A Qualitative Study Exploring the Lived Experiences of Homelessness and Barriers to Accessing Mental Health Services: An Interpretative Phenomenological Analysis.

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Declaration

I, Charlotte Davey, declare that this thesis is my own work and has been composed by myself. It has not been submitted, either in whole or in part, for any other academic degree or professional qualification. All sources of information have been appropriately acknowledged and referenced. I confirm that this thesis adheres to the guidelines for thesis submission as set out by London Metropolitan University.

Signature:  Date: 27.05.26

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In loving memory of my Maisie, who saw me through it all.

Abstract

While a correlation exists between homelessness and mental health distress, people experiencing homelessness (PEH) encounter personal, societal, and structural barriers that impede their access to and engagement with care. This study interviewed four people experiencing homelessness to explore: 1) the broader lived experience of homelessness and how this shapes mental health needs, 2) the specific systemic and personal barriers faced when seeking mental health support, 3) how individual circumstances and demographics influence these experiences, and 4) perceptions of current support and potential service improvements. An Interpretative Phenomenological Analysis (IPA) was adopted to examine how participants subjectively make sense of these intersecting realities.

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1. Introduction

Although the relationship between homelessness and mental health difficulties is well documented (Barry et al., 2024), people experiencing homelessness (PEH) often struggle to access appropriate support. When support is delayed, fragmented, or unavailable, distress may worsen and make it harder for individuals to move towards stability (Simon et al., 2025). Not only are there reported barriers when PEH attempt to access support, but also in being able to continue care once accessed (Simon & Kirk, 2024). Exploring how PEH make sense of these barriers can provide important insight when developing more effective mental health support in the future.

Aldridge's (2020) framing of homelessness as a social justice issue is particularly relevant to counselling psychology, given the profession's concern with social context, marginalisation and access to care. The British Psychological Society's Practice Guidelines (BPS, 2017) emphasise that psychologists should consider their responsibilities within wider social, cultural and political contexts. This is reinforced by current BPS professional standards, which identify a commitment to "inclusivity, equality, and justice" as central to the discipline's identity (BPS, 2025). By prioritising the lived experiences of people experiencing homelessness, this study focuses on an often-overlooked group whose access to mental health care may be shaped by social injustice and structural exclusion. This aligns with the BPS (2025) call for inclusive, psychologically informed practice and reflects counselling psychology's commitment to understanding the individual holistically, within their personal, relational and social contexts.

This chapter introduces the research topic by defining homelessness, outlining its scale and demographic patterns, and positioning the study within counselling psychology. It then presents the researcher's reflexive stance. Chapter 2 provides the contextual background, systematic search strategy and narrative synthesis of academic literature concerning access to mental health support for people experiencing homelessness. It then identifies the knowledge gaps, rationale and research questions that guide the present study.

1.1 Homelessness

1.1.1 Defining "homelessness"

The Oxford English Dictionary (2023) defines homelessness as "the state of having no home." While this definition avoids the narrow historical stereotype of rough sleeping, it underscores the conceptual breadth of the issue. In an academic context, the state of homelessness is recognised as a complex problem influenced by a convergence of structural failures, such as housing market volatility, and individual vulnerabilities, rather than a singular event of visible displacement (Bramley, 2021).

In England, the legal definition of homelessness is primarily set out in Part VII of the Housing Act 1996. Under section 175, a person may be legally homeless if they have no accommodation available for their occupation in the United Kingdom (UK) or elsewhere which they have a legal right to occupy. A person may also be homeless if they have accommodation but cannot secure entry to it, or where it is not reasonable for them to continue occupying it. This may include circumstances where accommodation is unaffordable, overcrowded, unsafe, in poor condition, or where remaining would expose the person or a member of their household to domestic abuse or other violence (Shelter, 2025). More recent legislative developments, including the Renters' Rights Act 2025, are relevant to homelessness prevention and private renting, but the core statutory definition of homelessness remains grounded in the Housing Act 1996.

