free people to move forward in their lives (i.e. as measured by the ‘hard outcomes’ described above).

Homeless adults with mental health-related difficulties have been, and often still are, hard to reach and easy to ignore. This should not be the case because all mental health practitioners have a role in ensuring equal access to healthcare for vulnerable groups such as adults who are homeless (Owen & Khalil, 2007). What the current review has shown is that presently the UK research literature provides only a series of ‘snap-shots’ into the potential for specialist mental health services to meet this group’s needs. The UK evidence base was not strong enough at the time of writing to determine the comparative effectiveness of different types of service models, or which types of interventions might be most useful for subgroups within the homeless population (e.g. women, young people). The current lack of research evidence in homelessness in the UK, reflects similar findings across Europe and the US where research has also been found to be predominantly descriptive and poorly controlled methodologically (Coldwell & Bender, 2007; Philappot et al., 2007). This results in there being no consensus on what comprises the ‘best’ intervention for homeless adults with mental health-related difficulties (Coldwell & Bender, 2007).

A stronger knowledge base is required to promote the development of evidence based recommendations that can be used to guide either individual clinical practice, or new service initiatives. Further outcome-focused research is needed in the UK in several key areas. Firstly, due to the diverse range of outcomes currently used in the homelessness literature, research into what type of outcomes are acceptable for service providers and their clients is needed to determine how future services are evaluated. This may contribute to increased consistency in research approaches, which as the amount of research in this field grows, will aide the ability for comparisons to be made

between services and approaches. Secondly, longitudinal research, although costly in time and resources, will be the only way to establish the long term impact of any service. In the UK qualitative research is currently almost non-existent in the field of homelessness, this gap is also mirrored within the US research literature (O'Campo et al., 2009). This is possibly because recruiting homeless adults is at least three times as time consuming as recruiting individuals from more stable populations with less complex needs (Bhui et al., 2006). Thirdly therefore, further qualitative explorations of service users' views are needed to ensure that the very few existing services in the UK are understood from their perspectives, particularly in regard to whether they feel their needs are being met (Bhugra et al., 1997). This will ensure that the research literature provides more than just thin descriptions of what works for whom, and why (O'Campo et al., 2009). Qualitative research will also help to ensure that service users' views are, as they should be, positioned at the centre of any future development or restructuring of NHS (National Health Service) services (Bhui et al., 2006). Fourthly, because all homelessness research is likely to represent an atypical homeless population (i.e. those who are aware of and who engage with services and with research), innovative research approaches are needed to access the experiences of those 'hidden homeless' who do not engage. To inform the development of future service models, all further research should aim to investigate the particular components of a service that contribute towards effectiveness and describe the service being evaluated in sufficient detail to enable assessment of intervention quality (Herbert & Bø, 2005).

For the quality of research in this field to improve, funding needs to be made available. This is particularly important given that the current review identified that only three of the included research studies were externally funded (i.e. Bhui et al., 2006; Taylor et al., 2007a; Taylor et al., 2007b), and the rest were 'in house' evaluations or

publications of existing service data. Whilst some researchers are likely to be put off by working in this field due to the inherent challenges of engaging with homeless adults, it is hoped that others will recognise the need for further research and endeavour to contribute to this neglected area.

4.1. Limitations of the current review

The findings of the current literature review were limited by the small number of research articles available for inclusion. As with all reviews, whether or not any relevant studies were missed is unknown (Dixon-Woods et al., 2006; Evans, 2007). This review could have been improved by having a second reviewer independently screen all potential abstracts to increase reliability (Khan et al., 2003) and by including conference proceedings, unpublished literature and reports. As well as increasing the breadth of review, the inclusion of 'grey literature' may also have reduced the propensity for publication bias to affect the overall conclusions (Glasziou et al., 2001).

5. Practitioner points⁴

- All mental health practitioners have a responsibility to ensure that homeless adults have equitable access to services.
- The current review has identified that specialist mental health services in the UK have had a positive therapeutic impact on the mental health and wellbeing of homeless adults, as measured on a range of outcomes.
- This review has also identified how specialist mental health services promote stability and inclusion through ‘hard outcomes’ for homeless adults (e.g. housing, education or training).
- These findings show that homeless adults can, and will engage with services, when such services are adapted to meet their needs.
- These findings are based upon a very small knowledge base of only 13 research studies, all of which contained methodological weaknesses.
- Further research in this field is essential to strengthen the existing knowledge base and to provide a basis on which to guide the development of future services.

⁴ In line with the British Journal of Clinical Psychology guidelines, these practitioner points would be placed under the abstract. They have been positioned here instead so as not to conflict with the DClinPsy thesis guidelines.

References

*Bhugra, D., Bhamra, J., & Taylor, P. (1997). Users' views of a drop-in project for the homeless. *International Journal of Social Psychiatry*, 43, 95-103.

*Bhui, K., Shanahan, L., & Harding, G. (2006). Homelessness and mental illness: A literature review and qualitative study of perceptions of the adequacy of care. *International Journal of Social Psychiatry*, 52, 152-165.

Ciliska, D., Dobbins, M., & Thomas, H. (2007). Using systematic reviews in health services. In Webb, C., & Roe, B. (Eds.), *Reviewing research evidence for nursing practice: Systematic reviews*. Oxford: Blackwell.

*Cockersell, P. (2011). Homelessness and mental health: Adding clinical mental health interventions to existing social ones can greatly enhance positive outcomes. *Journal of Public Mental Health*, 10, 88-98.

Coldwell, C., & Bender, W. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry*, 164, 393-399.

*Commander, M., Odell, S., & Sashidharan, S. (1997). Psychiatric admission for homeless people: The impact of a specialist community mental health team. *Psychiatric Bulletin*, 21, 260-263.

Craig, T., & Hodson, S. (2000). Homeless youth in London: II. Accommodation, employment and health outcomes at 1 year. *Psychological Medicine*, 30, 187-194.

Crane, M., Byrne, K., Fu, R., Lipmann, B., Mirabelli, F., Rota-Bartelink, A., Ryan, M., Shea, R., Watt, H., & Warnes, A. (2005). The causes of homelessness in later life: Findings from a 3-nation study. *Journal of Gerontology*, 60B, 152-159.

Crane, M., & Warnes, A. (2001). The responsibility to care for single homeless people. *Health and Social Care in the Community*, 9, 436,444.

Crane, M., & Warnes, A. (2005). Responding to the needs of older homeless people: The effectiveness and limitations of British services. *Innovation*, 18, 137-152.

Crisis (2009). *Mental ill health in the adult single homeless population: A review of the literature*. London: Crisis.

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D., Miller, T., Sutton, A., Shaw, R., Smith, A., & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, 6, 27-44.

Evans, D. (2007). Overview of methods. In Webb, C., & Roe, B. (Eds.), *Reviewing research evidence for nursing practice: Systematic reviews*. Oxford: Blackwell.

Forchuck, C., Brown, S., Schofield, R., & Jensen, E. (2008). Perceptions of health and health service utilization among homeless and housed psychiatric consumers/survivors. *Journal of Psychiatric and Mental Health Nursing*, 15, 399-407.

*Graham, Z., Salton-Cox, F., & White, P. (1999). The outcome of rough sleepers with mental health problems admitted to a psychiatric ward. *Psychiatric Bulletin*, 23, 164-166.

Glasziou, P., Irwig, L., Bain, C., & Colditz, G. (2001). *Systematic reviews in healthcare: A practical guide*. Cambridge: Cambridge University Press.

Herbert, R., & Bø, K. (2005). Analysis of quality of interventions in systematic reviews. *British Medical Journal*, 331, 507-509.

HM Government (2009). *New horizons: A shared vision for mental health*. London: HM Government.

Holland, A. (1996). The mental health of single homeless people in Northampton hostels. *Public Health*, 110, 299-303.

*Joseph, P., Bridgewater, J., Ramsden, S., & Kabir, D. (1990). A psychiatric clinic for the single homeless in a primary care setting in inner London. *Psychiatric Bulletin*, 14, 270-271.

Kershaw, A., Singleton, N., & Meltzer, H. (2003). Survey of health and well-being of homeless people in Glasgow. *International Review of Psychiatry*, 15, 141-143.

Khan, K., Kunz, R., Kleijnen, J., & Antes, G. (2003). *Systematic reviews to support evidence based medicine: How to review and apply findings of healthcare research*. London: Royal Society of Medicine Press Ltd.

*Killaspy, H., Ritchie, C., Greer, E., & Robertson, M. (2004). Treating the homeless mentally ill: Does a designated inpatient facility improve outcome? *Journal of Mental Health*, 13, 593-599.

*Maguire, N. (2006). Cognitive behavioural therapy and homelessness: A case series pilot study. *Behavioural and Cognitive Psychotherapy*, 34, 107-111.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D., The PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *Annals of Internal Medicine*, 154, 264-269.

O'Campo, P., Kirst, M., Schaefer-McDaniel, N., Firestone, M., Scott, A., & McShane, K. (2009). Community-based services for homeless adults experiencing concurrent mental health and substance use disorders: A realist approach to synthesizing evidence. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 86, 965-989.

*Odell, S., & Commander, M. (1999). A follow-up study of people with severe mental illness treated by a specialist homeless team. *Psychiatric Bulletin*, 23, 139-142.

O'Reilly, M., Taylor, H., & Vostanis, P. (2009). 'Nuts, schiz, psycho': An explanation of young homeless people's perceptions and dilemmas of defining mental health. *Social Science and Medicine*, 68, 1737-1744.

Owen, S., & Khalil, E. (2007). Addressing diversity in mental health care: A review of guidance documents. *International Journal of Nursing Studies*, 44, 467-468.

Philappot, P., Lecocq, C., Sempoux, F, Nachtergaele, H., & Galand, B. (2007). Psychological research on homelessness in Western Europe: A review from 1970 to 2001. *Journal of Social Issues*, 63 (3), 483-504.

Prochaska, L., & DiClemente, C., (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19, 276-288.

*Power, C., & Attenborough, J. (2003). Up from the streets: A follow-up study of people referred to a specialist team for the homeless mentally ill. *Journal of Mental Health*, 12, 41-49.

Sandelowski, M., Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship*, 213-219.

Scott, J. (1993). Homelessness and mental illness. *British Journal of Psychiatry*, 162, 314-324.

Shelter (2008). *A long way from home: Mental distress and long term homelessness*. London: Shelter.

Shepherd, M., Gunnel, D., Maxwell, B., & Mumford, D. (1998). Development and evaluation of an inner city mental health team. *Social Psychiatry and Psychiatric Epidemiology*, 33, 129-135.

Sims, J., & Victor, C. (1999). Mental health of the statutorily homeless population: Secondary analysis of the psychiatric morbidity surveys. *Journal of Mental Health*, 8, 523-532.

Spence, S. (2009). Roofless in a steel city: Learning from the homeless mentally ill. *Psychiatric Bulletin*, 33, 64-69.

Symington, J. (2010). Beyond bricks and mortar. *Mental Health Today*, October, 14-15.

Taylor, H., Stuttford, M., Broad, B., & Vostanis, P. (2006). Why a 'roof' is not enough: The characteristics of young homeless people referred to a designated mental health service. *Journal of Mental Health*, 15, 491-501.

*Taylor, H., Stuttford, M., Broad, B., & Vostanis, P. (2007a). Listening to service users: Young homeless people's experiences of a new mental health service. *Journal of Child Health Care, 11*, 221-230.

*Taylor, H., Stuttford, M., & Vostanis, P. (2007b). Short-term outcome of young homeless people in contact with a designated mental health service. *European Journal of Psychiatry, 21*, 268-278.

The Marmot Review (2010). *Fair society, healthy lives: Executive summary*. London: The Marmot Review.

Timms, P., & Borrell, T. (2001). Doing the right thing: Ethical and practical dilemmas in working with homeless mentally ill people. *Journal of Mental Health, 10*, 419-426.

Victor, C. (1992). Health status of the temporarily homeless population and residents of north-west-thames region. *British Medical Journal, 305*, 387-391.

Webb, C., & Roe, B. (2007). Reflections on the past, present and future of systematic reviews. In Webb, C., & Roe, B. (Eds.), *Reviewing research evidence for nursing practice: Systematic reviews*. Oxford: Blackwell.

Whittemore, R. (2007). Rigour in integrative reviews. In Webb, C., & Roe, B. (Eds.), *Reviewing research evidence for nursing practice: Systematic reviews*. Oxford: Blackwell.

*Wood, A., Sclare, P., & Love, J. (2001). Service innovations: A service for the homeless with mental illness in Aberdeen. *Psychiatric Bulletin*, 25, 137-140.

Wright, N., & Tompkins, C. (2006). How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*, 286-293.

Part 2: Research Report

**Being homeless and experiencing mental health-related difficulties:
Listening to and learning from the experiences of service users of a designated
homeless psychology service**

Helen Taylor

Abstract

Homeless adults are known to experience higher levels of mental health-related difficulties than the general population, but their needs are not met by mainstream mental health services (The Marmot Review, 2010). This places them at risk of longer, more damaging homelessness. In response to this, a handful of innovative homeless mental health services have developed across the UK, including two specialist Homeless Psychology Services. As yet, little attention has been paid to their evaluation.

The aim of the current research study was to understand from service users' perspectives their experiences of: homelessness and mental health; psychological needs; a Homeless Psychology Service; and, their ideas regarding future service development. Interviews with seven recently homeless adults were analysed using Interpretative Phenomenological Analysis (IPA).

Analysis revealed that becoming homeless had a detrimental psychological impact on all of the participants (e.g. feeling rejected, out of control and fearful). Being homeless caused further negative psychological impacts (e.g. alienation from society, disruption of pre-existing relationships, threat to or loss of self identity, erosion of trust in others, building psychological defences and feelings of hopelessness and helplessness). Prior to becoming homeless all of the participants had also experienced traumatic life events and experienced mental health-related difficulties.

All but one participant felt they benefited from engaging with the Homeless Psychology Service (e.g. through catharsis, gaining insight, overcoming hopelessness, making positive changes). These findings are presented within the context of the barriers to engagement, psychological needs, and suggested improvements to the service and to service provision nationally. Clinical implications (e.g. that these findings support the need for specialist services for homeless adults), and suggestions for further research are also provided.

**Being homeless and experiencing mental health-related difficulties:
Listening to and learning from the experiences of service users of a
designated homeless psychology service**

1. Introduction

The research literature has consistently identified that homeless adults⁵ are much more likely to experience mental health-related difficulties than the general population (Rees, 2009) and are at increased risk of committing suicide (Bickley et al., 2006). A recent systematic review found that prevalence rates for ‘mental disorders’ in homeless populations across Western Europe, ranged from 58%, to 100% (Philappot et al., 2007).

Despite their level of need, adults who are homeless face significant barriers to accessing mainstream mental health services (Randall et al., 2007; The Marmot Review, 2010). Homeless adults are often not registered with GPs (Little & Watson, 1996; Owen & Kahalil, 2007). This in itself creates a formidable barrier in the UK to accessing both physical health care and mental health services (Randall et al., 2007). Furthermore, many homeless adults may have additional personal reasons for choosing not to access services including: fearfulness of engaging with services that are not understood due to the stigma surrounding mental health; and holding low expectations of what services can provide (O’Reilly et al., 2009, Randall et al., 2007).

Whilst their needs are not well understood, when homeless adults are referred to mainstream services it appears that there is often a mismatch between their needs and what these services provide. For example, traditional services that have inflexible appointment systems and discharge procedures (i.e. that do not seek out vulnerable non-

⁵ Defining homelessness is not straightforward and there exists no widely agreed definition (Power & Attenborough, 2003). The current study defines homelessness as having no fixed abode (e.g. rough sleeping or residing in temporary accommodation such as hostels).

attendees) are often ineffective in maintaining engagement with this client group (Crane & Warnes, 2001; Spence, 2009). This is because they are not set up to meet the needs of people who frequently have chaotic lifestyles (Shelter, 2008). The ongoing roll-out of IAPT (Improving Access to Psychological Therapies) services (Department of Health, 2008), will be very unlikely to increase access to psychological therapies for homeless adults. This is because homeless people are ‘socially excluded’ and create very real challenges in terms of engagement for IAPT in the same way that they do for all other services, especially if they are also using drugs and/or alcohol (Dunning, 2009; Hall & Marzillier, 2009). By inadvertently excluding homeless adults, mental health services can be viewed as further contributing to the social exclusion of this population.

Delays in receiving mental health support are likely to exacerbate current difficulties and increase suffering, whilst also placing additional pressure on other support services such as hostels (Randall et al., 2007). The effect is cyclical, where remaining disengaged from services results in homeless adults with mental health needs becoming at even greater risk of experiencing longer, more damaging homelessness (Shelter, 2008). With the average length of stay in hostels being estimated as eight years (Abdul-Hamid et al., 2010), homeless adults can remain physically and psychologically vulnerable for a long time.

1.1. National service developments

The current economic crisis is likely to continue to increase the number of homeless adults in need of mental health care (Abdul-Hamid et al., 2010). Homelessness is therefore a growing area of concern for both the UK government and non-governmental agencies (Williams & Strickley, 2011). As Seager (2011, page 183) identified, in the UK, “*getting a roof over a person’s head*” is often mistakenly seen as

more important than “*what is going on inside their head*”. This perception is gradually changing, as accumulating commentaries and research evidence have highlighted that social solutions to homelessness (e.g. housing) are not sufficient on their own because mental health and homelessness cannot easily be separated (Cockersell, 2011). It is now understood that mental health problems contribute to the cause of homelessness, develop as a result of homelessness, and are exacerbated by the experience of living as a homeless adult (Randall et al., 2007). As a result of this, serious consideration is now being given to how hostels for homeless adults can be improved by becoming ‘psychologically informed environments’ (see Seager, 2011 for a review).

In recognition of the complex needs of the homeless client group, and recommendations for specialist community-based services (Abdul-Hamid et al., 2010), investment by charities and the Government has enabled the development of a handful of innovative homeless mental health services across the UK (Shelter, 2008; Communities and Local Government, 2010). However, to date, little attention has been paid to evaluating their effectiveness, appropriateness or acceptability.

1.2. Research evidence

Research into homelessness has historically taken a very narrow focus both nationally and internationally. The research literature tends to focus on prevalence studies highlighting the types of mental health difficulties experienced, rather than attempts to evaluate either the appropriateness or effectiveness of any type of mental health service for this population (Philappot et al., 2007). The lack of research literature has been seen by Cockersell (2011) as reflecting the very poor access that homeless adults have to any mental health-related services in the UK, apart from medication (Cockersell 2011, personal communication).

In an attempt to draw together what is known from the UK research literature, a recent systematic review found that only 13 research papers evaluating specialist mental health services for homeless adults had been published in the last 20 years (Taylor, 2012). Although many of these studies suffered from methodological weaknesses, it was clear that they did provide snapshots into the potential for specialist services to promote positive outcomes for this client group. As a whole however, the very small evidence base currently provides little scope for guiding the future development of service provision in the UK. The literature review also confirmed previously held views that there has been very little qualitative research conducted in this field (e.g. Williams & Stickley, 2011). To date, the UK research literature contains no evidence of any qualitative research having been conducted into the experiences of homeless adults who access designated psychological services. This is problematic, given that in line with Government Policy, the views of service users should be positioned at the centre of any NHS service developments to ensure that effective mental health services are available to all who need them (Bhui et al., 2006; HM Government, 2009).

At a time when the UK Government are pledging to reduce inequalities in access to health care for marginalised groups including homeless adults (HM Government, 2009), and appeals are being made for psychological therapies to be ‘rolled out’ for homeless populations (Shelter, 2008), tentative conclusions about which therapeutic or service models might help this population are not enough (Rees, 2009). What is needed is a clearer understanding of how existing services in the UK are perceived by service users (Bhugra et al., 1997). This is needed to guide any further service developments in this field.