For the purposes of this thesis, it is important to distinguish between the definitions of statutory homelessness and core homelessness, as these definitions capture different aspects of housing insecurity. Statutory homelessness refers to a legal and administrative category, primarily governed by the Housing Act 1996 and the Homelessness Reduction Act 2017. It includes households to whom a local housing authority owes a prevention or relief duty. While the Ministry of Housing, Communities and Local Government (MHCLG, 2025) monitors these duties through the Homelessness Case Level Information Collection (H-CLIC) data system, this administrative definition

does not capture the full range of housing insecurity and exclusion (Bramley, 2021; Fitzpatrick et al., 2025).

To address this limitation, homelessness is increasingly understood through broader typologies such as the European Typology of Homelessness and Housing Exclusion Light framework (ETHOS Light), developed by the European Federation of National Organisations Working with the Homeless (FEANTSA, 2007). ETHOS Light has been used in recent core homelessness research and monitoring, including the Homelessness Monitor: England 2025 and associated baseline estimates for core homelessness in England (Bramley, 2025; Crisis, 2025).

This framework identifies four overlapping forms of housing exclusion:

Rooflessness: people without shelter, including those sleeping rough in open-air locations;

Houselessness: people living in temporary or institutional accommodation, such as hostels, night shelters or emergency accommodation;

Insecure housing: people living under the immediate threat of exclusion, including those facing eviction or sofa-surfing due to a lack of permanent accommodation;

Inadequate housing: people living in unfit, unsafe or non-conventional accommodation, or in conditions of extreme overcrowding that pose risks to health (Abbé Pierre Foundation & FEANTSA, 2024).

Understanding homelessness as a spectrum of housing instability allows this thesis to attend to both visible and hidden forms of homelessness. This matters because people who fall outside statutory definitions or official data systems may still experience significant instability, exclusion and barriers to healthcare, mental health support and social inclusion.

1.1.2. Demographics

Homelessness in England is not experienced evenly across the population. Research from the Institute for Social Policy, Housing, Equalities Research describes homelessness as a "racialised experience", reporting that Black households are nearly four times more likely to experience statutory homelessness than White households. This disparity has been linked to wider structural

inequalities, including discrimination in the private rented sector, barriers associated with “right to rent” checks, and unequal access to secure and affordable housing (Fitzpatrick et al., 2025).

Official statutory homelessness data also show that homelessness is concentrated among adults in early and mid-adulthood. In 2025, the largest proportion of lead applicants owed a prevention or relief duty were aged 25 to 34, accounting for approximately 28.6% of cases, followed by those aged 35 to 44 at 25.5% (MHCLG, 2026). These figures suggest that homelessness is particularly affecting adults at stages of life often associated with employment, family formation and housing independence.

Gendered patterns of homelessness are difficult to measure because different data sources capture different aspects of homelessness. Official rough sleeping snapshot data show that visible rough sleeping remains predominantly male. In autumn 2025, men accounted for 82% of people estimated to be sleeping rough on a single night in England, while women accounted for 15% and gender was recorded as not known for 3% (MHCLG, 2026). However, these figures need to be interpreted with caution. MHCLG notes that women’s rough sleeping may be more hidden, transient and intermittent, meaning that it may not be fully captured by snapshot methods. Women may be more likely to stay in less visible spaces, including places open through the night, or to avoid bedding down in public because of safety concerns. The 2025 Rough Sleeping Questionnaire expanded findings on women also show that women who have slept rough often experience overlapping vulnerabilities. Multiple disadvantage was identified among 84% of women compared with 65% of men; 91% of women reported a current mental health need compared with 81% of men; and 69% of women reported domestic abuse since the age of 16 compared with 31% of men (MHCLG, 2026). These findings suggest that while men remain overrepresented in visible rough sleeping counts, women’s homelessness may be less visible and more closely associated with safety, abuse, trauma and multiple support needs.

LGBTQ+ young people are also overrepresented among populations experiencing homelessness. Sector-specific data suggest that approximately 24% of young people experiencing homelessness

identify as LGBTQ+, with familial rejection, abuse or being forced to leave home frequently reported as contributing factors (AKT, 2025). This is relevant to the present study because it shows how homelessness may be shaped by identity-based exclusion and relational rupture, rather than by housing availability alone. These experiences may also influence trust, safety and willingness to seek support from services.

Homelessness is also associated with institutional transitions, including discharge from prisons, hospitals and psychiatric settings. Statutory homelessness data record households becoming homeless following departure from institutional accommodation, raising questions about the effectiveness of referral and prevention duties under the Homelessness Reduction Act 2017 (MHCLG, 2026). This is important because institutional transitions may create points of heightened vulnerability where mental health need, housing instability and service discontinuity intersect.

Taken together, these demographic patterns suggest that homelessness is shaped by intersecting inequalities, including race, age, gender, sexuality and institutional history. These differences matter because barriers to mental health support are unlikely to be experienced uniformly by people experiencing homelessness. Access to care may be shaped not only by housing status, but also by experiences of discrimination, safety, relational loss, trauma, institutional contact and previous service exclusion. This provides important context for the present study, which explores how people experiencing homelessness make sense of mental health need and access to support within their own social and personal circumstances.

1.1.3. Number of people experiencing homelessness

The scale of homelessness in England is difficult to measure because different data sources capture different forms of housing instability. Government rough sleeping statistics estimated that 4,667 people were sleeping rough in England on a single night in autumn 2024, representing a 20% increase from 2023 and a third consecutive annual rise. This was also higher than the pre-pandemic figure recorded in 2019, although slightly below the previous peak in 2017 (Ministry of Housing, Communities and Local Government [MHCLG], 2025). More recent government figures suggest that

rough sleeping continued to increase in autumn 2025, reaching 4,793 people on a single night in England (MHCLG, 2026).

However, rough sleeping statistics capture only one part of homelessness. Temporary accommodation data show a wider and growing problem. On 30 June 2025, 132,410 households were living in temporary accommodation in England, an 8.1% increase from the same date in 2024 and the highest number recorded (MHCLG, 2025). This suggests that the temporary reduction in rough sleeping during the COVID-19 period did not reflect a sustained reduction in homelessness overall. Instead, many people moved from visible street homelessness into temporary or emergency accommodation, while wider housing instability continued to increase.

These figures also highlight the limitations of relying on rough sleeping counts alone. Many people experiencing homelessness are not visible in official street counts because they may be sofa-surfing, living in squats, staying temporarily with others, sleeping in unsafe arrangements, or avoiding contact with services. This is often referred to as hidden homelessness. As a result, official figures are likely to underestimate the total number of people experiencing homelessness, particularly those whose housing instability does not meet statutory thresholds or who are not known to local authorities.

A broader estimate is provided by Shelter, which combines official homelessness statistics with additional data sources to estimate the number of people without a permanent home. Shelter's 2025 analysis estimated that at least 382,000 people were homeless in England, including approximately 175,000 children. This equates to around one in every 153 people. The estimate includes people sleeping rough, households in temporary accommodation, people living in hostels or other homelessness accommodation, and people supported by social services departments.
Taken together, these figures suggest that homelessness should not be understood only through rough sleeping. While rough sleeping remains the most visible form of homelessness, temporary accommodation and hidden homelessness indicate a much wider problem. This is important for the

present study because people who are not visibly rough sleeping may still experience instability, exclusion and barriers to mental health support.

1.2. Reflexivity

Finlay (2002) defines reflexivity as conscious self-awareness and states that reflexivity can be achieved by continually evaluating subjective responses, inter-subjective dynamics, and the research process itself. Reflexivity allows for “bracketing” to take place, where self-awareness can ensure the researchers personal assumptions and values are not inadvertently attributed to those of the participants (McWhorter, 2019), increasing the validity of interpreting the participants “truth”. The process of reflexivity highlights the researcher's engagement with the study and how personal reflections may affect the analysis of the data (Finlay, 2002). This is beneficial in allowing fellow researchers and readers to critique the research to improve validity in the findings.