1.3. Research aims and research questions

At the time of writing there were only two dedicated Homeless Psychology Services in the UK (Jarrett, 2010). The current research project responded to the identified need for further research, by interviewing service users from one of these services to understand from their perspective: what it is like for them to be homeless and experience difficulties with their mental health; what they perceive their mental health needs to be; what ‘psychology’ means to them personally; what their experiences have been of the service; what improvements they would suggest; and, what guidance they would offer on how other services should be developed in the future. The research also aimed to answer the following research questions:

- What does it mean to be homeless and to also experience mental health-related difficulties?
- By listening to service users’ experiences, what can we learn about their psychological needs?
- What guidance would service users offer to those who provide psychological services to homeless adults?

1.4. Implications for Clinical Psychology practice

In addition to contributing to the existing research literature in this field, it is intended that the current research will have a positive impact on Clinical Psychology practice. Although very few Clinical Psychologists work specifically with the homeless population, it is likely that many Psychologists working within mainstream services

would receive referrals of adults who are homeless because as a profession they tend to take on clients with complex presenting problems. By increasing understanding of the experiences and psychological needs of this group, applied psychologists across the profession (i.e. Clinical, Health, Counselling and Forensic), will be able to work more effectively in meeting their needs. This may also encourage Psychologists across the UK to reflect on whether or not the services in which they operate are currently doing enough to meet the needs of homeless adults.

The insight provided by the current research into how an existing Homeless Psychology Service is perceived by those who use it, will also be of interest to both NHS and non-statutory services. This is because the findings could be used to promote the commissioning, development and management of user-friendly services for people who are homeless, in line with their perspectives and preferences.

2. Methodology

2.1. Design

A qualitative approach was necessary to meet the aims of the current study. Service users were interviewed to facilitate an in-depth understanding of their experiences of homelessness and of using a designated Homeless Psychology Service.

2.2. Position of the Researcher/forestructure

The current research was conducted in line with the Researcher's epistemological framework of 'critical realism' (see Appendix E for further information). By attempting to understand what being homeless and having mental health-related difficulties was really like for participants, it also took a phenomenological approach to understanding their individual experiences (Smith et al., 2009).

2.2.1. Reflexivity.

The Researcher had both previous clinical and research experience of working with homeless adults. The knowledge gained through these experiences (e.g. of unmet mental health needs), are what motivated the Researcher to conduct the current study. The Researcher recognised that their past experiences will have shaped their assumptions regarding the potential findings of this study: i.e. being homeless would have been a difficult experience for most if not all participants, and that many, but not necessary all, would have benefited from engaging with a service that had been specifically designed to meet their needs.

2.3. Research context

The Homeless Psychology Service was located in a city in the UK and was part of a larger multi-disciplinary Homeless Mental Health Service. It provided assessment (including cognitive assessment) and direct individual and group psychological therapy to homeless adults in easily accessible locations (e.g. hostels, day centres). The service worked closely with wider homeless services, providing indirect support and consultancy through regular attendance at hostel-based multi-agency meetings. Since its inception over ten years ago, the Homeless Psychology Service has been staffed by three Clinical Psychologists and has offered placements to approximately ten Trainee Clinical Psychologists.

2.4. Participants

To enable in-depth and detailed analysis, the proposed sample size for the current research study was six to ten interviewees (Shaw, 2010).

2.4.1. Inclusion and exclusion criteria.

The sampling was purposive, and focused on recruiting participants who had been service users of the Homeless Psychology Service. Potential participants were excluded from the study if they were known to the Researcher, or if they were deemed by members of the Homeless Psychology Service as being too distressed (e.g. due to mental health-related difficulties), unable to consent (e.g. lacking capacity due to excessive use of drugs or alcohol), or as posing a potential risk to the Researcher. To promote inclusion, the use of an interpreter could be offered to any service users who did not feel comfortable communicating in English.

2.4.2. Final sample.

The final sample consisted of seven service users. The youngest interviewee was in their early twenties, the oldest in their late fifties. There was an equal balance between male and female participants (i.e. four were male). Five of the participants were White British whilst the remaining two had different ethnic backgrounds.⁶

2.5. Materials

The research materials developed for use within the current study can be seen in Appendix F to M (i.e. materials used for the recruitment of participants and conduct of interviews). Further description and information regarding their use is provided within the following Procedure section.

2.6. Procedure

2.6.1. Ethical considerations.

This research was conducted in line with the British Psychological Society's ethical principles (BPS, 2011) of: respect for the autonomy and dignity of persons; scientific value; social responsibility; and, maximising benefit and minimising harm. Following peer review at the University of Leicester, a full application for ethical approval was submitted to a LREC (Local Research Ethics Committee). Favourable ethical opinion was received following minor changes to the Participant Information Sheet. Letters to and from the LREC can be seen in Appendix N. Approval was also received from a NHS Trust Research and Development Department⁷. Particular care was taken to ensure that participants gave valid consent and their data was treated

⁶ To protect their anonymity, limited information has been purposefully provided regarding the demographic characteristics of the interviewees.

⁷ The location of this Research and Development department has been anonymised to protect the identity of the service.

confidentially. Further information on additional ethical considerations (i.e. minimising harm, providing gift vouchers to participants, necessary breaches to confidentiality) can be seen in Appendix O.

2.6.2. Recruitment.

Recruitment took place over a period of approximately six months. The study was advertised by Homeless Psychology Service staff, who spoke directly to service users (n=10) and provided them with copies of the Brief Information Leaflet (see Appendix F). This leaflet was designed to be more accessible than the full length Participant Information Sheet (see Appendix G), which was also made available to service users at this time. The service also chose to post letters to service users (i.e. n=10 male, 8 female) who had been discharged and provided them with the same information about the research study.

Staff from the Homeless Psychology Service also distributed over 100 Brief Information Leaflets and 20 coloured posters (see Appendix H) across hostels and other community settings frequented by homeless adults. To raise further awareness of the current study, copies of these materials were also taken to a hostel-based multi-disciplinary team meeting and distributed to attending staff.

Whether they had been approached by staff, or whether they had seen information advertising the study, interested service users were given two options. They could either give verbal consent for a member of the Homeless Psychology Service to pass their contact details on to the Researcher; or if they preferred, they could contact the Researcher directly by texting or calling a research mobile telephone number. In this way, the study promoted the same access pathways as the Homeless Psychology Service, which also accepted self referrals.

To avoid any potential confusion, a procedure was set up for the Researcher to contact a designated administrator working for the Homeless Psychology Service to check names against service records of anyone who contacted the Researcher directly. No information from the service users' records was disclosed, except confirmation of whether or not they had used the service.

In total, eight service users provided their contact details to the Researcher via a member of Homeless Psychology Service staff, and a further five made contact directly after seeing advertising. Only one of these service users was excluded from participating. This was because they were known to the Researcher.

The Researcher was unable to make contact with three of the potential interviewees, but spoke to the remaining nine (i.e. by telephone to their mobile, or to the hostel where they were staying). During this initial conversation the Researcher provided further information and offered the opportunity for them to ask questions. The Researcher also offered to send further information (i.e. the Participant Information Sheet). At this early stage, all nine expressed interest in being interviewed and arranged a time to meet with the Researcher. Two service users subsequently decided not to be interviewed (i.e. one did not attend their interview, and one cancelled twice before deciding not to re-arrange).

2.6.3. Conducting qualitative interviews.

Interview locations were chosen by participants, and interviews were conducted in a range of locations across the city (e.g. health centre, library). In the interests of safety for the Researcher and the participants, all interviews took place during working hours when other professionals were on site. In accordance with their employer's risk management policy, the Researcher also used a call-back system and provided another

member of staff with information regarding their whereabouts when meeting with participants.

Each meeting began by the Researcher asking whether participants had read the Participant Information Sheet. If they had not, they were offered the option of reading a copy, or for the Researcher to read it to them, and then ask further questions. All participants chose to consent to taking part in the study and were asked to sign two copies of a Consent Form (see Appendix I). For their future reference, participants kept one of these copies along with a copy of the Participant Information Sheet.

To strike a balance between ordinary and interviewer-led conversation, the interviews were semi-structured (Madill & Gough, 2008). A Topic Guide was used (see Appendix J), that included a small number of open-ended questions upon which elaboration of both positive and negative experiences was encouraged by the Researcher. This provided freedom for participants to talk in detail about what was meaningful to them by telling their own stories, (Reid et al., 2005), and enabling a rich insight into their worlds whilst also providing sufficient focus on the topic areas of interest to this research project.

All interviews were audio recorded because taking notes would have failed to provide the level of detail required and also because this would have interfered with the ability of the Researcher to develop rapport with participants. (Willig, 2001). Interviews ranged in length from 42 to 73 minutes. To capture the process of data collection, reflexive notes were taken after each interview by the Researcher which were used to inform the early stages of data analysis (Crowley, 2010; King & Horrocks, 2010).

Participants were encouraged to reflect on the interview process before the tape recorder was switched off. This enabled the Researcher to assess any negative impact that the interview may have had on each participant's wellbeing. Participants were

asked if they would like to receive a £10 gift voucher in recognition of their time. This was presented to them at the end of their interview after they had signed a copy of the Voucher Receipt Form to document their acceptance (see Appendix K). They were also asked if they would like to be informed of the findings from the research study and if so to provide their contact details on the Summary Report Request Form (see Appendix L). A list of local support agencies (see Appendix M⁸), which had been prepared in conjunction with the Homeless Psychology Service was also provided to all participants.

To immerse themselves fully in the research data, all interviews were transcribed verbatim by the Researcher at a level of detail necessary for the level of analysis (Tilley, 2003). As there exists no universally accepted format for transcription (McLennan et al., 2003), the Researcher devised their own which included non-verbal sounds (e.g. sighs and laughter) and the false starts, repetition and grammatical errors found in everyday speech. During this process, information that might identify participants was removed and they were given pseudonyms (see Appendix P for transcription notation and list of pseudonyms).

2.6.4. Analysis.

The aims of the current study were used to guide decision making regarding the most appropriate analytic approach. Neither Grounded Theory, which aims to generate a theoretical model to explain the research data (Gordon-Finlayson, 2010), or Discourse Analysis which examines how participants construct their experiences through language (Wiggins & Riley, 2010), fitted comfortably. Interpretative Phenomenological Analysis (IPA) has been categorised as a type of ‘thematic analysis’ (Madill & Gough, 2008),

⁸ To protect the anonymity of the service, the services on this form have also been anonymised.

which focuses upon understanding the individual experiences of participants, and which enables links to be made with theoretical understanding within mainstream psychology (Smith et al., 2009). IPA was chosen because it has an idiographic focus which fitted well with what the current research study was aiming to achieve, by seeing participants as experts in their own experiences (Reid et al., 2005). It was also chosen because IPA recognises that participants' 'life worlds' are not directly accessible through language, but instead can only be 'interpreted' through the interaction of the research interview (i.e. between Researcher and Interviewee) and via the Researcher's own experiences and views (Willig, 2001). In this way, IPA also fitted well with the 'critical realist' epistemology (Shaw, 2010), which underpins the current study (see Appendix E).

The process of IPA analysis followed the steps advocated by Smith et al. (2009). This included reading and re-reading each transcript, making initial notes, and developing emerging themes before looking for patterns and connections in themes across participants' accounts. This resulted in the identification of six 'super-ordinate themes' that were identified in all participants' accounts, and 'sub-themes' that reflected the individual differences between participants' experiences. In IPA, anything over six participants is thought to be a 'large' sample (Smith et al., 2009). For this reason the Researcher followed guidance on working with large samples provided by Smith et al. (2009) which advocates the documentation of re-occurrence of themes within a data set to aide transparency. To achieve this, each transcript was re-examined to ascertain the frequency of all themes across participants' accounts. Further detail on the analytic process can be seen in Appendix Q and an example of initial noting can be seen in Appendix R.

2.7. Quality issues

Qualitative research requires different approaches to assessing quality than quantitative methods (Cote & Turgeon, 2005). To endeavour to produce quality research, the current research study was planned and written in line with Evans' (2007) recommendations for qualitative appraisal. These recommendations highlight the importance of: clarifying research questions; making explicit the Researcher's position and role; ensuring that the process of data collection and analysis is clearly described; and, producing findings that are both relevant and useful.

Reflexivity (i.e. the process of reflecting on the potential influence of the Researcher), is an inherent part of qualitative research (Willig, 2001) and forms a further criterion through which readers can evaluate qualitative research studies (Crowley, 2010). It is for this reason that the Researcher's motivations, prior experiences and assumptions have been documented above (Willig, 2001; Yardley, 2000).

A full chronology of the research process can be seen in Appendix S.

3. Results

The six broad themes that were identified through IPA analysis were used to structure the following results section, as shown in Table 1 below.

Theme	Title
A:	The psychological impact of becoming homeless
B:	The psychological impact of being homeless
C:	Traumatic events and/or mental health difficulties prior to homelessness
D:	Personal experiences of using the Homeless Psychology Service
E:	Views on the national provision of psychology services for homeless adults
F:	Personal experience of being interviewed

Table 1: Super-ordinate Themes

Each of the ‘super-ordinate themes’ were constructed from a multitude of less common, but equally important ‘sub-themes’ which enabled closer reflection on the experiences of the participants as individuals. A diagrammatic representation of the relationships between the key emergent themes which are discussed below can be seen in Appendix T.

As the data set from which these findings were drawn was large, it was inevitable that the analysis of each case could not be as detailed as in IPA studies with smaller samples (Smith et al., 2009). It was for this reason that as recommended by Smith et al., (2009), the emphasis of this results section was to ensure that insights into shared commonalities which have been identified across participant accounts (i.e.

‘super-ordinate themes’) were provided, whilst also maintaining an idiographic focus on each interviewee’s experience (Reid et al., 2005; Smith et al, 2009). The 28 ‘sub-themes’, which reflected the idiosyncratic ways in which participants experienced the six ‘super-ordinate’ themes, were not representative of all of the participants’ experiences. To promote transparency and to further evidence the claims made within this results section (Smith et al., 2009), information pertaining to the frequency of ‘sub-themes’ across transcripts can be seen in Appendix U.

3.1. Theme A: The psychological impact of becoming homeless

The very process of becoming homeless had immediate psychological consequences for all of the participants. The individual circumstances through which people became homeless evoked deep feelings of rejection in over half of those interviewed. Mike, like several of the other participants, became homeless when a long term relationship ended.

“Well I was with a-a girlfriend for five years... And, (short pause) (coughs), basically she sent me down town one day to go and get something...and by the time I come back, she’d gone...Obviously, we didn’t-we had been getting on-well I thought we had, but, we can’t have been for her to do that. So, I had to-I was made homeless basically.”

(Mike, Transcript 6)

Within this quote, Mike communicates his confusion in relation to how this relationship finished and how his girlfriend’s actions resulted in him being “made

homeless". Mike's thoughts during his time in a hostel often centred around this break up, with him explaining that *"I was just thinking, if I was still with my girlfriend then I wouldn't be in that-in this position"*. For Mike, this was the start of his journey through homelessness, which he frequently related to throughout his narrative as being *"the worst nightmare"* of his life.

Alongside rejection, becoming homeless also evoked for almost all of the participants a feeling that they had lost control of their lives. In similar circumstances to Mike, Daniel also became homeless when a long term relationship ended suddenly and his partner decided to *"boot"* him out leaving him feeling, in his words *"hurt, upset, let down"* and *"lonely"*. Drawing upon his experiences, Daniel described how he believes homelessness can be caused through external circumstances over which people have no control.

"Well people in modern day society, don't understand that, if you are homeless it doesn't mean that you are poorly educated, because you have done nothing with your life. It's just, being homeless is circumstances, a lot of them, beyond your control...It could happen to anybody."

(Daniel, Transcript 3)

In the above quote, Daniel also expresses frustration regarding what he sees as the mismatch between society's perceptions and the realities of becoming homelessness. His use of the words *"it could happen to anybody"* appear to communicate his need to break down any underpinning notion that only certain types of people become homeless.

For several other participants, becoming homeless brought with it a very strong sense of apprehension and fear. Prior to becoming homeless, Eve had been living in a domestically violent relationship. She became homeless when she made the decision to leave her home, after she had been physically assaulted by her partner, and she movingly recalled her fears at this time.

“At the time, I, you know, I-I-I didn’t have a plan, I can remember thinking I was scared, so, so scared, I didn’t even know what the next hour would bring. I honestly...I didn’t even have a roof over my head, I didn’t know what to do.”

(Eve, Transcript 5)

For Eve, her fears of not having a “*plan*”, or a “*roof*” were added to by further fears for her own safety once in a hostel. In her second quote below, Eve’s use of metaphor conjures up visual images of horror through which the gravity of her fears is communicated.

“I had heard horror stories about what could happen in hostels...And, the hostel was probably, in-in my mind, in my subconscious, I guess I just thought I was going into the pit of the abyss, inner-inner hell, in a hostel.”

(Eve, Transcript 5)

3.2. Theme B: The psychological impact of being homeless

Analysis revealed that it is not just ‘becoming homeless’ that had a psychological impact, the experience of ‘being’ a homeless adult was also found to compromise the psychological wellbeing of all of the participants. For over half, being homeless made them feel like they were isolated from the rest of society and normal life. Daniel, who spoke earlier about society’s misperceptions that only certain types of people become homeless, also described how living in a hostel made him feel as though he was wearing a “*stigma badge*”. Daniel had noticed how other people, including health care professionals at local hospitals “*look*” at him differently.

“The stigma of being homeless is that everybody thinks you are an alkie, a druggie, that you have come just out of prison, you are basically, society’s rubbish. That’s what people think. They are wrong.”

(Daniel, Transcript 3)

For Daniel, being alienated from society and stigmatised in this way by “*everybody*”, resulted in him internalising the view that “*nobody cares*”. This made him feel that he was a “*lost cause*” and that he might as well carry on drinking.

Albeit experienced in different ways, being homeless was found to directly threaten the self identity of every one of the participants. Whilst for some, like Daniel, this was due to being encumbered with the stigma of being homeless, for others, losing personal possessions whilst living in hostels had a clear impact on their identity. This was particularly true for Denise who had initially become homeless due to “*rent problems*”. She then lost her “*bed space*” at her hostel, which resulted in her

possessions being put into storage. In the following quote she describes how she felt when on returning, she realised some very important photographs were missing. In this moment Denise lost part of her history, and felt a loss that she knew could not be replaced. She reflected on how during that moment, she lost her usual strong exterior and cried.

“It was horrible. Horrible. All emotional, I broke down crying about it. Because, really the tellies and that, you know-I’m not bothered about because they can be replaced. But umm, you know I have never known my family, I have never met them. When I was in kids homes, but I did have a few photos...They got thrown out. And that was all that I had...”

(Denise, Transcript 7)

For over half of the participants the psychological impact of being homeless also served to disrupt pre-existing social relationships. Eve, who had initially felt so scared about moving into a hostel also described feeling “*so depressed*” that she couldn’t even cry. For her, these first few weeks were “*a terrible time*” during which she found herself actively alienating adult members of her family.

“And by this time I had alienated my family. I didn’t want visitors, I didn’t want nobody-I didn’t even want nobody to know where I was, apart from my son...I knew-I-I-I-I was getting depressed as well with him seeing me the way I was.”

(Eve, Transcript 5)

The above quote reveals Eve’s motivation for distancing herself in this way. What she described was a vicious circle whereby being seen to be distressed by those close to her served to increase her distress even further, which further reinforced her desire not to be visited and therefore increased her isolation.

Living in a hostel also highlighted for nearly all participants their own sense of vulnerability. Jen, who became homeless when she was made to leave her family home following arguments with relatives, used visual imagery to communicate how her ability to protect herself, crumbled away once she was homeless.

“... people broke my wall so much, I got so vulnerable...And, then people just started seeing the little cracks, and started drawing me into them.”

(Jen, Transcript 2)

Throughout her interview Jen talked at length about how being emotional following leaving home put her into a “*weak position*” which enabled other hostel residents to “*weigh*” her up, and take advantage of her vulnerability by pretending to be her friends. These encounters resulted in Jen being taken advantage of for “*food*” and “*money*” and her possessions, which once lent, were not returned. On learning that

others were only *“out to get just what they wanted”* , Jen became very aware of her vulnerability in comparison to others, and hostel life became a scary place in which she believed she could have easily been led *“into danger”*, *“attacked”*, *“kidnapped”*, or *“put out”* as a *“prostitute”*.

“...well two of the girls, they used to go out at night time, selling themselves basically. And they-because I’m a fresh person, they were kind of weighing me up, saying how much they could get for me, if I wanted to go out there, and do it...”

(Jen, Transcript 2)

Over half of participants also talked about how being homeless resulted in a general erosion of trust in other people. This psychological impact can clearly be identified in Jen’s account (above). A further example comes from Ruby, who had experienced a long history of emotional distress and became homeless when she *“packed up”* her clothes and in her words, *“disappeared”* from her family home. On the recommendation of hostel staff, she began attending a day centre for homeless adults, but for several months *“didn’t even speak to a soul there”*. In the following quote, Ruby described that this was because she no longer knew who she could trust. Because of this she built her own *“brick wall”* to protect herself from *“relationships”* and *“talking to people”*.

“I felt-I felt like I was alive, but dead inside. I felt like I was living-the walking dead. I-I just felt like I was just a shell. Really dead inside. You know not knowing-not knowing who you can trust and who you can talk

to and stuff like that. So, you could say that I well-built a great big strong brick wall in front of myself so-I wouldn't let anybody near me."

(Ruby, Transcript 4)

Withdrawing from others through the active process of 'building' psychological defences was something that was identified across the experiences of almost all of the participants. One further example can be seen within Jon's experiences, who had become homeless after taking opiates following a painful bereavement. Jon described living through "*real bad situations*" in hostels which included witnessing extreme violence and being physically attacked and "*stabbed*". He also spoke about the impact of living with people who have "*no consideration or respect*" and how he had to withdraw how much he "*cared*" about others to defend against being overloaded by other people's distress.

"...if I have shown them respect first, and they don't return it then I will just not bother with them ever again, they have had their one chance, that's it. I haven't got the time to carry the world on my shoulders, cos it-going back, six or seven years I was bordering on martyrdom, you know, trying to help people out, and, causing a load of grief for myself..."

(Jon, Transcript 1)

In response to the extreme circumstances that they found themselves in once homeless, almost all participants displayed some level of psychological denial. For some like Ruby, who talked before about feeling “*alive, but dead inside*”, this seemed to happen subconsciously through a type of dissociation. Others talked about making more conscious efforts to distance themselves from reality through the use of drugs and alcohol. Jen started drinking in the hostel because she thought that it would help to “*ease*” her “*pain*” and provide a welcome break from the harsh reality of being homeless.

“Some people would like take spliffs, some people would smoke, drinking was an ease for me...once I drank I thought ‘yeah! I’m alright’, you know like when you drink it’s like ‘yeah, there’s a cool breeze’ you know, takes the pain away, things like that.”

(Jen, Transcript 2)

Over time, Jen’s perception of alcohol shifted when she realised that for her, the short term benefits of drinking were far outweighed by the negative impact that alcohol had on her life.

“...it’s not a good thing when you drink. Because you think it’s like ok at first, and yeah it’s nice when you’re squiggling it, but the after-the (sighs), the things you do. Seriously. I thought I was going to die at one point.”

(Jen, Transcript 2)

Further analysis also revealed that facing the daily struggles of being homeless seemed to erode belief in the possibility of change. At some point all of the participants had felt a sense of hopelessness and helplessness, a sentiment that Daniel previously described by saying that being homeless had made him feel like he was a “*lost cause*”. For Denise, her feelings of hopelessness were also combined with what she had also accepted as a sense of inevitability about her life. While she may have laughed whilst saying the following words, her tone of voice revealed that what she said was far from “*funny*” to her.

“It’s funny really that when I was on the streets, that I was meeting a lot of people that I was in them kids homes with as well. They were there. It seemed that our patterns were inevitable it seems, and at times you think, (laughing nervously) I was meant to end up on the street.”

(Denise, Transcript 7)

For Ruby the experience of hopelessness was driven by her belief that “*whatever it is inside you*” cannot “*go away*”. This led, as it did for two other participants, to her trying to commit suicide whilst living in a hostel.

“(Sighs), it was so har-hard, I umm just went to the day centre, everyday... and sometimes, I used to overdose. Sometimes I umm, self asphyxiated myself and ended up going backwards and forwards down the hospital and stuff like that.”

(Ruby, Transcript 4)

3.3. Theme C: Traumatic events and mental health difficulties prior to homelessness

Through analysis of the participants’ individual lived experiences, it emerged that events preceding homelessness were also important to understanding them psychologically. Prior to becoming homeless, every one of them had experienced what was interpreted by the Researcher as being both traumatic events (e.g. abuse) and mental health-related difficulties (e.g. depression). To provide a brief insight into the events that had previously shaped their lives, what emerged within participants’ narratives has been summarised in Appendix V. Appendix V needs to be interpreted with care, however, because it represents simply what was mentioned through the course of the interviews, and therefore is likely to under represent the frequency of past events in their lives. It has been included as an indication of these people’s historical contexts, on which their accounts of being homeless can be grounded.

Analysis also revealed that for more than half of the participants, being homeless made it harder to cope with, or exacerbated, these existing difficulties. One participant who talked about this in detail was Mike, who as mentioned earlier, had become homeless after his relationship broke down. Whilst trying to manage living in a hostel, he found the courage to report to the police that he had been abused as a child. At this time he was also trying to find a lost family member, but was unable to find “the

answers”. In the following quote he explains the impact of finding out that his case was not going to be taken to court and, through using the words, “*it just didn’t seem right,*” the unfairness of his current circumstances.

“...there was no further action...Which again, made things even worse and again led me to-feeling really low and wanting to end my life because, with some of the other things that were going on, it just didn’t seem right. There was a lot of stuff-a lot of rejection I think. I just couldn’t handle being homeless as well as all the other stuff that I had got going on.”

(Mike, Transcript 6)

3.4. Theme D: Personal experiences of using the Homeless Psychology Service

Whilst each participant’s experience of using the Homeless Psychology Service was different, seven common sub-themes emerged through analysis which were: barriers to overcome; engagement as an active choice; psychological needs; therapeutic impact; fears of where they would be without psychology; safety in re-referral and suggested improvements. Each of these sub-themes were identifiable across over half of participants accounts, but were experienced in different ways. To capture the diversity of experiences, 20 ‘sub-sub themes’ were also developed (which can be seen in Appendix U), which are used to illustrate participants’ thoughts, feelings and experiences within the following sections.

3.4.1. Barriers to overcome.

One participant self referred themselves to the Homeless Psychology Service and the others were referred by staff within their hostel, or by a CPN within the Homeless Mental Health Service. Whilst these referral pathways ensured ease of access, analysis revealed that all of the participants had to negotiate internal barriers when deciding whether or not to meet with a psychologist. For some of the participants, like Jen who explained “*I hated psychologists*”, these barriers were caused by having had previous negative experiences with mental health services. For over half of the participants, not understanding what psychology was (e.g. Mike who explained “*I had never even heard the word*”), served as a further barrier to their engagement. For Eve, the word psychology felt “*daunting*” because to her it meant somebody “*analysing you*” and then “*putting a label on you*”. Eve’s perceptions of psychology at this time resulted in her questioning how working with a psychologist could ever be helpful to her. Her use of imagery in the following quote highlights just how nonsensical psychology seemed at this time.

“How can somebody tell you-or, make you well, or fix something through psychology. ...it’s almost as if an alien is coming down for you and taking you in a space craft and then suddenly you have got this new brain (laughing), or this new way of functioning... how could a psychologist, unless-shy of taking your brain cells and picking them and putting them back, and fixing things, what would a psychologist actually do?...”

(Eve, Transcript 5)

Furthermore, over half of the participants talked about how not being able to trust others formed a further barrier to engaging with the service. Such mistrust, which has already been expressed by Jon and Ruby in their quotes above, is expanded on by Mike in terms of not knowing whether to, or even how to trust his psychologist.

“...it took me a while to get-to talk-to open up about things because...I didn’t know how to-how to trust her ...I knew she was a professional person, but, I didn’t know whether I could trust her or not. I had to try to build a relationship... and trust somebody who was going to sit there and listen, sort of thing. Difficult...But I’m glad that I did it in the end.”

(Mike, Transcript 6)

3.4.2. Engagement as an active choice.

Mike’s quote above also serves to introduce the next sub-theme, that engagement with the service was an active choice for all but one of the participants. This for many was motivated by a sense of despair whereby they felt that they simply had to ‘try’ psychology in the hope that it would help to change something in their current circumstances. Decisions to engage with psychology were also seen by many of the participants as requiring an ongoing commitment to what was difficult work. As Jon explains below, psychology is not magic.

“I can’t state it enough, that I am happy that I let it on board that there was help... these people can’t wave a magic wand at yer, at the end of the day you have got to dig deep.”

(Jon, Transcript 1)

Ruby had a very different experience in regard to engagement. Whilst acknowledging her belief that “*nobody can really help you until you commit yourself*”, she referred to herself as being “*the wrong kind of client*”. In her following quote, Ruby explained this further by talking about her active resistance to engaging and “*opening up*” and talking about her past experiences.

“For certain people-you know-talking through that kind of thing might umm sort of open up to combat how they feel...But I thought, ‘why should I?’ ... And I’m afraid, I just let it go in one ear, and out the other.”

(Ruby, Transcript 4)

3.4.3. Psychological needs.

Whilst using different language to describe their psychological needs, all of the participants described wanting what is commonly understood as a ‘therapeutic relationship’. Denise talked about needing to have somebody to talk to at a time in her life when she felt incredibly isolated because she had “*no family*” or close “*friends*”. Like Denise, Eve also felt isolated and in the quote below she highlights how feeling “*empathy*” through being understood was more valuable to her than being prescribed anti-depressants.

“But I’ve found that the therapy, the talking...the empathy, you-you can sense empathy in somebody understanding. You can’t get that in a drug...the talking has been so beneficial to me...that’s my medicine, has been the therapy.”

(Eve, Transcript 5)

More specifically, a couple of the participants highlighted how their therapeutic relationship needed to be with someone who understood homelessness. Reflecting on the lack of “*rapport*” that he experienced with professionals outside of the Homeless Psychology Service, Jon highlighted below how he believed working in the field is essential if a professional is going to be, “*switched on to your plight*”.

“I think it’s too much academia and not enough (short pause), on the ground level, having a look and witnessing things...I just wish some of the professionals...need to go on-to go out in the field and witness it...Be on street level. I mean.”

(Jon, Transcript 1)

Within their therapeutic relationship, over half of participants highlighted the need to have control over what was discussed within their sessions. For some like Jen, it was important to choose not to talk about certain things, whereas for others like Ruby, it was important to be able to broach ‘taboo’ subjects in therapy because they are avoided by society.

“I think us as human beings, we talk about lots of stuff. We don’t talk about illnesses, we don’t talk about like, umm, sexual assaults, rapes, and nobody talks about death. ”

(Ruby, Transcript 4)

Several participants specifically highlighted that what they needed psychologically was to find out how to navigate their way out of homelessness. For Daniel, achieving this also required exploring how he had ended up being homeless in the first place, and the identification that he was not the “*lost cause*” that he had previously thought he had been.

“Well, I needed to know, that somebody was there to listen to me and help me to understand my problems. And (short pause), possibly see from their perspective what I have been through in my life. And, how it all snowballed to these two incidents I’ve had. And to understand why I wanted to-to get back on my feet, and help me get that way. ”

(Daniel, Transcript 3)

3.4.4. Therapeutic impact.

For all but one of the participants (i.e. Ruby), working with a psychologist in the Homeless Psychology Service had a positive therapeutic impact on their lives albeit in different ways. Over half explained how simply talking about their difficulties made them feel better. In the quote below, Eve who felt that her psychologist “*helped*” her

“so much”, talked about her own experiences of catharsis and by doing so also highlighted how difficult being in therapy can be.

“...there were some areas where I would get really upset...it’s gonna happen with therapy, that-that’s probably negative at the time, but, it’s a positive-you know-eventually the positives kick in, that’s the whole idea...I guess what makes you bad, makes you better.”

(Eve, Transcript 5)

Eve also talked about how her psychologist “taught” her to understand her “emotional state” and helped her to “figure out” why she felt like she did. Gaining understanding about their situations was identified as a therapeutic outcome by over half of participants. A further example of this came from Jon who described “working together” with his psychologist to identify the point in his life where he had first felt depressed. Making sense of his “deep depression”, and the impact that it had on his life was also necessary for Jon to understand how to make positive changes in the future.

“...something wasn’t right and I wanted to give it a go to see...how I could make sense of-some kind of sense...I felt we got somewhere there for me. ...to try and understand how to make better, umm, of my life now.”

(Jon, Transcript 1)

Over half of the participants explicitly commented on how working with their psychologist had helped them to overcome their feelings of hopelessness. Mike, who in an earlier quote had talked about how he had wanted to end his life, explained how “*talking*” about his “*problems*” to a “*professional*” helped him to see what he described visually as “*the light at the end of the tunnel*”. Rediscovering hope and being “*helped*” is what Mike believed protected him from committing suicide during his time in the hostel.

*“...she helped me get through it all. If it wasn’t for ***** (name of psychologist), I don’t know where I’d be. I think I would have done something stupid before, before, if I hadn’t had ***** to talk to. It did really help. We did a lot of work together.”*

(Mike, Transcript 6)

Unlike Mike, after contact with the Homeless Psychology Service, Ruby continued to feel suicidal. Below, Ruby uses impossible solutions, which she laughs at, as a way of emphasising her belief that there really is nothing “*anybody*” can do to take her “*pain away*,” (an expectation not expressed by any of the other participants). For Ruby, this belief contributed to her feeling that in the future, suicide is still her only option.

“...I think that at the end of the day, there’s nothing-there’s nothing anybody can do, unless somebody can wave-wave a magic wand (laughs), and make it all go away. Or someone to develop a time machine, so I can take myself

backwards...if there is none of that, then the only way out that I can see is death...the only way I can feel I can be at peace, is to make this all go away...I know it sounds awful but.”

(Ruby, Transcript 4)

Understanding Ruby's beliefs about change helped to explain her difficulties engaging with psychology. Ruby shared openly that she did not find the Homeless Psychology Service helpful because it did not help to change how she felt “*inside*”; it didn't take her ‘*pain away*’. She felt that this was because, “*the help came too late*”. In this statement she was referring to a “*crisis*” in her life, five years previously, a point at which she felt that “*somebody could have helped me*”. This was a time when things did not feel so hopeless for Ruby, and a time before she built her “*wall*” to protect herself from other people in hostels.

More than half of the participants believed that their work with a psychologist had been influential in enabling them to make positive changes in their lives. Eve explained how her life felt “*brilliant now*” because she had learnt how to “*deal with the bad days*” (i.e. of depression) and had “*so much to look forward to*”, including starting college. Daniel explained that seeing a psychologist had enabled him to leave “*all forms of internal turmoil behind*” and “*psychologically sort [himself] out*”. It appeared that by changing the negative perceptions that Daniel previously held about himself and others (i.e. of being a lost cause who no-one cared about), enabled him to make some important changes in his life.

“I’m picking myself up and getting on, because I have been helped...I feel like it has sorted out my confidence, my self confidence, belief in myself...It has helped me, understand that... it’s pointless giving up, I have got something to give, like, I mentioned earlier, the two volunteer posts that I’m applying for and I’m being called forward for an interview. Umm, the courses I mentioned, and of course I’m here.”

(Daniel, Transcript 3)

Whilst many of the participants (as described above) maintained the positive impact of psychological therapy after their sessions had ended, Denise had a very different experience. Denise described herself during her interview as having suffered from depression since “*childhood*”. Whilst homeless, Denise had been in a “*difficult relationship*”, and she had initially found it “*helpful*” to talk about this with her psychologist. A few years later she was re-referred to the Homeless Psychology Service, but this time, did not find her sessions “*so helpful*” and continued to feel depressed. As she describes below, Denise’s need for “*constant counselling*” was underpinned by ongoing feelings of helplessness. She conveyed a sense of abandonment in her narrative of what it was like for her to be outside of therapy.

“I need constant counselling, not just seeing somebody for three months and then leaving it...leaving me twiddling my thumbs...she said that she will see me again...I don’t know whether that’s worth it. It’s not worth just seeing her for a couple of months, and then what am I meant to do then?”

(Denise, Transcript 7)

3.4.5. Fears of what would have happened without psychological therapy.

In addition to talking about what they had gained from using the Homeless Psychology Service, over half of the participants also talked about their fears of what would have happened to them if they had not been able to access it. For some, like Mike who previously explained that without the service, he “*would have done something stupid*”, these fears were related to their own survival. For others like Daniel, who felt that the service prevented him “*ending up in a park*” rough sleeping again, their fears were related to remaining stuck in homelessness. For Jen, her increased awareness of her own vulnerability and the risks that hostel life posed to her (e.g. of physical and sexual violence), resulted in her linking both of these fears together. For her, the service contributed to her getting her own flat, which ensured her safety. In the following quote, Jen’s nervous laughter served to illustrate the gravity of these fears.

“I don’t think that without any of that help, I wouldn’t have even got a flat, I probably would have been with those people, going and doing what-you know, I don’t know what I would have-I probably would have been in danger, I would have been like, well I don’t know. But luckily,

that (laughs nervously) didn't happen so, so (laughs nervously) t-touch wood."

(Jen, Transcript 2)

3.4.6. Safety in re-referral.

Analysis also revealed that for over half of participants, knowing that they could return to the service brought them comfort. Jen described how she had already said "yes" to being re-referred to the service in the future. This was linked to her perception that, at the time of her interview, her difficulties with drinking and controlling her emotions had gone "*down hill again*". Daniel, who described knowing that he didn't have to "*battle on, on [his] own*" and Eve who described feeling as though she had a "*safety net*", both used visual imagery to express the importance of the service leaving the door open to them.

"...I was only ever going to have twelve sessions with her...if I feel like I need to self refer myself back, there is always that safety net. That she's assured me that-that will be there. And I think subconsciously I have realised that that's-I love them words in my-in my mind. You know, I've got that safety net, the fact that that psychology service is there, if I need it again."

(Eve, Transcript 5)

3.4.7. Suggested improvements.

Drawing upon their experiences, all of the participants made at least one suggestion of how they thought the Homeless Psychology Service could be improved. Several commented on how they thought awareness of the service should be raised within the hostel system. Jon, talked about whilst it is “*right under their nose*”, the service remains “*hidden*” to people who need it because it is “*wrapped in so much of the stigma*” surrounding mental health services. Holding similar views to Jon, Ruby felt that advertising the service (e.g. through brightly coloured leaflets) would help reduce stigma by enabling people to have a more realistic idea of what working with a psychologist might involve. Others, like Denise, suggested that, in line with a person centred approach, more flexibility would be beneficial in regard to the number of sessions offered.

“The counselling stops, obviously when the patient wants it to stop, not when you say ‘right, that’s it, your sessions are up’. Do you know what I mean.”

(Denise, Transcript 7)

In addition to these suggestions, Daniel who had felt like “*getting up and going*” whilst waiting for his sessions, suggested having a separate quiet waiting area. With the aim of guaranteeing “*open doors, not closed doors*”, Ruby suggested that referrals should be made to other services once sessions came to an end (e.g. to services that provide practical support around cooking, cleaning and finding a job). Finally, Eve

suggested that a Psychologist or a CPN should be “*automatically allocated*” to everyone in hostels and then it should be “*up to them if they want to*” access it.

3.5. Theme E: The national provision of psychology services for homeless adults

Almost all of the participants made comments about the current provision of specialist psychology services for homeless adults. The news that similar services were not available nationally was experienced by Daniel, Eve and Mike as being “*shocking*”, “*unbelievable*” and “*horrendous*” and they, like Jon and even Ruby, all felt that more resources should be made available to enable the set up of further services. Drawing upon his own experiences, and echoing the views of many, Daniel questioned how homeless adults were “*ever going to get back on their feet*” without such “*help*” and described how he thought services should be set up “*in every major city*”. Sharing a similar view, Mike explained how he believed access to such services should be equitable for everyone who is living in a hostel.

“Because people-people need, they are going to need to help. There are all different sorts of reasons why they need help... you have got hostels everywhere in-in England, ...Where there is a hostel, there should be somewhere for everyone, not just in two parts of the country.”

(Mike, Transcript 6)

In addition to expressing a need for more services, and in line with her personal experiences, Ruby emphasised the need for services to notice when people are “*crying out*” for help before they even become homeless and to offer support “*right at the*

beginning". Finally, because, in her experience, homeless adults are all "very unique", Eve felt it was important for service providers to "listen to individuals" rather than "label" them, or "generalise" their needs.

3.6. Theme F: Personal experience of being interviewed

All of the participants described how being interviewed and talking about their experiences had felt good, and for many, this had also been a cathartic experience. Jen described how it "helped" to "let it all out". As described previously Daniel linked his participation with his realisation that he does have "something to give". Over half of the participants consented to being interviewed because it provided them with the opportunity to have a voice and express their feelings, whilst others did so out of gratitude to the Homeless Psychology Service, or like Ruby, to help others facing similar situations to access "help" when they need it.

*"Because, like with you, you said that you wanted to talk to somebody.
And, it's a way of, umm, getting a voice...I have got a lot of things off my
system. I know that they will never go away...it might be able to help
other people, and hopefully, umm, help when they need it. Not
necessarily when they are adults, like me."*

(Ruby, Transcript 4)

4. Discussion

From the perspective of seven recently homeless adults, the current research study used IPA to explore: their experiences of being homeless; having mental health-related difficulties; and their encounters with a specialist Homeless Psychology Service. Whilst they all had different experiences, the themes that emerged through analysis clustered into groups and formed six common ‘super-ordinate’ themes. In this discussion, these themes are summarised and considered in relation to the research literature, before moving on to focus upon: implications for clinical practice; strengths and limitations; and recommendations for future research.

4.1. Summary of research findings

Listening to the participants reflect upon their thoughts, and feelings, it became clear that becoming homeless was in itself a traumatic event that had a psychological impact on all of them (e.g. feeling rejected, out of control and fearful). Furthermore, the ongoing experience of being homeless was found to have a formidable impact on their psychological wellbeing. This impact was experienced in a multitude of different ways by individuals including: feeling alienated from society and ‘normal life’; threat to, or loss of self identity; disruption of pre-existing social relationships; realisation of own vulnerability; erosion of trust in other people; building of psychological defences; denial; hopelessness and helplessness.

The current findings offer support to emerging understandings of how the trauma and indignity of being homeless can undermine and reshape an individual’s self identity (Williams & Stickley, 2011). They also provide research evidence to support the understanding that homeless adults try to defend themselves as best they can from

the often lonely, deeply demoralising and frightening world that is homelessness (Cockersell, 2011). Echoing the findings of previous research studies (e.g. McNaughton, 2008), drugs and alcohol were used by some participants as a means of promoting emotional escape. Many of the participants also spoke about how they had built their own psychological and social defences, which whilst protective often served to isolate them further from both social and professional support.

It was found that prior to becoming homeless, all of the participants had experienced what the Researcher interpreted as being both traumatic life events and mental health-related difficulties. This finding is perhaps unsurprising given that all of the participants had accessed a Psychology service. It does support the plethora of existing research evidence that has documented the characteristics of homeless adults in the UK (e.g. Rees, 2009), and recent claims that ‘psychological disorders’ are likely to contribute to causing homelessness (Communities & Local Government, 2010). With over half of those interviewed also feeling that homelessness exacerbated their existing difficulties, these findings also support the need for housing services to recognise and respond to the impact of previous life experiences on homeless adults (Burlington et al., 2010). Furthermore as described above, because all participants felt that being homeless had a negative impact on their psychological wellbeing, these findings also support the view that whilst homelessness can be a result of mental health-related difficulties, it can also cause them (Seager, 2011).

The participants consistently expressed a psychological need for a therapeutic relationship. This reflects the powerful potential of relationships to repair emotional damage and combat feelings of alienation (Seager, 2011), by forming the primary curative component of any therapeutic intervention (Lambert & Barley, 2001). Barriers to gaining this through actively engaging with the Homeless Psychology Service were

built not just out of lack of awareness of what the service could offer and negative past experiences with mental health services, but also out of ‘mistrust’ in others which had developed directly as a result of being homeless. This highlights the challenge to services in engaging with homeless adults, who like these seven participants, may be feeling isolated, scared, suspicious and hopeless as a result of their experiences (Seager, 2011). This provides further support for the need for specialist services that persistently seek to engage with homeless adults within their own environment (Holmes et al., 2005).

When talking openly about using the Homeless Psychology Service, all but one of the participants spoke about experiencing a combination of positive outcomes (i.e. catharsis, gaining insight, overcoming hopelessness, making positive changes). For over half of the participants, these outcomes were also linked to enabling them to move out of homelessness and/or staying safe from serious risk of harm. Interestingly, these findings relate closely to the themes of *‘relate to me’*, *‘know me as a person’*, and *‘get to the solution’*, which have been identified within other mental health service users’ experiences of a successful therapeutic relationship (Shattell et al., 2007). These findings also reflect the meeting of what is claimed to be a universal list of psychological needs (Seager & Manning, 2009, as cited within Seager, 2011), which includes: being loved and listened to; belonging; achieving; and having meaning and hope. These findings mean that the Homeless Psychology Service successfully engaged and made a real difference in the lives of almost all of the current participants. Given these findings, it is of no surprise that all of the participants who commented on national service provision felt that more services like the Homeless Psychology Service should be set up across the UK.

4.2. Implications for clinical psychology practice

In line with the current study's qualitative framework, no attempts were made to overtly 'generalise' the findings to the broader homeless population. However they are potentially transferable (Hefferon & Gil-Rodriguez, 2011), and can be seen as useful for increasing awareness of the psychological needs of homeless adults and supporting the need for specialist services for this population nationally.

Irrespective of where they practice, the current findings are relevant to all mental health workers, including Clinical Psychologists who may have clients referred to them who are homeless. By aiding understanding in regard to the psychological impact of homelessness, they encourage insight into what makes this client group different from non-homeless populations (i.e. homelessness is much more than not having a 'roof'). Such knowledge will be helpful to anyone who wishes to work empathically with homeless adults and understand the complexity of their needs. It is also anticipated that these findings will encourage clinicians in mainstream mental health services to think carefully about what they can do to tailor their services to promote engagement with this particular client group (e.g. advertising within hostels, offering more flexible appointment locations and times). This is important because disengagement from services is likely not to be experienced as a neutral event, but as the current research study has found risks evoking further feelings of alienation and loss of trust in services.

Locally, the suggestions for improvements will be useful to the Homeless Psychology Service. By providing the first insight into how service users have experienced a designated Homeless Psychology Service in the UK, these findings also suggest that this service offers a potential service model for future developments. The specific components of this service which were appreciated by interviewees, and are not provided by mainstream services, include: flexible referral pathways which enable ease

of access (i.e. including self-referral); professionals who understand homelessness and who work persistently to promote engagement; flexibility in regard to appointment times and locations; and doors that are left open for service users to re-refer if necessary. Ideas for the dissemination of these findings can be seen in Appendix W.

4.3. Strengths and limitations

By documenting the assumptions and biases of the Researcher (i.e. through reflexivity), and by remaining true to the ‘critical realist’ perspective, the current study has explicitly acknowledged that the Researcher’s influence cannot be separated from its findings (Sandelowski & Barroso, 2002). This is because the Researcher contributed deeply to how each interviewee constructed their narrative through the collaborative process of interviewing, and to how the transcripts were analysed and the findings interpreted (Smith et al., 2009). It is for this reason that inter-rater reliability (i.e. the checking of themes by another qualitative researcher) was deemed meaningless for this study, as this process would be seen as constructing an alternative form of reality rather than providing any useful validation of the first (Yardley, 2000).

The key strengths of the current study were: the extent to which the participants were willing to explore their experiences (i.e. transcripts totalling 66,969 words); the commitment made to retaining the idiographic focus upon individual service users’ experiences (e.g. by analysing each transcript individually before looking for similarities and patterns across participants); and, the employment of an appropriate methodological process which has been meticulously described to provide an transparent account to readers. Enabling readers to assess the re-occurrence of ‘sub-themes’ across the data set has provided further transparency and enhances the validity (i.e. the quality) of the current study’s findings as a whole (Smith et al., 2009).

Limitations to the current study include the difficulty of ascertaining whether or not participants felt that they should provide socially desirable answers (e.g. positive views of the Homeless Psychology Service). This seems unlikely given: the independent nature of the current study; the use of prompts for negative as well as positive narratives during interviews; and the fact that as it can be seen in the findings, participants did feel able to talk about their negative experiences of the service. Despite these factors, the potential for bias in this direction still remains. Whilst doing so would not have fitted with the current study's research questions, interviewing those who had been referred to the service, but who chose not to use it may have provided some additional interesting insights.

The limited amount of words available for this write up has meant that analysis only focussed on themes that were related to answering the research questions. In particular this bias has resulted in less emphasis being placed upon other interesting areas, such as examining participants' resilience in surviving homelessness and any experiences of post-traumatic growth. Further analysis of this data set may well reveal themes that add to existing understandings of how post-traumatic growth can follow a range of aversive experiences (see Linley & Joseph, 2004 for a recent review), and to the much smaller research base that has identified this impact following homelessness (e.g. Morgan, 2011). It is recognised that if further analysis is conducted on this data set, any new findings will also need to be included in any future write up for publication.

4.4. Recommendations for further research

Given the current gap in the research literature regarding therapeutic outcome studies with homeless adults in the UK, much more research is required in this field. In

particular, further outcome focussed research of other mental health services that work with this client group are required from both quantitative and qualitative perspectives (i.e. to ensure that homeless adults are listened to as individuals). This would enable greater understanding of how different types of service models and therapeutic approaches are experienced by this population, which would provide a broader knowledge base on which to base future service development. Further analysis of the current study's data is also likely to reveal additional clinically useful findings, particularly in regard to moving on from homelessness and the processes through which self efficacy is regained (see Appendix X for further information).

Given that it is likely that other specialist psychology and mental health services exist across the UK but are not represented within the research literature, it is also vital that they publish any service data that they routinely collect, even if this does not constitute formal research findings.

It has been said that recruiting homeless adults can be at least three times as time consuming than those who have less complex needs (Bhui et al., 2006). Unfortunately, these narratives serve to deter researchers and result in homeless adults being marginalised in research, in the same way that they are in society. The current Researcher had little trouble finding participants and had a very low attrition rate. One final message from the current research study is that homeless adults wanted to talk about their experiences and be heard by those who choose to listen.

References

- Abdul-Hamid, W., Wykes, T., & Stansfeld, S. (2010). Needs of homeless people for mental healthcare. *The Psychiatrist*, 34, 334-337.
- Bhugra, D., Bhamra, J., & Taylor, P. (1997). User's views of a drop-in project for the homeless. *International Journal of Social Psychiatry*, 43, 95-103.
- Bhui, K., Shanahan, L., & Harding, G. (2006). Homelessness and mental illness: A literature review and qualitative study of perceptions of the adequacy of care. *International Journal of Social Psychiatry*, 52, 152-165.
- Bickley, H., Kapur, N., Hunt, I., Robinson, J., Meehan, J., Parsons, R., McCann, K., Flynn, S., Burns, J., Amos, T., Shaw, J., & Appleby, L. (2006). Suicide in the homeless within 12 months of contact with mental health services: A national clinical survey in the UK. *Social Psychiatry and Psychiatric Epidemiology*, 41, 686-691.
- British Psychological Society (2011). *Code of human research ethics*. Leicester: British Psychological Society.
- Burlington, B., Andrasik, M., Larimer, M., Marlatt, A., & Spigner, C. (2010). A house is not a home: A qualitative assessment of the life experiences of alcoholic homeless women. *Journal of Social Work Practice in the Addictions*, 10 (2), 158-179.

Cockersell, P. (2011). More for less? Using PIEs and recovery to improve efficiency in supported housing. *Housing, Care and Support*, 14 (2), 45-50.

Communities and Local Government (2010). *Mental health good practice guide: Meeting the psychological and emotional needs of homeless people*. London: Communities and Local Government.

Cote, L., & Turgeon, J. (2005). Appraising qualitative research articles in medicine and medical education. *Medical Teacher*, 27 (1), 71-75.

Crane, M., & Warnes, A. (2001). The responsibility to care for single homeless people. *Health and Social Care in the Community*, 9, 436,444.

Crowley, C. (2010). Writing up the qualitative methods research report. In M Forrester (Eds.), *Doing qualitative research in psychology: A practical guide* (pp 135-153). London: Sage.

Department of Health (2008). Commissioning IAPT for the whole community: Improving access to psychological therapies. London: Department of Health.

Dunning, J. (2009). Phil Hope urged to act on homelessness and mental health. <http://www.communitycare.co.uk/Articles/2009/10/01/112735/phil-hope-urged-to-act-on-homelessness-and-mental-health.htm>.

Evans, D. (2007). Overview of methods. In C. Webb & B. Roe (Eds.), *Reviewing research evidence for nursing practice: Systematic reviews* (pp3-8). Oxford: Blackwell.

Gordon-Finlayson, A. (2010). Grounded Theory. In M. Forrester (Eds.), *Doing qualitative research in psychology: A practical guide* (pp 135-153). London: Sage.

Hall, J., & Marzillier, J. (2009). Alternative ways of working. *The Psychologist*, 22, 406-408.

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, 12, 335-344.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist*, 24 (10), 756-759.

HM Government (2009). *New horizons: A shared vision for mental health*. London: HM Government.

Holmes, A., Hodge, M., Newton, R., Bradley, G., Bluhm, A., Hodges, J., Didio, L., & Doidge, G. (2005). Development of an inner urban homeless mental health service. *Australian Psychiatry*, 13 (1), 64-67.

Jarrett, C. (2010). Helping the homeless. *The Psychologist*, 23, 284-287.

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage.

Linley, A. & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17 (1)*, 11-21.

Little, G., & Watson, D. (1996). The homeless in the emergency department: A patient profile. *Journal of Accidental and Emergency Medicine, 13*, 415-417.

Madill, A., & Gough, B. (2008). Qualitative research and its place in psychological science. *Psychological Methods, 13*, 254-271.

McLennan, E., MacQueen, K. M., & Neidig, J. (2003). Beyond the qualitative interview: Data preparation and transcription. *Field Methods, 15*, 63-84.

McNaughton, C. (2008). Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. *Drugs: Education, prevention and policy, 15 (2)*, 177-188.

Morgan, B. (2011). Escaping from homelessness: An interpretative phenomenological study. *Unpublished manuscript*.

O'Reilly, M., Taylor, H., & Vostanis, P. (2009). 'Nuts, schiz, psycho': An explanation of young homeless people's perceptions and dilemmas of defining mental health. *Social Science and Medicine, 68*, 1737-1744.

- Philappot, P., Lecocq, C., Sempoux, F., Nachtergaeel, H., & Galand, B. (2007). Psychological research on homelessness in Western Europe: A review from 1970 to 2001. *Journal of Social Issues*, 63 (3), 483-504.
- Power, C., & Attenborough, J. (2003). Up from the streets: A follow-up study of people referred to a specialist team for the homeless mentally ill. *Journal of Mental Health*, 12, 41-49.
- Randall, G., Britton, J., Brown, S., & Craig, T. (2007). *Getting through: Access to mental health services for people who are homeless or living in temporary or insecure accommodation*. London: Department of Health (DoH), Communities and Local Government (CLG) and Care Service Improvement Partnership (CSIP).
- Rees, S. (2009). *Mental ill health in the adult homeless population: A review of the literature*. London: Crisis.
- Reid, K., Flowers, P., Larkin, M. (2005). Exploring lived experience. *The Psychologist*, 18 (1), 20-23.
- Sandelowski, M., Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship*, 213-219.
- 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.

Shattell, M., Starr, S., & Thomas, S. (2007). 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship.

International Journal of Mental Health Nursing, 16 (4), 274-84.

Shaw, R. (2010). Interpretative phenomenological analysis. In M Forrester (Eds.), *Doing qualitative research in psychology: A practical guide* (pp 135-153). London: Sage.

Shelter. (2008). *A long way from home: Mental distress and long term homelessness*. London: Shelter.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Spence, S. (2009). Roofless in a steel city: Learning from the homeless mentally ill. *Psychiatric Bulletin*, 33, 64-69.

Taylor, H. (2012). What is the evidence for the therapeutic impact of providing mental health-related services for adult homeless populations? A systematic review of the UK research literature. (*Unpublished manuscript*).

The Marmot Review (2010). *Fair society, healthy lives: Executive summary*. London: The Marmot Review.

Thompson, S. (1996). Paying respondents and informants. *Social Research Update, Autumn, 14*.

Tilley, S. (2003). 'Challenging' research practices: Turning a critical lens on the work of transcription. *Qualitative Inquiry, 9*, 750-773.

Tischler, V., Vostanis, P. (2007). Homeless mothers: Is there a relationship between coping strategies, mental health and goal achievement? *Journal of Community and Applied Psychology, 17*, 85-102.

Wiggins, S., & Riley, S. (2010). Discourse analysis. In M Forrester (Eds.), *Doing qualitative research in psychology: A practical guide* (pp 135-153). London: Sage.

Williams, S., & Stickley, T. (2011). Stories from the streets: People's experiences of homelessness. *Journal of Psychiatric & Mental Health Nursing, 18* (5), 432-9.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

Part 3: Critical Appraisal

Critical Appraisal

1. Introduction

This critical appraisal was based upon the reflective notes that were taken throughout the research process. The aims within this paper are: to reflect personally upon the experience of carrying out an independent piece of research; to consider the limitations of the research study; to discuss future research opportunities in this field; and, to summarise what was learned through this process.

2. Conducting the research

2.1. Choosing a research topic.

I felt very fortunate to have the freedom to choose my own research topic. On reflection, my choice was heavily influenced by my previous experiences.

Prior to making my decision, I had worked clinically with homeless adults and I had spent three years working as a Research Associate on a national study that had explored the mental health needs of homeless young people. During this time, I learnt a great deal from spending time in hostels across the country and from hearing about the experiences of those who had no choice but to live in these very challenging environments. I had seen how people's lives could be changed by homelessness and how their mental health suffered as a result. I had heard how homeless adults often felt excluded from society and how climbing out of homelessness was so much harder than falling in. I had learnt a lot about inequality in service provision and felt frustrated that the physical and mental health needs of this client group were often left unmet. My experiences made me question why traditional mental health services did not work more flexibly to engage with this often very vulnerable group of people. My experiences had

also made me wonder what it was that made the needs of homeless adults ‘different’. Vicariously, I also gained some insight into the stigma that surrounds homelessness. I noticed how people interested in my work frequently conveyed within their narratives the view that *‘homeless people were very different’* to themselves. These attitudes jarred uncomfortably with my personal belief that whilst many of us are fortunate to be surrounded by a multitude of protective factors (e.g. money, social support), anybody can become homeless.

My personal experiences have also contributed to my interest in the area of homelessness. Whilst I have never lived in a hostel, I have had experiences both as a child and as an adult where I have lived in places that have not felt safe. When it was necessary, I also spent short periods of my childhood staying at friends’ houses. These experiences led me to appreciate what I have now. I own my own house, it is my home, and it is a safe place for me to be. I recognise that my life experiences make me naturally empathetic towards anyone who is without somewhere safe to live, and a place that feels like home.

Not long after I started my DClinPsy, Jarrett (2010) published an article in *‘The Psychologist’* entitled: *‘Helping the homeless’* which identified that there were only two specialist Homeless Psychology Services in the country. This sparked within me what felt like a unique opportunity to combine my existing research interests with a specific focus on the provision of psychological services. I approached a Psychologist within one of the services and felt delighted when they agreed to provide me with field supervision and help with recruitment.

2.2. Choosing a methodology.

My previous experience of working on mixed methods research projects had taught me that whilst I can see the worth of quantitative methods, I have never felt particularly comfortable with the way that individual's unique experiences are lost when they are reported as part of a large group. I chose a qualitative methodology because I believe strongly that service users' views need to be heard and respected by those who make decisions regarding service provision. Whilst this view is recognised within Government Policy (e.g. HM Government, 2009), I knew that service users' experiences of specialist Homeless Psychology Services in the UK were yet to be explored .

I was also aware that being a Trainee Clinical Psychologist was likely to position me as having relatively greater 'power' (e.g. with personal and material resources) than those who I would be interviewing (Hagan & Smail, 1997). I hoped that I would be able to use my position to enable the voices of this client group to be amplified and heard by others.

2.3. Collecting data.

During the planning phase of my research, concerns were raised regarding how I would find participants (i.e. by staff at the University of Leicester and members of the ethics committee). Whilst this did concern me, I drew upon my previous experiences of strategies which might increase the likelihood of participation (e.g. offering flexibility in interview locations and times) which seemed to work.

I really enjoyed interviewing. I felt amazed by the openness, honesty and depth at which these participants were willing to share their experiences with me. I felt inspired by their resilience, and how despite experiencing such adversity, they had not

given up. I recognised that what I was hearing resonated with my own theoretical beliefs, that whilst it can be '*thwarted or warped*', the intrinsic human tendency to strive towards '*self actualisation*' cannot ever be destroyed (i.e. Rogers, 1980).

When conversations involved the exploration of very painful memories and emotions (e.g. suicide attempts), I found myself trying to maintain a balance between monitoring the wellbeing of the participants whilst also being mindful not to silence their choice to explore these issues. I was pleased that they all had a positive experience of being interviewed. I have also wondered how much the attempts that I made to address the power imbalance contributed to this (e.g. by employing a relaxed interview style that positioned them as being experts in their own experiences, and by providing drinks and snacks to promote comfort and informality).

Whilst most of the interviewees appeared happy to receive a £10 gift voucher in recognition of their time, several were reluctant to take it until I explained that they had not been paid for out of my own money. One participant refused to take the voucher, and asked for it to be donated to someone who needed it more than he did⁹. It became apparent to me that these gift vouchers definitely did not provide an incentive to participate. It also left me wondering whether what was communicated in the offering of these vouchers (i.e. direct acknowledgement of their time and expertise) was more important to these participants than the receipt of the voucher itself.

2.4. Transcription and analysis.

I chose to do my own transcription because I knew that transcribing is much more than just moving words from tape to text (Tilley, 2003). Whilst it was a painfully slow process, (i.e. taking a total of 75 hours), I do not regret this decision. This is

⁹ This was used to purchase tea and coffee supplies for a voluntary sector mental health group.

because it prevented interference being brought into the analytic process (i.e. another person's interpretations), and served to fully immerse me in my data (Halomb et al., 2006, Tilley, 2003).

My research supervisor suggested that I use IPA (Interpretative Phenomenological Analysis) rather than the thematic approach (i.e. Braun & Clarke, 2006) that I had originally proposed. Knowing nothing about IPA, this took me out of my comfort zone. I began learning by reading books (i.e. Smith et al., 2009; Willig, 2001) and scanning published IPA research articles to see the range of styles in which findings were presented. I also joined a qualitative analysis group with other members of my cohort. I took comfort in the words of Smith et al. (2009, pg 80) that "*there is no clear right or wrong way of conducting this sort of analysis*", and, from the reassurance given to me by my research supervisor.

Analysing my first transcript took me four days. I became concerned about timeframe and my research supervisor suggested that I could consider carrying over codes from my first transcript to the next (a much quicker process than analysing each transcript separately before making comparisons). I thought about this, and felt that whilst it is a recognised form of IPA (i.e. by Willig, 2001), it did not feel focussed enough on individuals' experiences. I decided to work every weekend and most evenings for two months to enable me to fully embrace the IPA method as advocated by Smith et al., 2009. The time consuming and detailed nature of this process often felt bewildering. Despite this I became fascinated by how much more I noticed by working in this way (e.g. how throughout an individual's transcript their narrative shifts slightly, or how metaphors are expanded upon throughout their accounts). This enabled me to stay connected with my participants as individual people.

2.5. Dissemination.

To enable the voices of my participants to be heard, I will be disseminating my findings to clinicians (i.e. Clinical Psychologists and other professionals who work with homeless adults), statutory and non statutory agencies, policy makers and commissioners. I intend that my research will encourage greater understanding of the experiences and mental health needs of homeless adults. I also believe that it will contribute to future changes to mental health services to enable the needs of this population to be better met in the UK.

I plan to disseminate my findings by publishing in journal articles, presenting at conferences, and by producing a Summary Report to ensure that my findings reach those outside of the academic community (e.g. local services). I have already planned to present my research at a Research Conference this summer and following their expressed interest, a copy of the Summary Report will be provided to all of my participants. Findings will also be reflected back to the service involved in this research project, to promote further service development. After submission I will be consulting with staff who work for, or closely with the Homeless Psychology Service to identify further avenues to disseminate what I have found.

3. Limitations

By including epistemological and personal reflexivity within my research report, I have explicitly acknowledged the inevitable impact that I will have had on the research process (King & Horrocks, 2010). I have also recognised the potential for social desirability to have influenced my findings.

One of the biggest challenges of conducting an IPA study with a large sample is maintaining a focus on the individual experiences of participants, whilst also making

claims for the larger group (Smith et al., 2009). For this reason, I remain interested in whether or not readers of my research can hear my participants' individual voices.

4. Future research opportunities

Very little UK-based qualitative or quantitative research has explored the impact of mental health service provision for homeless adults. Whilst the current absence of research in this field provides researchers with a great deal of methodological freedom, further IPA research, which respects the unique nature of homeless adult's experiences, would be beneficial to build a larger picture of this population's experiences (Smith et al., 2009). The use of PAR (Participatory Action Research) methods that promote inclusion, empowerment and action through the research process would be a further fascinating avenue to explore with this client group (e.g. by enabling homeless adults to decide what should be researched and how).

5. Reflections on personal and professional development

I have learnt a great deal from carrying out my research both personally and professionally. When it placed huge demands on my time, I kept in mind the importance of '*self care as a practitioner*' (Bond, 2000). This was something that was instilled within me through my previous training as a counsellor, and it ensured that I always ate and slept well and rewarded myself by scheduling in breaks to see friends. On a personal level I have learnt that I am capable of working very long hours. I have also learnt that setting myself daily targets helps to motivate me and protects me from feeling overwhelmed by my work load. From reading the compassion-focussed therapy literature (i.e. Gilbert, 2010), I have also noticed that I have become better at being kind to myself on the days where my personal goals were not reached.

Professionally I have learnt about homelessness on a much deeper level. I have also learnt about Psychology from the perspective of my participants, which I will find useful throughout my career (e.g. their experiences of engagement, therapeutic process and impact). I have developed new skills in IPA; it is an analytic approach that I would like to use again. I have also gained more experience at academic writing and I feel proud of the work that I have produced. Finally, from conducting this piece of research I have become even more interested in service users' views of mental health services. I know that wherever I work as a Clinical Psychologist I will try to contribute to ensuring that the views of service users will be explored and listened to.

References

- Bond, T. (2000). *Standards and ethics for counselling in action*. London: Sage.
- Braun, V. & Clarke, V. (2006). Using thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Gilbert, P. (2010). *Compassion focused therapy*. London: Routledge.
- Hagan, T., & Smail, D. (1997). Power mapping 1. Background and basic methodology. *Journal of community and applied social psychology*, 7, 257-267.
- Halomb, E., & Davidson, P. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research*, 19, 38-42.
- HM Government (2009). *New horizons: A shared vision for mental health*. London: HM Government.
- Jarrett, C. (2010). Helping the homeless. *The Psychologist*, 23, 284-287.
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage.
- Rogers, C. (1980). *A way of being*. New York: Houghton Mifflin.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Tilley, S. (2003). "Challenging" research practices: Turning a critical lens on the work of transcription. *Qualitative Inquiry*, 9, 750-773.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Appendices

Appendix A: Guidelines to authors for journal targeted for literature review

British Journal of Clinical Psychology

Published on behalf of the British Psychological Society

Edited by:

Julie Henry and Mike Startup

Print ISSN: 0144-6657

Online ISSN: 2044-8260

Frequency: Four issues a year

Current Volume: 50 / 2011

ISI Journal Citation Reports® Ranking: 2010: Psychology, Clinical: 43 / 102

Impact Factor: 1.697

Author Guidelines

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via <http://www.editorialmanager.com/bjcp/>. The Journal operates a policy of anonymous peer review. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#).

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- All Articles must include Practitioner Points - these are 2-4 bullet points to detail the positive clinical implications of the work, with a further 2-4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at <http://authorservices.wiley.com/bauthor/suppmat.asp>

7. Copyright

Authors will be required to assign copyright to The British Psychological Society. Copyright assignment is a condition of publication and papers will not be passed to the publisher for production unless copyright has been assigned. To assist authors an appropriate copyright assignment form will be supplied by the editorial office and is also available on the journal's website at http://www.blackwellpublishing.com/pdf/CTA_BPS.pdf. Government employees in both the US and the UK need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned.

8. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded [here](#).

9. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

10. OnlineOpen

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the

author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms

Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website
at: <https://onlinelibrary.wiley.com/onlineOpenOrder>

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

11. Author Services

Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit <http://authorservices.wiley.com/bauthor/> for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

12. The Later Stages


The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:
<http://www.adobe.com/products/acrobat/readstep2.html>.

This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

13. Early View

British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they

cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document: [What happens to my paper?](#) [Top](#) 

Appendix B: Data extraction template

Study reference number: Date: Author/s: Methodology: Quantitative <input type="checkbox"/> Qualitative <input type="checkbox"/> Mixed methods <input type="checkbox"/>		
	A) Descriptive summary	B) Critical appraisal
1. Aim		
2. Intervention		
3. Setting		
4. Study design		
5. Sampling process		
6. Sample characteristics		
7. Data collected		
8. Type of analysis		
9. Findings		
10. Clinical impact		
11. Ethics		
12. Reflexivity		
13. Key strengths		
14. Key limitations		
15. Additional notes		

Appendix C: A table displaying the aim, setting, intervention, study design, sampling process and characteristics of 13 research studies

Study	Aim	Setting	Intervention	Study design	Sampling process and characteristics
1. Joseph et al. (1990).	To assess whether a psychiatric clinic was an 'effective option' for single homeless clients.	General Practice surgery in London.	A psychiatric drop-in clinic that offered one three hour session a week. <u>Staffing:</u> Not described.	Quantitative study using a case series design.	<u>Process:</u> Case notes reviewed of referrals between June 1984 and May 1987. <u>Characteristics:</u> 260 single, homeless clients. Male (89%), aged 14-71 years.
2. Bhugra et al. (1997).	To ascertain service users' views in relation to their 'satisfaction' with the service.	Voluntary sector drop-in project.	Baron's Court Project, a drop-in which aimed to meet the needs of those who were homeless and vulnerable due to mental health problems. Offered therapeutic individual and group work. <u>Staffing:</u> Not described	Quantitative study using a post-test design.	<u>Process:</u> Service users approached by an independent researcher and interviewed. <u>Characteristics:</u> 70 service users, predominantly male (77%). 11 refused. Demographics between the consenting and non-consenting groups did not differ.
3. Commander et al. (1997).	To explore the impact of a community mental health team on in-patient admissions who had no 'fixed abode' (i.e. those 'strictly roofless' and those 'living in direct access hostels').	Birmingham, in-patient psychiatric wards.	A specialist community mental health team for homeless people (CMHT) that offered services to those experiencing severe mental illness. <u>Staffing:</u> One half-time Consultant Psychiatrist, three CPN's, one Social Worker, two Resettlement Officers and one Secretary.	Quantitative study using a historical control design.	<u>Process:</u> Retrospective record search between 1989 to 1992 for historical controls. Weekly telephone calls were made to acute wards to collect case data between February 1995 and January 1996. <u>Characteristics:</u> Control group: 87 people (105 admissions), 79% male. Case group: 91 people (106 admissions), 89% male.
4. Graham et al. (1999).	To describe 'outcomes' for rough sleepers in terms of following admittance to an acute psychiatric ward.	London, in-patient psychiatric ward within St. Bartholomew's Hospital.	A psychiatric team on Strauss Ward provided on the street assessments and in-patient treatment for rough sleepers. They worked closely with the East London Homeless Healthcare Team (HHELP) outreach service. <u>Staffing:</u> Not described.	Quantitative study using a post-test design.	<u>Process:</u> Staff interviewed regarding all rough sleepers admitted 1991-1995. <u>Characteristics:</u> 22 rough sleepers, 73% female. Age ranged from 21 to 66 years (mean age=42). Two cases were lost through attrition.

Appendix C (continued)					
Study	Aim	Setting	Intervention	Study design	Sampling process and characteristics
5. Odell & Commander (1999).	To examine the impact of a specialist community mental health team on outcomes for homeless clients who experience psychosis.	Birmingham.	<p>A specialist community mental health team for homeless people (CMHTH) offered ‘patient-led’ interventions (e.g. housing, benefits, medication).</p> <p><u>Staffing:</u> One half-time Consultant Psychiatrist, three CPN’s, one Social Worker, two Resettlement Officers and one Secretary.</p>	Quantitative study using a pre-test post-test design.	<p><u>Process:</u> Data collected by clinicians at assessment and end of contact on all new clients diagnosed with a psychotic disorder and treated by the CMHTH in a two year period.</p> <p><u>Characteristics:</u> 82 homeless clients, predominantly male (87%), between 20 and 70 years of age (mean age=38).</p>
6. Wood et al. (2001).	To evaluate a service for the homeless mentally ill.	Aberdeen, outreach at a variety of locations (e.g. hostels).	<p>The CPN offered a drop-in service.</p> <p><u>Staffing:</u> One CPN linked to an existing adult mental health team that had access to in-patient facilities.</p>	Quantitative study using a case series design.	<p><u>Process:</u> CPN collected data on all new clients referred in the first three years of the service.</p> <p><u>Characteristics:</u> 86 referrals, predominantly male (n=64) and average age was 35.8 years.</p>
7. Power & Attenborough (2003).	The study aimed to investigate how successful the project has been at ‘helping clients to achieve a more settled lifestyle’.	Lambeth, Lewisham and Southwark (inner London boroughs).	<p>South Thames Assessment Resource and Training (START) operated as an outreach model and aimed to integrate homeless clients with mental health problems back into their communities and increase access to mental health services by establishing contact with local and statutory and voluntary organisations.</p> <p><u>Staffing:</u> Initially five mental health professionals, expanding to twenty including CPN’s, Social Workers, Occupational Therapists and Psychiatrists.</p>	Quantitative study using post-test design.	<p><u>Process:</u> Follow up data was collected on previous START clients approximately four years after their initial referral to the project from current caseworkers or from their last known addresses.</p> <p><u>Characteristics:</u> 100 consecutive clients referred to START between January 1994 and December 1994. Sample was predominantly male (90%) and ranged in age from 17 to 71 years of age. There was a 27% attrition rate.</p>

Appendix C (continued)					
Study	Aim	Setting	Intervention	Study design	Sampling process and characteristics
8. Killapsy et al. (2004).	To identify whether admission to a designated in-patient ward for the homeless improved outcome 12 months after discharge.	London boroughs of Camden and Islington.	<p>A new 12 bed inpatient ward designated for Focus clients (a homeless outreach team) was set up with the aim of providing more co-ordinated discharge plans, to promote further engagement with the Focus Team and increase the chance of stable housing both at discharge and 12 months later.</p> <p><u>Staffing:</u> No information given in relation to the Focus Team, but 'one Consultant Psychiatrist' was described as overseeing the new inpatient ward.</p>	Quantitative cohort study using a pre-test post-test design.	<p><u>Process:</u> Data collected from care co-ordinators on all Focus Team clients admitted to an inpatient facility between January 2001 and January 2002. From this total sample, 29 (58%) were admitted to the designated ward and the remaining 21 clients who were admitted to other wards became the control group.</p> <p><u>Characteristics:</u> 50 clients, 74% of which were male and the mean age was 42.</p>
9. Maguire (2006).	To investigate the effects of a CBT intervention (a pilot study).	A 'house' providing a therapeutic environment in Southampton.	<p>Staff training on CBT combined with ongoing supervision and reflective practice, one to one weekly sessions with service users with the Psychologist and further input for the clients from the support workers.</p> <p><u>Staffing:</u> One Clinical Psychologist.</p>	Quantitative study using a pre-test post-test design.	<p><u>Process:</u> Sample identified on the basis of need and data was collected at assessment, entry to the project and at ten weeks.</p> <p><u>Characteristics:</u> Four homeless men, who had recently attended a physiological detoxification for alcohol and/or substance misuse problems, were sleeping rough and found it difficult to access hostels. 15 support staff received the training.</p>
10. Taylor et al. (2007a).	To ascertain the clinical outcome for homeless young people referred to a new mental health service.	18 voluntary sector homeless shelters for young people in various sites across England.	<p>'Strong Minded', a mental health service covering 18 homeless shelters in five areas. Staff offered a variety of interventions including counselling skills, CBT, substance use interventions and psycho-education.</p> <p><u>Staffing:</u> 5 mental health professionals.</p>	Quantitative study using a pre-test post-test design.	<p><u>Process:</u> Sample included all young people referred to the service in its first year. Data was collected by service staff pre and post intervention.</p> <p><u>Characteristics:</u> 150 young people aged between 16 and 29 (mean=19). 53% were female.</p>

Appendix C (continued)					
Study	Aim	Setting	Intervention	Study design	Sampling process and characteristics
11. Cockersell (2011).	To investigate whether a psychotherapeutic intervention reduced the exclusion of chronically excluded adults.	Rooms used in eight different community and hospital settings in London (e.g. at a hostel, GP practice, psychiatric hospital).	<p>A psychodynamic psychotherapy service offering up to 25 sessions of individual therapy.</p> <p><u>Staffing:</u> Experienced part time UKCP registered psychodynamic psychotherapists delivering up to 100 sessions a week. Other staff included a project manager, an information and referrals worker and two clinical supervisors.</p>	Quantitative study using a pre-test, post-test design (NB: Also incorporates a comparison group).	<p><u>Process:</u> Sample included all clients referred to the service who attended a first appointment. Comparison group drawn from residents of St Mungo's with 'similar baselines' that had not attended psychotherapy, numbers unknown.</p> <p><u>Characteristics:</u> 247 homeless adults, 70% male, 68% 'white' and 32% 'black'. Comparable to overall population of St Mungo's residents (i.e. 76% male, 66% 'white', 34% 'black'). 30% of those referred did not attend their first appointment, therefore are excluded.</p>
12. Bhui et al. (2006).	To ascertain the perceptions of service users in regard to the adequacy of services for homeless clients with mental health.	Homeless services (voluntary and statutory) across East London.	Not applicable as the study asked about services in general rather than in regard to one in particular.	Qualitative study using semi-structured interviews.	<p><u>Process:</u> Posters displayed in homeless services invited service users experiencing 'mental health problems' to take part in an interview.</p> <p><u>Characteristics:</u> 10 homeless adults aged between 19 and 54 (6 were male).</p>
13. Taylor et al. (2007b)	To establish young homeless people's experiences of a new voluntary sector mental health service.	18 voluntary sector homeless shelters for young people across five locations in the UK.	<p>Strong Minded, voluntary sector mental health service for homeless young people It provided assessment, therapeutic sessions (e.g. CBT and counselling), referral to external services and training.</p> <p><u>Staffing:</u> Five 'Mental Health Co-ordinators' four trained as CPN's and one was a Counsellor.</p>	Qualitative study using semi-structured interviews.	<p><u>Process:</u> Five homeless shelters selected based on size and location and then all clients in current caseloads were asked to take part. If caseloads were less than five then the most recently discharged young people were also asked to participate.</p> <p><u>Characteristics:</u> 19 young people aged 16-23 (mean=19), 13 were female and six were male.</p>

Appendix D: A table displaying the data collected, analysis, key findings, reflexivity and key limitations of each of 13 research studies

Study	Data collected	Analysis	Key findings	Ethical considerations	Reflexivity	Key limitations
1. Joseph et al. (1990).	Psychiatric diagnosis and attendance rate at the clinic.	Not described. Findings included descriptive and non-parametric statistics.	<p>Clients diagnosed with schizophrenia were more likely to be ‘long attenders’ than clients without this diagnosis.</p> <p>Clients diagnosed with schizophrenia in particular ‘appeared’ to benefit most from attending the clinic and the ‘mental state’ of ‘many’ of these clients was found to have either ‘stabilised’ or ‘improved’.</p>	Not described.	Not applicable.	Limited description of the setting and intervention.
2. Bhugra et al. (1997).	Questionnaires including history of psychiatric illness, socio-demographics and user satisfaction (GHQ-12).	Analysis described as being conducted on SPSS. Descriptive and parametric statistics were presented in the findings.	<p>All found the service to be both ‘safe’ and ‘welcoming’. Two people described the workers as ‘unhelpful’ whereas the remaining 68 found them ‘helpful’ and ‘friendly’.</p> <p>Out of the 36 clients who had used the project for ‘support’, and ‘advice’, 6% described it as ‘average’, 8% as ‘poor’ and 86% ‘good’ or ‘excellent’.</p>	Service users were informed that opting out of taking part in the research would not affect the services they received.	Not applicable.	<p>Limited description of the setting and intervention.</p> <p>Sample not representative of a homeless population only 35% were living in ‘insecure accommodation’.</p> <p>Outcome measures not well described.</p>
3. Commander et al. (1997).	Data collected on numbers and characteristics of admissions to the psychiatric wards and follow up rates at discharge.	Not described. Findings section reported both descriptive statistics and referred to ‘statistical differences’ but no full statistical output was reported.	<p>91 people were admitted to the psychiatric ward (106 admissions) following the inception of the CMHT compared with 87 people (105 admissions) previously recorded. Therefore the development of the CMHT did not reduce the need for in-patient care.</p> <p>In many cases discharge still occurred without follow-up but increased from 46% of cases to 72% of cases with the inception of the team.</p>	Not described.	Not applicable.	Different data collection methods (i.e. record search and the direct questioning of ward staff) may not be directly comparable, especially as the data was also drawn from different hospital wards.

Appendix D (continued)						
Study	Data collected	Analysis	Key findings	Ethical considerations	Reflexivity	Key limitations
4. Graham et al. (1999).	Professionals with 'current and personal knowledge' of clients were 'interviewed' in regard to 'outcome' (e.g. good/average).	Not described. Descriptive and non-parametric statistics are presented.	Outcomes were determined to be 'good' in 11 cases and 'average' in seven cases. Factors identified as contributing to these positive outcomes were identified. Clients who experienced psychosis at admission were significantly more likely to be in touch with 'generic' services at follow-up and have 'confirmed accommodation' than those who did not.	Not described.	Not applicable.	Hard to ascertain clearly the aims and outcomes. Potential for measurement bias is high due to collecting self-report data from staff who were asked to recall patients discharged between 12 and 28 months previously.
5. Odell & Commander (1999).	Information was collected on housing status, risk and mental state.	Data analysis described as non-parametric tests using SPSS.	Significant improvements found in the number of clients experiencing psychotic symptoms and those who were rough sleeping at follow-up. Lower rates of substance use and depressed mood were not statistically significant. Risk issues remained prevalent (i.e. substance misuse and criminality).	Not described.	Not applicable.	Potential for measurement bias as data was collected by staff, who due to their employment had a vested interest in the outcome.
6. Wood et al. (2001).	Current psychiatric symptoms and the length of contact with the service.	Not described. Descriptive statistics were presented.	42 out of the 86 clients presented with a 'serious and enduring mental illness'. Many received 'assessment' only' (n=50), 25 had 'brief contact' (i.e. maximum five sessions) and 11 received 'on-going care' from the service (i.e. more than five sessions).	Not described.	Not applicable.	The study appears to describe rather than 'evaluate' the service due to the use of length of contact as an outcome measure.
7. Power & Attenborough (2003).	Housing status and if clients remained in contact with other mental health services.	Not described. Descriptive statistics were presented on outcome variables.	At follow-up, 49% of clients were living in more permanent accommodation with 28% of these living in their own flats. 10% were still homeless (i.e. sleeping out, living within a direct access hostel or sleeping on a friend's floor). 55% of clients were still in contact with some kind of mental health-related service.	Not described.	Not applicable.	Exclusion of clients from the sample that had less than six contacts with the service could introduce sampling bias.

Appendix D (continued)						
Study	Data collected	Analysis	Key findings	Ethical considerations	Reflexivity	Key limitations
8. Killaspy et al. (2004).	Housing status at twelve months and whether or not they engaged with the Focus team following discharge from the inpatient facility.	Statistical analysis was conducted using SPSS and Stata software to compare cases and controls using parametric and non parametric tests.	<p>No statistical differences were found between the two groups in regard their likelihood of living in stable accommodation at 12 month follow up.</p> <p>There were statistical differences found between cases and controls in regard to engagement, with cases being more likely to improve on this measure.</p>	A Local Research Ethics Committee approved the study and that anonymised outcome data could be collected for all eligible clients regardless of their consent.	Not applicable.	Clients in the case group were found to be more likely to be living on the streets at admission than controls. It is unlikely that ward allocation was naturalistic and therefore introduces selection bias in allocation to the two groups.
9. Maguire (2006).	<p>Measures of self efficacy, alcohol dependence, functioning and risk and self-report data from clients.</p> <p>Pre-post training questionnaires completed by staff on self efficacy and stress levels.</p>	No description of analysis or framework given. Results are presented as descriptive statistics and one parametric test.	<p>At ten week follow up, all four men displayed reduced levels of theft, violence, alcohol consumption and risk to self and others. Perceived self efficacy increased slightly for all men. Pre-post scores on CORE (Clinical Outcomes for Routine Evaluation) showed mixed results with total scores increasing for half of the sample, and decreasing for the other half.</p> <p>There were significant differences found in the questionnaire scores completed by staff reflecting lower levels of stress post training and increased self efficacy in influencing change in their client group.</p>	Not described.	Not applicable.	<p>Intervention context not well described.</p> <p>Recent detoxification of the sample prior to being recruited may have contributed to the positive outcome as could the recent move into stable accommodation.</p> <p>Not all measures used are described.</p> <p>Small sample and short follow-up period.</p>

Appendix D (continued)						
Study	Data collected	Analysis	Key findings	Ethical considerations	Reflexivity	Key limitations
10. Taylor et al. (2007a).	A risk assessment and HoNOS (Health of the Nation Outcome Scales).	Statistical analysis using both descriptive and non-parametric statistics.	For those young people who had contact with the service on more than one occasion (n=74), HoNOS total scores and ten of the subscales improved significantly. Only one risk behaviour was found to significantly decrease (self harm).	Not described.	Not applicable.	High attrition rate increased risk of sampling bias. Potential for response bias due to staff with a vested interest in the service completing the outcome measures.
11. Cockersell (2011).	Attendance rates, two outcome measures (i.e. Wellbeing Impact Assessment Measure, Outcomes Star), changes in accommodation status and take up of employment or training opportunities.	Not described in detail. Information given in regard to how the Outcomes Star domains were mapped on the Cycle of Change enabling outcomes to be determined in terms of progress through this cycle. Descriptive statistics were presented.	80% who attended assessment attended four or more times. Attendance rate 76%. 76% of clients 'positively improved' on range of domains measured by the Wellbeing Impact Assessment Measure. Clients showed greater outcomes on all areas of the Outcomes Star in comparison to the control group, largest improvement in the domain of 'meaningful occupation.' Clients three times more likely to progress through the 'Cycle of Change' (i.e. from 'pre- contemplation' to 'action') than controls. At discharge, 42% of client's were in employment, education, voluntary placements or training, in comparison to 21% of the control group. No information on changes in accommodation status presented.	Not described.	Not applicable.	Findings only provided in regard to four of the five areas in which data was collected. Reasons unknown. Missing information regarding size and characteristics of comparison group and how used, description of the outcome measures, and how and why the data was collected make it difficult to gain full grasp of the study. No raw data is presented on which the findings are drawn. Not a 'proper research program' (i.e. as identified by the author).

Appendix D (continued)						
Study	Data collected	Analysis	Key findings	Ethical considerations	Reflexivity	Key limitations
12. Bhui et al. (2006).	Semi-structured interviews.	Tape recorded interviews were transcribed and then subjected to thematic analysis.	Seven broad themes were identified, these were 'health and biography', 'stigma', 'service provision', 'coping', 'finances', 'hostels and homelessness' and 'recommendations to improve services'. Mental health services were rarely mentioned. Physical health and social problems appeared to be more important for the interviewees.	Informed consent was ensured and a Local Research Ethics Committee provided ethical approval.	None identified.	Small, self selected sample. Findings may be influenced by their interview guide which prompted for 'mental illness' in regard to problem areas in their lives but did not appear to prompt for their views of mental health services.
13. Taylor et al. (2007b).	Semi-structured interviews.	Interviews professionally transcribed and subjected to thematic analysis using Nvivo (computerised data analysis package) and pen and paper techniques. Emerging themes were discussed by the research team periodically.	Two main themes were identified. Firstly, young people's views were consistently positive. They all felt that they had benefited from being referred to the service. Secondly, aspects of the service which were perceived by the young people as contributing to its effectiveness were identified (i.e. confidentiality, mental health co-ordinator being separate from shelter staff, offering in-house services, telephone contact, meeting outside of the homeless shelter, supporting referral to other agencies, outreach work).	Ethical approval granted by NHS Multi-centre Research Ethics Committee (MREC). The interview process was fully explained (e.g. confidentiality and right to withdraw).	None identified.	Small sample. Reliance on self report.

Appendix E: Statement of epistemological position

Underpinning the current research design lies the epistemological assumption of ‘critical realism’. This position accepts that the world and the social and psychological realities within it, are seen to be neither objectively knowable (i.e. a position of ‘naïve realism’), or non existent (i.e. ‘extreme relativism’), but instead as falling somewhere in-between (Willig, 2001). From this critical realist perspective, reality is seen to exist, but attempts to understand it are seen as distorted by the distal powers in society and different people’s perspectives and the meanings that they place upon it (Shaw, 2010).

In line with this epistemological position, whilst attempting to ‘hear’ what it means for participants to be homeless and have psychological needs, the Researcher acknowledged that their ‘life worlds’ cannot be directly accessed through language (i.e. through interview). It is therefore accepted by the Researcher that the ‘findings’ that emerge from the current research study will reflect only one version of each participant’s reality. It is also recognised that these collective versions will have been distorted both by the participant’s attempts to make sense of their experiences during the research interview, and the Researcher’s attempts to make sense of their account through later analysis (Smith et al., 2009).

Appendix F: Brief Information Leaflet

(Designed to be folded into three)

7) How do I know that taking part in this research is safe?

This research has been independently reviewed and approved by a Research Ethics Committee.

8) What should I do next if I want to take part?

You can either:

- A) Tell a member of the Homeless Psychology Service (or the Homeless Mental Health Service) that you are happy for your contact details to be passed on to Ellie.

OR

- A) Phone, text or write to Ellie directly on the contact details given on this leaflet and let her know the best way to contact you.

Ellie will then arrange a convenient time to meet up and will answer any questions that you might have. You will be asked to sign a consent form to show that you are happy to take part.

9) Contact details:

Text, phone or write to:

Miss Ellie Taylor,
School of Psychology
Doctorate in Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Mobile number (for research purposes only): *****

Please ask if you would like any further information before making your decision.

Please note: Interviews will be conducted up until September 2011, after this time it will no longer be possible to participate in this project. The short title of this research is "The experiences of service users of a homeless psychology service (v1)" This Brief Information Leaflet was written on the 19th of October 2010. Further information can be found in the full length 'Participant Information Sheet'. Copies of this are available from Ellie and from the Homeless Psychology Service.

Have you ever used the Homeless Psychology Service?

Would you be happy to talk to someone about your experiences and receive a £10 shop voucher in recognition of your time?

If so, we could really do with your help

This brief information leaflet will tell you more about what will happen if you choose to take part in this research study.

Help us to increase understanding so that services can do better at meeting the needs of homeless adults.



1) Why is this research important?

It is well known that being homeless can be a very negative experience for many people. Lots of research has shown that being homeless can make it especially difficult to access services (e.g. if you need to see a doctor, or speak to someone if you feel unhappy). This is very unfair because everyone should be able to access services.

Specialist services for homeless adults are rare. There are only two specialist Homeless Psychology services in the country (one here in ***** and one in *****).

This will be the first piece of research in this country to ask service users how they have experienced these services.

We are hoping that by understanding your experiences we can start to look at how services across the country can become better at meeting the needs of people who are homeless. We also hope that our research will help to provide more funding so that more services can be set up.

2) What is the purpose of this research?

We want to understand the lives, needs and experiences of service users (who

have used the Homeless Psychology Service). Only you can provide us with this information and this is why we are asking for your help.

3) What will agreeing to take part involve?

If you agree to take part, you will be asked to meet with a researcher (called Ellie) in a convenient location to have a chat about your experiences of being homeless and of using the Homeless Psychology Service.

You can choose how much information you would like to share with Ellie. This will take about an hour and the conversation will be recorded on a small tape recorder. This is nothing to worry about; it is just to make sure that we do not miss anything that you say.

4) Will it be confidential?

Yes, when we write the findings of this research into a report, what you have said will be quoted anonymously (without your name). We will also do all that we can to ensure that anyone reading the research findings will not know that you took part in it (e.g. by removing any names of places or people that you have mentioned).

All information that you disclose to us that could be used to identify you (i.e. name, address) will be stored securely.

The only times that we might have to breach your confidentiality is if you tell us that you or a child or young person is in danger, or if you want to make a serious complaint against an NHS service.

4) Do I have to take part?

You can choose whether or not you want to take part. Your decision will not affect the care that you are receiving from any service.

5) What will happen to the findings of the study?

The findings will be written up as a report and summaries of the findings will be made available to service users, services and managers locally and nationally. You will be asked if you would like to receive a copy.

6) Who is organising and funding this research?

This research is funded by the University of Leicester. It is an independent research study that is being organised by the University of Leicester.

Appendix G: Participant Information Sheet

(Printed on University of Leicester headed paper)

Protocol reference number: v8
Participant Information Sheet (service users)
Version 2, 25/2/2011

The experiences of service users of a homeless psychology service

Participant Information Sheet

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being done, and what taking part would involve for you. A member of our research team will go through this information sheet with you and will answer any questions that you may have. We think that this should take about fifteen minutes. You can talk to other people about this research study if you wish to. Please take your time to read the following information carefully. Part one tells you about the purpose of this research study and what will happen if you take part. Part two gives you more information about this research study. Please ask if anything is not clear.

Part 1

Background

Over the past twenty years there has been a lot written about how being homeless can be a very negative experience for many people. Lots of research has found that homeless adults are more likely to be more physically and emotionally unwell than housed adults. It is also well known that being homeless can make it especially difficult to access services (for example if you need to see a doctor, or speak to someone if you feel stressed or upset). This is very unfair as everyone should be able to access services in our society.

In some areas, these difficulties have been recognised and specialist services have been set up to try to make sure that homeless adults can access the services that they need. Right now there are only two specialist Homeless Psychology Services in England, one of these is here in ***** and the other is in *****.

Right now, we do not know how these services are experienced by the people who use them, but we really want to find out! This research is very important so that we can understand how people experience services and how they might be improved. It is also hoped that the findings from this research will open doors to more funding opportunities so that more services like the Homeless Psychology Service can be set up across the country.

What is the purpose of the study?

The aim of this study is to understand the lives, needs and experiences of service users (who have used the Homeless Psychology Service). Only you can provide us with this information which is why we are asking for your help.

Why have I been invited to take part?

Over the next six months we will be asking people who have had contact with the Homeless Psychology Service to help us with our research. We would really appreciate it if you would spare the time to meet with a researcher (called Ellie) for a chat so that we can learn about your experiences and ideas and understand your views.

Do I have to take part?

It is up to you to choose whether you wish to take part in this research study. If you agree to take part we will ask you to sign a consent form to show your agreement. You are free to withdraw from this study at any time, without giving a reason.

What will I have to do?

If you agree to help us, Ellie will come and meet with you and have a chat with you about a number of things including:

- What it has been like for you being homeless
- What you think you have needed in regard to support
- Your experience of the Homeless Psychology Service
- What you think needs to change to ensure that people who are homeless get the support that they need.

You do not have to worry about saying the right or wrong thing because there are no right or wrong answers! We just want to know what you think. You will not be asked any really personal questions and you can choose not to answer any questions that you feel uncomfortable with. It will take about an hour, and during this time you can also ask to stop for a break or terminate the discussion at any time you wish to.

This interview would take place at a time and place convenient to you (e.g. ***** or at a Hostel). Your interview will be recorded on a small tape recorder, and will be transcribed (written down) onto paper. This is nothing to worry about; it is just to make sure that we do not miss anything that you say.

What are the possible disadvantages and risks of taking part?

This study has been designed to ensure that the possible disadvantages and risks to you from taking part in this study are very small. This study has also been designed to cause minimal inconvenience to you in relation to time (i.e. one hour) and travel. Although talking about personal experiences can sometimes be difficult, it is not expected that taking part in this research study will cause you personal distress. If you do find taking part in the interview difficult, we may recommend that you be re-referred to the

Homeless Psychology or Mental Health Service for support, or that you seek further support from your GP.

What are the possible benefits of taking part?

It is hoped that the information that you share will have a direct impact on the quality of services received by adults who are homeless. In recognition of your time, you will be offered a £10 gift voucher for taking part in this research study and will be provided with a drink and a snack during the interview.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?

Yes. The interview will be just between Ellie and yourself and you do not need to mention your name or any personal details during the interview. We will follow ethical and legal practice and all information will be handled in confidence. Further details are included in Part 2.

This completes Part 1 of this information sheet. If you are considering taking part, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study

You are free to drop out of this research at any time, without giving us any reason for your withdrawal. The standard of care that you receive will not be affected by either your decision to take part, or your decision to withdraw from the research at a later stage. If you decide to withdraw from the research we will destroy any information that may identify you (i.e. address, telephone number) but we will need to use the data that we have collected from you up until the point of your withdrawal.

What if there is a problem in the future?

If you have any concerns about any aspect of this research study, or if you feel that you have experienced any harm from taking part then please contact Ellie who will do her best to solve your concerns or deal with your complaint.

If you remain unhappy and feel that you were harmed during the research and that this is due to somebody's negligence then you may have grounds of a legal action for compensation against the University of Leicester, but you may have to pay your legal costs. If you would rather speak to someone other than Ellie about your complaint, or if you would like to find out about the University complaints procedure, then please contact Dr. Marilyn Christie at the University of Leicester on 0116 2231639.

Will my taking part in the study be kept confidential?

Yes, all information that you share with us will be handled in confidence and stored securely. Information that you disclose to us that could be used to identify you (i.e. name, address, telephone number) will be stored separately from your research data and will be destroyed at the end of the research programme. Access to research data will only be available to Ellie and her supervisor at the University of Leicester (Dr. Marilyn Christie). At the end of the research project, in line with University of Leicester guidelines, the research data (i.e. audio tape) will be stored securely at the University for five years.

When this research is made into a report, what you have said may be quoted anonymously (without your name). In writing any reports we will do all that we can to ensure that it will not be possible for anyone who reads the research to know that you took part in it, or what you told Ellie. If you do mention any names of people or places, these will either be changed or deleted from your interview transcript.

The only two exceptions are if you tell Ellie that you or a child or young person is in danger, or if you wish to make raise a serious complaint against the Homeless Psychology Service. If you share information of this nature then it will be necessary to take this information forward in line with ***** NHS Trust policy which may mean breaking your confidentiality.

What will happen to the results of the research study?

The results will be presented in a final report for the University of Leicester and shorter summary reports will be made available to local service users, services and managers. Findings may also be incorporated into the Homeless Psychology Service's advertising so that new users of the service can learn about what other people have found helpful. To make sure that other staff, organisations, policy makers and those responsible for funding and planning services outside of ***** hear about your views, attempts will also be made to publish these findings in journals and present them at conferences. As explained above, no personal details that might identify you will be included. Please ask if you wish to receive a copy of the findings of the study.

Who is organising and funding the research?

This research is funded by the University of Leicester. It is an independent piece of research which is being organised by Ellie Taylor (a trainee Clinical Psychologist) and her supervisor at the University of Leicester, Dr Marilyn Christie as part of a Doctorate in Clinical Psychology. Both Ellie and Marilyn are based at the University of Leicester.

Who has reviewed the study?

To protect your rights and safety this research has been reviewed by an independent group of people called a Research Ethics Committee. This study has been given a favourable opinion by the ***** Research Ethics Committee. It is being conducted in line with the British Psychological Society's ethical guidelines.

What if I have any more questions now?

Please ask if you would like any further information before making your decision.
Text, phone or write to:

Miss Ellie Taylor,
School of Psychology
Doctorate in Clinical Psychology
104 Regent Road, Leicester, LE1 7LT.
Mobile number (for research purposes only): *****

What should I do next if I want to take part?

If you do not wish to take part, you do not have to and this will not affect the services that you receive in any way. However, if you would like to take part and share your experiences you can either:

- A) Tell a member of the Homeless Psychology Service/Homeless Mental Health Service that you are happy for your contact details to be passed on to Ellie.

OR

- B) Phone, text or write to Ellie directly on the contact details given above and let her know the best way to contact you.

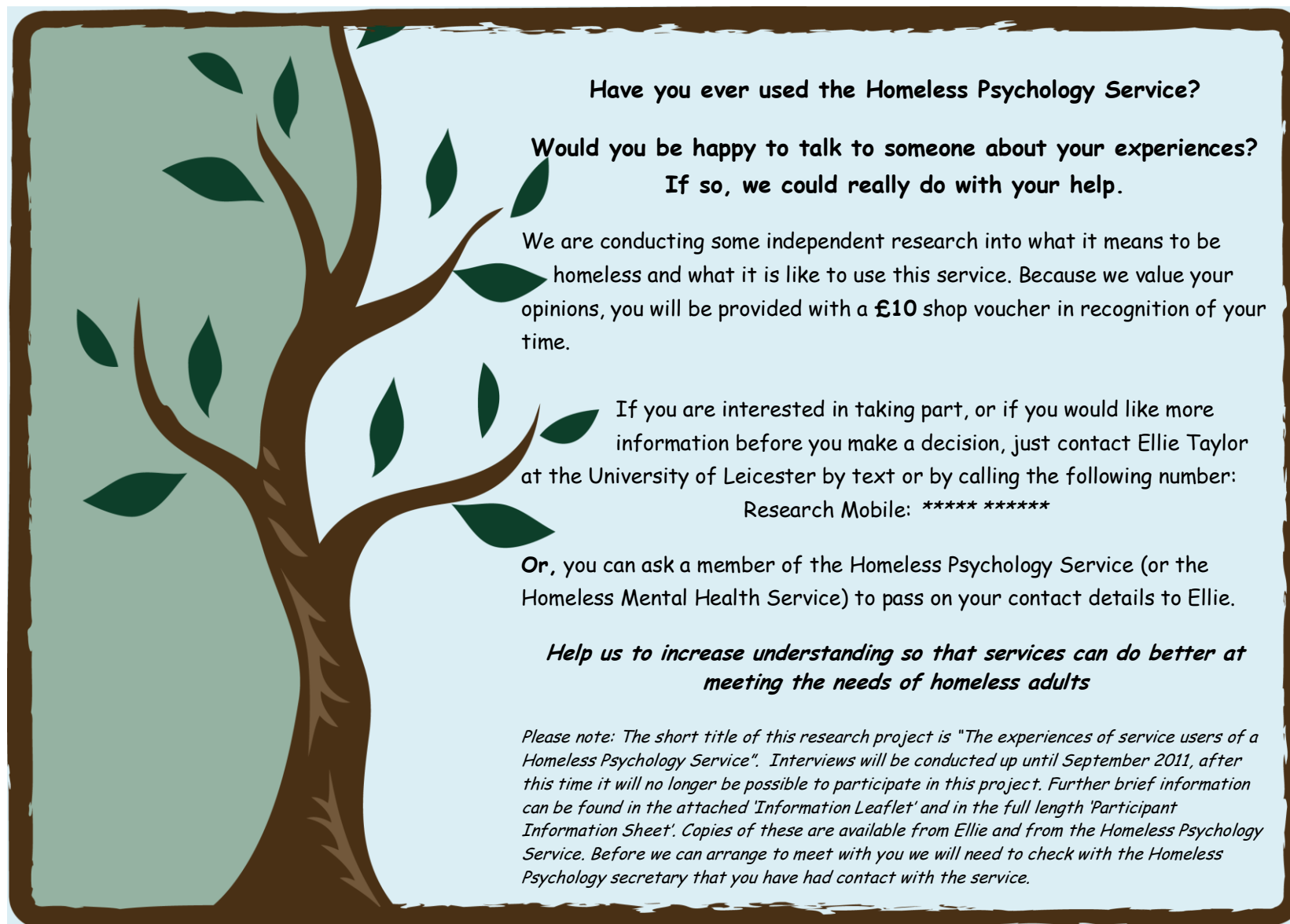
Ellie will then talk to you to arrange a convenient time to meet up and will answer any questions that you might have. When you meet with Ellie you will be given the opportunity to ask more questions if you would like to and you will be asked to sign a consent form to show that you are happy to take part.

Thank you for taking the time to read this information sheet. Please keep hold of this information sheet so that you can look at it again in the future if you wish to.

Miss Ellie Taylor (Researcher)

Dr. Marilyn Christie (Supervisor)

Appendix H: Poster advertising the research study



Appendix I: Consent Form

(Printed on University of Leicester headed paper)

Centre Number: 1

Study Number: 11/EM/0012

Patient Identification Number for this trial:

CONSENT FORM (service users)

Title of Project: **The experiences of service users of a homeless psychology service**

Name of Researcher: Helen (known as Ellie) Taylor

Please initial box

- | | | |
|----|--|--------------------------|
| 1. | I confirm that I have read and understand the information sheet dated 25/2/2011 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2. | I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. | <input type="checkbox"/> |
| 3. | I understand that research data collected during the study may be looked at by individuals from the University of Leicester. I give permission for these individuals to have access to my research data. | <input type="checkbox"/> |
| 4. | I agree to take part in the above study. | <input type="checkbox"/> |

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

When completed, 1 for participant; 1 for researcher site file. This Consent Form will not be linked with your interview tape, and your name will not be used within any research report.

Appendix J: Topic Guide

The experiences of service users of a homeless psychology service

Topic Guide

- Tell me about how you became homeless and what being homeless has been like for you?
- Tell me about what led up to your contact with the Homeless Psychology Service? (*i.e. asking about mental health/psychological difficulties and needs without using this terminology*).
 - Possible prompts for further information may be in regard to:
 - Needs/impact (*of mental health-related difficulties on their lives*)
 - What has been most difficult
 - What helps
 - Choices (*how referred*)
 - Understanding (*advertising*)
 - Hopes/fears/desired ‘outcomes’
- I’m very interested in the word ‘psychology’ and what it means to people: What does it mean to you personally?
- What was it like for you using the Homeless Psychology Service?
 - Possible prompts for further information may be in regard to:
 - Barriers (e.g. stigma, drugs/alcohol, DNA-ing, disengagement)
 - Positives/negatives/‘outcomes’
- What do you think needs to be changed to improve the support that people who are homeless receive?
- In many cities, services like the Homeless Psychology Service do not exist. From your perspective what advice would you offer in regard to how new services should be developed?
- Would you mind telling me why you decided to give up your time and take part in this interview today?
- Do you mind if I ask you what your experience of being interviewed has been like?

Appendix K: Voucher Receipt Form

The experiences of service users of a homeless psychology service

Voucher Receipt Form

Please complete the following to document the fact that you have received a £10 shop voucher in recognition of your time for taking part in the above research study.

Print your name here.....

Sign your name here.....

Date.....

NB: This Voucher Receipt form will not be linked with your interview tape, and your name will not be used within any research report.

Appendix L: Summary Report Request Form

The experiences of service users of a homeless psychology service

Summary Report Request Form

If you would like to receive a Summary Report of the findings from this research study, then please complete the following information below. It is anticipated that these research findings will be available in Summer 2012. Copies will also be available from the Homeless Psychology Service.

Print your name here

Address.....

.....
.....
.....
.....

If you do not have a current address, then please provide me with a contact telephone number. When the Summary Report is ready, I will make contact to find out where you would like it sent to.

.....
.....
.....
.....

NB: This Summary Report Request form will not be linked with your interview tape, and your name will not be used within any research report.

Appendix M: List of Local Support Agencies

The experiences of service users of a homeless psychology service

List of Local Support Agencies

If after I leave today you think of any questions or concerns about the interview then please contact me on the research mobile number: *****

Sometimes people find that taking part in a research interview where they talk about things that have happened in their lives can affect their mood. If you are worried about how you are feeling please contact your GP or the Homeless Mental Health Team on *****.

Alternatively, if you would like to, you could contact any of the organisations below. These organisations may also be able to offer you advice on who to contact for other related issues that are not listed here.

Type of support agency	Name and contact details	Opening times
General support	Samaritans National helpline: 08457 909090. Local helpline: *****.	<u>Helpline:</u> All day, every day.
Housing	Housing Options (***** City Council) Provides help and advice with housing issues (e.g. finding somewhere to live, understanding benefits and legal rights).***** *****.	<u>Open:</u> Mon, 9am-4pm. Tues, 1pm-4pm. Wed-Fri, 9am-4pm.
Rape/sexual abuse (men)	***** Local helpline and face to face counselling/support.*****.	<u>Helpline:</u> 4pm-8pm Mon & Tues. Answer phone available at other times for self referral.
Rape/sexual abuse (women)	***** Local helpline and face to face counselling/support.*****.	<u>Helpline:</u> 10am-4pm Tue-Fri and 6pm-9pm Wed & Thurs. Answer phone available at other times for self referral.

Domestic violence	***** Local helpline and face to face support: **** *.	<u>Helpline:</u> Mon-Fri, 10am-3pm. Mon-Thurs, 7pm-9pm. Sat, 10am-2:30pm. Sun, 12noon-3pm. Answer phone available at other times for self referral.
Alcohol	***** Local helpline and drop in centre for support and advice:**** *.	<u>Helpline:</u> Mon/Wed/Thurs 9am-4pm. <u>Drop in:</u> Mon/Wed/Fri 9am-3pm, Tue 12-3pm, Fri 9am-3pm.
Drugs	***** Centre Local helpline and drop in centre for support and advice:**** *.	<u>Drop in & Helpline:</u> Mon, 9:15am-4pm. Tues, 1pm-4pm. Wed, 9:15am-12:15pm. Thurs, 9:15am-4pm. Fri, 9:15am-12:15pm. <u>Drop in only:</u> Sat, 10am-2pm.
Mental health	SANeline National Helpline offering emotional support and information for people affected by mental health problems: 08457 678000.	<u>Helpline:</u> 6pm-11pm every day.
Crime	Victim Support Local helpline for emotional and practical support: **** *.	<u>Helpline:</u> 8am-8pm Mon-Fri.

You may also wish to complete the following information in regard to your own personal support network:

My doctor's (GP's) name & telephone

number:.....

Other people that I can rely on to support me (this might include other professionals or friends/family members).....

.....
.....
.....

Thank you again for taking part in this research study, Ellie Taylor ☺

Appendix N: Letters to and from ethics committees

[REDACTED] Research Ethics Committee

Telephone: [REDACTED]
Facsimile: [REDACTED]

07 February 2011

Miss Helen Taylor
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust
School of Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Miss Taylor

Full title of study: Being homeless and experiencing mental health related difficulties: Listening to and learning from the experiences of service users of a designated homeless psychology service.
REC reference number: 11/EM/0012

Thank you for your application for ethical review, which was received on 28 January 2011. I can confirm that the application is valid and will be reviewed by the Committee at the meeting on 15 February 2011.

Meeting arrangements

The meeting will be held in the [REDACTED] on 15 February 2011. The Committee would find it helpful if you could attend the meeting to respond to any questions from members. Other key investigators and a representative of the sponsor are also welcome to attend. This may avoid the need to request further information after the meeting and enable the Committee to make a decision on the application more quickly.

If you have a disability and need any practical support when attending the REC meeting you may wish to contact the REC office so appropriate arrangements can be made if necessary.

If you are unable to attend the meeting the Committee will review the application in your absence.

The review of the application has been scheduled for 14:30. Would you please let me know whether or not you would be available to attend at this time. Please note that it is difficult to be precise about the timing as it will depend on the progress of the meeting. We would kindly ask you to be prepared to wait beyond the allocated time if necessary.

Committee meetings are occasionally attended by observers, who will have no vested interest in the applications under review or take any part in discussion. All observers are required to sign a confidentiality agreement.

Documents received

The documents to be reviewed are as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Protocol	8	15 December 2010
Participant Information Sheet: Service Users	1	17 October 2010
REC application	69720/183414/1/85	15 December 2010
Service User Reference Group Evaluation of Trainee Research		21 January 2011
Participant Information Sheet: Dissemination Focus Group	1	26 October 2010
Investigator CV		20 January 2011
Investigator CV		
Participant Information Sheet: Brief	1	19 October 2010
Participant Consent Form: Dissemination Focus Group		
Participant Consent Form: Service Users		
Interview Schedules/Topic Guides	1	18 October 2010
Advertisement		
Referees or other scientific critique report		09 November 2010
Covering Letter		26 January 2011
Voucher Receipt Form	1	10 October 2010
Summary Report Request Form	1	10 October 2010
List of Local Support Agencies	1	10 October 2010

No changes may be made to the application before the meeting. If you envisage that changes might be required, we would advise you to withdraw the application and re-submit it.

Notification of the Committee's decision

You will receive written notification of the outcome of the review within 10 working days of the meeting. The Committee will issue a final ethical opinion on the application within a maximum of 60 days from the date of receipt, excluding any time taken by you to respond fully to one request for further information or clarification after the meeting.

R&D approval

All researchers and local research collaborators who intend to participate in this study at sites in the National Health Service (NHS) or Health and Social Care (HSC) in Northern Ireland should apply to the R&D office for the relevant care organisation. A copy of the Site-Specific Information (SSI) Form should be included with the application for R&D approval. You should advise researchers and local collaborators accordingly.

The R&D approval process may take place at the same time as the ethical review. Final R&D approval will not be confirmed until after a favourable ethical opinion has been given by this Committee.

Guidance on applying for R&D approval is available at <http://www.rdforum.nhs.uk/rdform>.

There is no requirement for separate Site-Specific Assessment as part of the ethical review of this research. The SSI Form should not be submitted to local RECs.

Communication with other bodies

All correspondence from the REC about the application will be copied to the research sponsor and to the R&D office for [REDACTED] NHS Trust. It will be your responsibility to ensure that other investigators, research collaborators and NHS care organisation(s) involved in the study are kept informed of the progress of the review, as necessary.

11/EM/0012**Please quote this number on all correspondence**

Yours sincerely

[REDACTED]**Committee Co-ordinator**

Email: [REDACTED]

Enclosure: *Further information about REC membership and meeting arrangements*

Copy to: Dr [REDACTED]
Dr Marilyn Christie
R&D office for NHS care organisation at lead site [REDACTED]
[REDACTED]



National Research Ethics Service

Research Ethics Committee

Telephone: [REDACTED]
Facsimile: [REDACTED]

22 February 2011

Miss Helen Taylor
Trainee Clinical Psychologist
School of Psychology,
104 Regent Road,
Leicester,
LE1 7LT

Dear Miss Taylor

Study Title: Being homeless and experiencing mental health related difficulties: Listening to and learning from the experiences of service users of a designated homeless psychology service.
REC reference number: 11/EM/0012

The Research Ethics Committee reviewed the above application at the meeting held on 15 February 2011. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Protocol	8	15 December 2010
Participant Information Sheet: Service Users	1	17 October 2010
Investigator CV		20 January 2011
Investigator CV		
Service User Reference Group Evaluation of Trainee Research		21 January 2011
Participant Information Sheet: Dissemination Focus Group	1	26 October 2010
Interview Schedules/Topic Guides	1	18 October 2010
Advertisement		
Referees or other scientific critique report		09 November 2010
REC application	69720/18341 4/1/85	15 December 2010
Participant Information Sheet: Brief	1	19 October 2010
Participant Consent Form: Dissemination Focus Group		
Participant Consent Form: Service Users		
Covering Letter		26 January 2011
Voucher Receipt Form	1	10 October 2010
Summary Report Request Form	1	10 October 2010
List of Local Support Agencies	1	10 October 2010

This Research Ethics Committee is an advisory committee to the [REDACTED] Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Provisional opinion

- The members asked you to explain the exclusion criteria, you informed the committee that poor understanding of English is not an exclusion criteria and you will be able to use the translation services provided if needed and you will go through the PIS and CF if required
- You advised the members that she will be including a complaints procedure leaflet with the PIS, when asked about access to telephones to make complaints you informed the committee that most homeless people have mobile phones and if they did not there is access to phones in some centres
- You showed the committee the voucher that will be used

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

1. Please include the following information in the PIS
 - a. Information about referral to psychology services or GP if required
 - b. Information about the location of the focus group
 - c. Please insert the university logo

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 22 June 2011.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

11/EM/0012**Please quote this number on all correspondence**

Yours sincerely

**Mr**
ChairEmail: 

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to:

Dr  NHS TrustDr Marilyn Christie
School of Psychology
104 Regent Road
Leicester, LE1 7LT

[REDACTED] Research Ethics Committee
Attendance at Committee meeting on 15 February 2011

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr [REDACTED]	Specialty Registrar in Public Health	Yes	
Dr [REDACTED]	Consultant in Pain Medicine	Yes	
Mr [REDACTED]	Statistician	Yes	
Dr [REDACTED]	PRIMIS + Learning Consultant	No	
Mr [REDACTED]	Acting Patient Safety Manager	Yes	
Mrs [REDACTED]	Lay member	Yes	
Dr [REDACTED]	Consultant Microbiologist	No	
Dr [REDACTED]	Senior Research Fellow	Yes	
Dr [REDACTED]	Consultant Gastroenterologist	Yes	
Mrs [REDACTED]	Lay Member	Yes	
Mr [REDACTED]	Senior Planning Inspector	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs [REDACTED]	Coordinater



School of Psychology
Doctorate in Clinical Psychology
104 Regent Road
Leicester
LE1 7LT
Tel: 0116 223 1639
Fax: 0116 223 1650

25th February 2011

Dear Mr [REDACTED]

**Study title: Being homeless and experiencing mental health related difficulties:
Listening to and learning from the experiences of service users of a
designated homeless psychology service.**

REC Reference number: 11/EM/0012

Thank you for your recent letter (dated 22nd February 2011) and for providing me with feedback from the meeting held on the 15th in regard to my research study.

In line with the guidance given by the Research Ethics Committee, I have made the following changes:

- Added information about re-referral to psychology services or GP if required to the service user PIS. The version number and date has been changed.
- Added information in regard to the location of the dissemination focus group on the staff PIS. The version number and date has been changed.
- Inserted the University logo at the top of both of these documents (i.e. service user PIS and staff PIS).

I have included copies of these two updated documents for your perusal. As requested, the changes within the text are highlighted in yellow for your convenience.

Please do not hesitate to contact me if you require any further information. Thank you again for your feedback on this application.

With kind regards

Helen Taylor
Trainee Clinical Psychologist,
University of Leicester.
hct6@le.ac.uk

Enclosures (2)



National Research Ethics Service

Research Ethics Committee

Telephone: [REDACTED]

Facsimile: [REDACTED]

29 March 2011

Miss Helen Taylor
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust
School of Psychology,
104 Regent Road,
Leicester,
LE1 7LT

Dear Miss Taylor

Study title: Being homeless and experiencing mental health related difficulties: Listening to and learning from the experiences of service users of a designated homeless psychology service.

REC reference: 11/EM/0012

Thank you for your letter of 25 February 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

This Research Ethics Committee is an advisory committee to the [REDACTED] Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Interview Schedules/Topic Guides	1	18 October 2010
Advertisement		
Response to Request for Further Information		25 February 2011
Participant Information Sheet: Service Users	2	25 February 2011
REC application	69720/18341 4/1/85	15 December 2010
Service User Reference Group Evaluation of Trainee Research		21 January 2011
Participant Information Sheet: Dissemination Focus Group	2	25 February 2011
Protocol	8	15 December 2010
Referees or other scientific critique report		09 November 2010
Investigator CV		20 January 2011
Investigator CV		
Participant Information Sheet: Brief	1	19 October 2010
Participant Consent Form: Dissemination Focus Group		
Participant Consent Form: Service Users		
Covering Letter		26 January 2011
Voucher Receipt Form	1	10 October 2010
Summary Report Request Form	1	10 October 2010
List of Local Support Agencies	1	10 October 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/EM/0012

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

[Redacted signature]

Mr [Redacted]
Chair

Email: [Redacted]

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr [Redacted]

R&D Office

[Redacted address block]

Appendix O: Additional ethical considerations

Although it was not anticipated that being interviewed would cause distress, the psychological vulnerability of this client group was recognised (Philappot et al., 2007). In an attempt to minimise harm, a list of support agencies was provided to all participants as a precautionary measure to ensure that they had access to support if required. Within the Participant Information Sheet it was also made clear that if participants did find being interviewed difficult, the Researcher could recommend that they were re-referred to the Homeless Mental Health Service, or that they seek further support from their GP. This was necessary on one occasion and agreed to by the individual concerned.

Whilst previous research studies with homeless adults have used monetary payments in recognition of an interviewee's time (e.g. Tischler & Vostanis, 2007), concerns have also been raised that money may be experienced as an incentive for participation and could therefore affect decision making around consent (Head, 2009). It is for this reason that high street gift vouchers were used in this research study. Offering vouchers served to challenge the conventional power dynamics between the 'Researcher' and the 'Researched' through the explicit acknowledgement that they as service users are the experts on their own experiences (Thompson, 1996).

Throughout this research study all personal information and interview data was stored securely (see Participant Information Sheet for further details). As described in the Participant Information Sheet, and inline with the Researcher's conditions of employment, participants were informed that the confidential nature of the their interview would need to be breached if they disclosed that they or a child were at risk

of danger, or if they wanted to make a serious complaint against the Homeless Psychology Service.

Appendix P: Transcription notation and list of pseudonyms

(?)	Missing word/words
(word?)	Not sure if word/words transcribed correctly
(<i>word</i>)	Commentary/notes
<u>word</u>	Verbal emphasis placed on word
*****	Anonymised information
-	Used when words overlap or are re-started
...	Overlap in speech between the interviewer and interviewee

NB: In the results section ‘...’ is used to denote where text has been removed within a quote (e.g. repetition).

Transcript 1: ‘Jon’ (male)

Transcript 2: ‘Jen’ (female)

Transcript 3: ‘Daniel’ (male)

Transcript 4: ‘Ruby’ (female)

Transcript 5: ‘Eve’ (female)

Transcript 6: ‘Mike’ (male)

Transcript 7: ‘Denise’ (female)

Appendix Q: Detailed description of analytic process

The process of IPA analysis followed the guidance offered by Smith et al. (2009). This began by taking the first transcript and reading and re-reading it several times before making initial notes in the margin to capture what mattered to the interviewee and why these things were meaningful to them. These initial notes took the form of: a) 'descriptive comments' (written in normal text); b) 'linguistic comments' (written in capitals); and c) 'conceptual comments' (underlined). Emergent themes were then developed by drawing upon these initial notes as well as the reflexive notes that had been taken during the interview process. Many of these themes reflected participants' original words (e.g. "*I was going through such a lot*"), thoughts (e.g. "*I couldn't understand it*") and feelings (e.g. "*scared*"), as well as early interpretations made by the Researcher (e.g. '*hopelessness*'). The development of these themes was facilitated through the use of Nvivo (i.e. a computerised qualitative data analysis programme) which, like a complex cut-and-pasting device, enabled more rigorous and finer level coding than what could be achieved by hand.

At this stage, although it has been advocated that initial themes from one transcript can be carried over and used to code subsequent transcripts in IPA (i.e. Willig, 2001), in line with Smith et al. (2009), to do justice to each person's individuality, the first transcript was then put to one side, and the same process (i.e. as described in the previous paragraph) was conducted for each individual transcript. The level of analysis was very detailed and identified a large number of themes within each transcript (i.e. between 56 and 119).

As recommended by Smith et al. (2009), because this research study by IPA standards had a large sample and the analysis of individual cases cannot be so detailed,

the search for patterns and connections between themes was held off until all of the transcript's themes were examined together. In order to capture an understanding of the interviewee's shared experiences, each list of themes was printed and stuck onto a very large piece of paper (i.e. divided into seven columns, each containing the themes from one transcript). Viewing all the themes together, it was then possible to look across the seven interviewee's experiences for patterns and connections, which resulted in the identification of six 'super-ordinate themes' which were identified across all transcripts. 'Sub-themes' were also identified which reflected the idiosyncratic ways in which participants experienced the higher order 'super-ordinate themes'.

Appendix R: Example of initial noting on a transcript excerpt

57 for my ankle and my hip (short pause). It has helped me, understand
 58 that (short pause), although ***** (his age) is considered (laughing
 59 slightly) to be old these days, it's pointless giving up, I have got
 60 something to give, like, I mentioned earlier, the two volunteer posts that
 61 I'm applying for and I'm being called forward for an interview. Umm, the
 62 courses I mentioned, and of course I'm here.

63 **Interviewer**
 64 IT WAS QUITE INTERESTING WHEN YOU WERE SAYING ABOUT-
 65 SORT OF-BEFORE YOU HAD CONTACT WITH THE PSYCHOLOGY
 66 SERVICE YOU MENTIONED THIS POINT WHERE YOU GAVE
 67 YOURSELF LIKE A VERBAL TALKING TO, TO MAKE SOME
 68 CHANGES. COULD YOU EXPLAIN A LITTLE BIT MORE ABOUT
 69 THAT TIME AND HOW THAT CAME ABOUT?

70 **Respondent**
 71 Well, in the forces I was always very strong, I was a leader, of men on
 72 operations on numerous times. And all I had done, for five years, well,
 73 a year previously, when I was homeless, I was just drinking everyday
 74 and just sleeping on ***** (name of place) park, believe it or not. And
 75 then I looked after somebody for five years, and (short pause), I had
 76 wasted five years of my life to myself-all though it was helping
 77 somebody else (short pause). It was gratifying in a way, but I got
 78 nothing out of it. I ended up back where I was after five years. Instead
 79 of going back to it-I'm a very strong person, wilful and physically, and I
 80 was just trying to sort myself out and get myself back to the person I
 81 used to be. And, I think I'm well on the track now [MMMM].

82 **Interviewer**
 83 DO YOU THINK THAT PROCESS WAS A GRADUAL ONE, OR WAS
 84 IT MORE SOMETHING THAT JUST ONE DAY-YOU MADE THAT
 85 DECISION TO MAKE CHANGES?

86 **Respondent**
 87 I think it was, just that one day (sighs). It was a sarcastic comment,
 88 actually, from ***** (name of lady who worked in the hostel he was
 89 living in), that Wednesday, I had been out and had my usual drink. And
 90 I did a pirouette, and fell on my backside in the corridor [MMM HMMM],
 91 and she walked past and said 'oh, I can see it's pay day again,' and
 92 from then onwards I haven't drunk. Not a drop. Not even a can of beer.

93 **Interviewer**
 94 CAN YOU REMEMBER WHAT YOU THOUGHT, ABOUT THAT
 95 COMMENT THAT SHE MADE?

96 **Respondent**
 97 I thought 'yeah, you are right.' The people you sometimes, see in the
 98 street, people who haven't got the willpower to help themselves, that
 99 you can see all the time and round the ***** (name of hostel). Maybe
 100 (short pause), they think they are a lost cause. Well, that's what I

101
 102
 103
 104
 105
 106

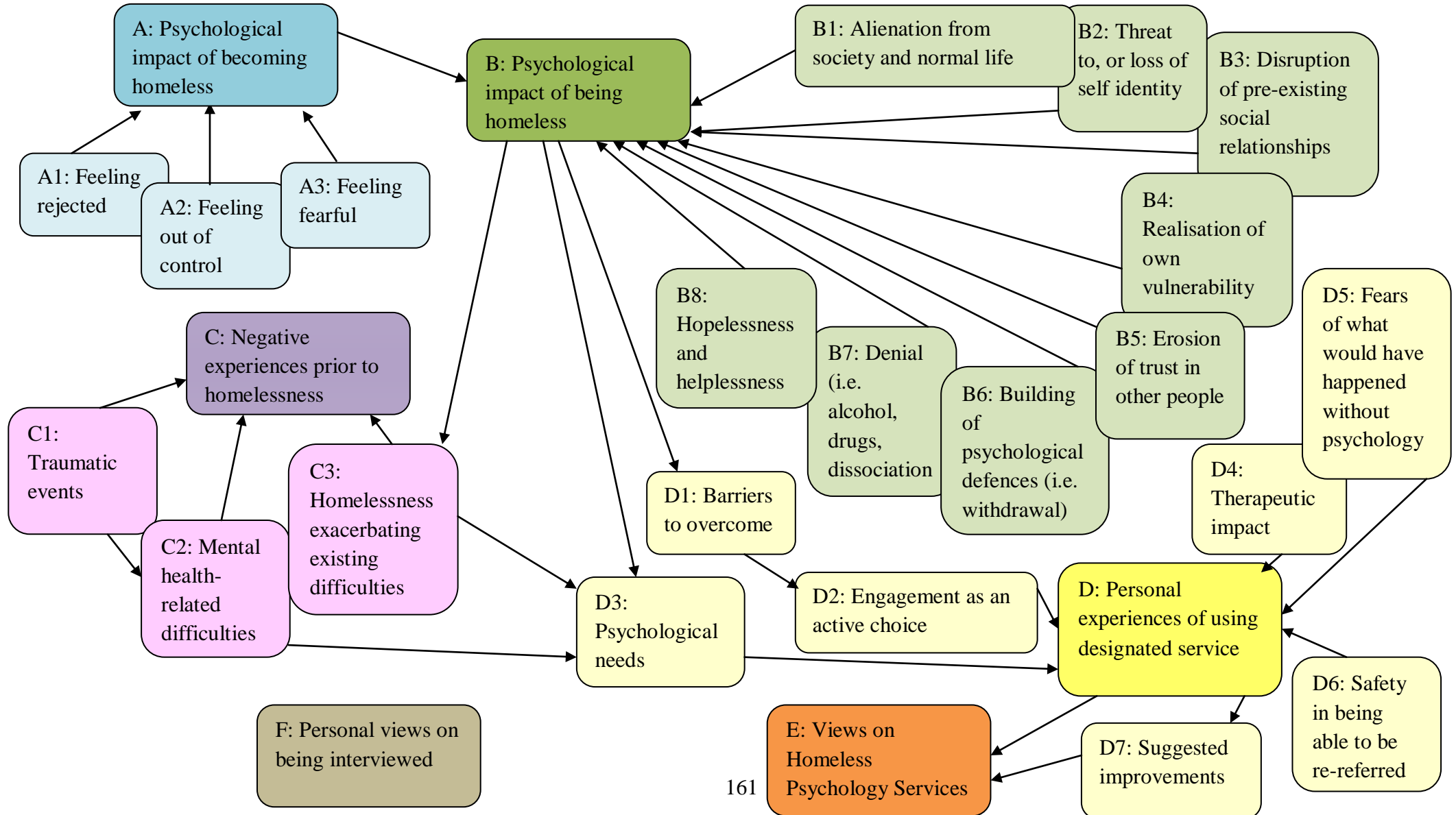
Handwritten notes:

- impact of - it's pointless giving up - something to give
- this realisation seems very important
- ways in which he can give
- interesting that he positions being interviewed as one of these
- CAN HE RELIEVE THIS OR WAS THIS ABOUT BELIEVING THIS?
- strength to make changes
- drinking rough sleeping
- Getting nowhere
- loss of identity who was he in between?
- moving in
- USUAL HABIT - TRAIN TRACK = CAN ONLY GO FORWARD?
- motivation to change triggered by a sarcastic comment
- more info on drinking experience
- stopped drinking
- need willpower to make changes
- He feels he had that sense of being lost
- Being a lost cause does that take away willpower? identity? self efficacy?
- EMPHASIS
- EMPHASIS
- does this offer link with previous work?
- links with increased self esteem?
- moving forward by giving back
- resilience - whether that helps him or not

Appendix S: Chronology of research progress

Date	Research activity
May 2010	Consultation with field supervisor and submission of initial proposal to the University of Leicester.
Jun-Sep 2010	Further development of research proposal.
Oct-Dec 2010	<p>Re-submission of research proposal.</p> <p>Organisation of the project including development of research materials (e.g. Participation Information Sheet).</p> <p>Internal peer review process completed and Peer Review Form completed.</p> <p>Preparation of application for ethical approval.</p>
Jan-Apr 2011	<p>Application made to the University of Leicester Service User Reference Group (SURG). Approval received in January.</p> <p>Application made for ethical approval from Local Research Ethics Committee (LREC) via IRAS. Meeting attended on the 15th of February. Approval received in March.</p> <p>Application made for NHS approval from the Research and Development Department (R&D). Approval received in April.</p>
Apr 2011-Feb 2012	<p>Recruitment and interview of participants.</p> <p>Transcription.</p> <p>IPA analysis.</p>
Dec 2011-May 2012	<p>Write up period.</p> <p>Submission of thesis to University of Leicester.</p>
May-Sep 2012	<p>Viva preparation.</p> <p>Preparation of journal article and poster presentation.</p> <p>Dissemination of research findings.</p>

Appendix T: A diagrammatic representation of key emergent themes



Appendix U: A table to show the frequency of ‘super-ordinate’ and ‘sub-ordinate’ themes

Themes	Transcript number							Recurrent? (over half)
	1	2	3	4	5	6	7	
A) Psychological impact of becoming homeless	x	x	x	x	x	x	x	Yes
A1: Feeling rejected		x	x			x	x	Yes
A2: Feeling out of control	x	x	x		x	x	x	Yes
A3: Feeling fearful				x	x	x		No
B) Psychological impact of being homeless	x	x	x	x	x	x	x	Yes
B1: Alienation from society and ‘normal life’	x	x	x		x	x		Yes
B2: Threat to, or loss of self identity	x	x	x	x	x	x	x	Yes
B3: Disruption of pre-existing social relationships		x	x		x		x	Yes
B4: Realisation of own vulnerability in hostel	x	x		x	x	x		Yes
B5: Erosion of trust in other people	x	x		x	x	x		Yes
B6: Building psychological defences (i.e. withdrawal)	x	x		x	x	x		Yes
B7: Denial (i.e. alcohol, drugs, dissociation)	x	x	x	x	x			Yes
B8: Hopelessness and helplessness	x	x	x	x	x	x	x	Yes
C) Negative experiences prior to homelessness	x	x	x	x	x	x	x	Yes
C1: Traumatic events	x	x	x	x	x	x	x	Yes
C2: Mental health-related difficulties	x	x	x	x	x	x	x	Yes
C3: Homelessness exacerbating existing difficulties		x		x		x	x	Yes
D) Experience of Homeless Psychology Service	x	x	x	x	x	x	x	Yes
D1: Barriers to overcome	x	x	x	x	x	x		Yes
• Mistrust	x	x		x	x	x		Yes
• Perceptions of ‘psychology’		x	x	x	x	x		Yes
• Previous experiences (mental health services)		x	x	x				No
D2: Engagement as an active choice	x	x	x		x	x	x	Yes
• Despair (i.e. having to engage)		x	x		x	x		Yes
• Need commitment (i.e. hard work)	x		x		x	x		Yes
D3: Psychological needs	x	x	x	x	x	x	x	Yes
• Therapeutic relationship	x	x	x	x	x	x	x	Yes
• Professional who understands homelessness	x		x					No
• Control over what is discussed	x	x	x	x			x	Yes
• Help to find a ‘way out’ of homelessness			x	x	x			No
D4: Therapeutic impact	x	x	x		x	x	x	Yes
• Catharsis		x	x		x	x	x	Yes
• Gaining insight into own difficulties	x	x	x		x			Yes
• Overcoming hopelessness		x	x		x	x		Yes
• Making positive changes		x	x		x	x		Yes

(Appendix U continued)

Themes	Transcript number							Recurrent? (over half)
	1	2	3	4	5	6	7	
D5: Fears of where they would be without psychology		x	x		x	x		Yes
• Serious risk to themselves		x			x	x		No
• Failure to ‘move on’ (i.e. out of homelessness)		x	x		x			No
D6: Safety in re-referral		x	x		x	x		Yes
D7: Suggested improvements	x	x	x	x	x	x	x	Yes
• Increase awareness of service	x			x		x		No
• Offer more sessions		x			x		x	No
• Have a separate ‘quiet’ waiting area			x					No
• Refer to other services				x				No
• Automatic allocation on moving to hostel					x			No
E: Views on Homeless Psychology nationally	x		x	x	x	x		Yes
E1: Need more services (accessible to all)	x		x	x	x	x		Yes
E2: Early intervention needed for those at risk				x				No
E3: Need to remain focussed on individual needs					x			No
F: Personal views on being interviewed	x	x	x	x	x	x	x	Yes
F1: Good to talk about own experiences (catharsis)	x	x	x	x	x	x	x	Yes
F2: Opportunity to have a voice		x	x	x	x		x	Yes
F3: Opportunity to give something back			x		x	x		No
F4: Hope that it will help others			x	x	x			No

Appendix V: Traumatic events and mental health-related difficulties prior to becoming homeless as interpreted by the Researcher

Experiences prior to becoming homeless	Transcript number							Recurrent? (over half)
	1	2	3	4	5	6	7	
Traumatic events	x	x	x	x	x	x	x	Yes
• Anti-social behaviour (property damage)			x					No
• Bereavement	x							No
• Child abuse						x	x	No
• Divorce			x					No
• Domestic violence				x	x		x	No
• Medical procedure				x				No
• Living in a children's home							x	No
• Problems in family relationships		x		x		x		No
• Rape				x				No
• Witnessing war			x					No
Mental health-related difficulties	x	x	x	x	x	x	x	Yes
• Alcohol use	x							No
• Anger		x						No
• Anxiety/Panic attacks				x				No
• Bipolar (Manic Depression)	x			x				No
• Cognitive difficulties		x						No
• Depression	x		x	x	x		x	Yes
• Drug use	x							No
• Low self esteem				x	x			No
• Obsessive Compulsive Disorder							x	No
• Paranoia		x						No
• Phobia (noise)				x				No
• PTSD			x					No
• Suicidal ideation (+ attempts)				x		x	x	No
• Uncertainty of own identity				x		x		No

Appendix W: Ideas for the dissemination of the research findings.

To ensure they reach Clinical Psychologists and other practitioners who work with homeless adults as well as statutory and non-statutory agencies, policy makers and commissioners, the findings of the current research study will be disseminated in a range of ways (e.g. journal articles, conferences). To enable broader dissemination outside of the academic community, a Summary Report will also be produced to enable ease of access to these findings for service users and local services. All of participants who took part in the current study have registered their interest in receiving a copy of the Summary Report. A focus group will also be conducted with staff who work either for, or closely with the service to determine additional routes for dissemination.

Appendix X: Ideas for further analysis of current data set

It is very likely that additional analysis of this study's data will provide further clinically useful findings. At the time of interview, five of the participants had moved out of homelessness and into their own accommodation and spoke at length about the challenges they faced at this time and how unsupported they had felt. This in itself risks re-enactment of past rejection and abandonment which is likely to have a further detrimental impact on their psychological wellbeing (Seager, 2011). Analysis and presentation of these findings would add to the emerging understandings drawn from qualitative research around how even after being housed, homeless adults can continue to feel marginalised and isolated (e.g. McNaughton, 2008). They would also provide insight into what these participants felt they needed at this time in terms of practical support. It has already been identified that further understanding is also needed into how self efficacy and learned helplessness influence the maintenance of homelessness (Philappot et al., 2007). Re-analysis of these interviewee's experiences could also provide some very interesting insights into their experiences of having, losing, and regaining a sense of internal control over their lives which could have very useful implications for clinical work with this client group.