Due to the qualitative nature of the proposed research, both researcher and participant have a two-way relationship in exploring how a participant makes sense of the world (“double hermeneutic”). This is beneficial in allowing the researcher the advantage of being able to offer an external understanding of this experience and interpret how themes may form in relation to larger phenomena (Smith, Flowers & Larkin, 2009). However, researchers' understanding is subjective and may be formed through personal assumptions, potentially deviating from the participants' frame of reference, and decreasing validity in the findings. Therefore, I must consider the role of my personal epistemological positioning within the research, which aligns with a critical realist perspective. Critical realism is based on the idea that although an objective world is observable, the complexity of the natural world introduces many subjective variables which influence an individual’s perception in alternative ways (Bhaskar, 1975). It is important to critically reflect on and acknowledge the limitations of my own subjective perception to consider the participants potential alternative viewpoints.

My own context is a white, working-class, heterosexual woman who has never experienced homelessness. My interest in the topic stemmed from my experience of growing up in Manchester

and moving to Liverpool during my young adulthood, both large cities which meant I saw significant rates of homelessness. I recall a vivid moment of being unsettled whilst watching several individuals on their daily commute to work, each ignoring a homeless man as they passed. It was a poignant visual representation of the normalisation of inequality in society which both hurt and frustrated me, as I felt powerless to help. My empathy towards this man potentially feeling unheard and invisible led to me wanting to understand him. I began trying to combat feelings of helplessness by educating myself about what this homeless man may have been experiencing, which seemed to be my way of giving him "a voice" and a story. This spurred my interest in the topic of homelessness, particularly in why people remain homeless.

Around 8 years have passed since that moment, and I have been working within the NHS in a hospital setting for the past 3 years. I frequently meet patients from disadvantaged backgrounds who sought A&E as the only option after struggling with mental health issues and suicidal ideation. These individuals were often discharged from the hospital shortly afterwards with no clear referral pathway. Many of them expressed to me that they had sought mental health support in the past, but it was not accessible, leading them to becoming repeat users of A&E. I believe my personality aligns with a career in counselling psychology, as I find great value in empowering individuals during personal difficulties. Therefore, feeling like I had limited support to offer individuals who were clearly distressed and actively attempting to seek support, created somewhat of a personal moral dilemma. I believe it was at this point that I experienced first-hand my professional identity gravitating from an individualistic perspective to one which considers my role in a societal context. This allowed me to broaden my counselling psychology identity from a social justice approach, by considering my responsibilities to the wider world (DCoP, 2005). As I have experienced working with disadvantaged groups in the past, it is important that I can bracket these people's experiences to explore the research participants' unique, subjective experience of being homeless, rather than applying a universal law (Cooper, 2009).

Over the past decade, I have also experienced changes in my personal identity in terms of my social class. I still consider being working-class as part of my identity, due to factors such as my family, dialect, and childhood experiences. However, I have frequently deliberated over whether my academic achievements and professional status have begun to push my identity into being considered middle-class. Although I still label myself working-class, I must consider that participants of the research may disagree due to the already unequal power-dynamic of interviewer and interviewee, my professional status and potentially due to my appearance. Therefore, I must reflect upon how my privilege may affect my research findings, as participants may refrain from opening due to feeling untrusting of me as a professional in a care setting or feel that I could not truly understand their experiences.

Overall, I recognise my privilege and I am grateful for the opportunities that have come along with it. Where once I felt powerless to challenge social injustice, I now feel I have a "unique vantage point" (Vera & Spright, 2003) in my new identity as a Trainee Counselling Psychologist. I am now able to hear the feelings of injustice faced by people when working together on a personal level, alongside contributing towards research which gives disadvantaged people a voice in challenging social injustice on a societal level.

2. Literature review

2.1. Contextual and Conceptual Background

Before presenting the narrative synthesis of studies identified through the systematic search, this section provides the wider background to the relationship between homelessness and access to mental health care. Homelessness is not only about the absence of housing. It is also shaped by social policy, welfare provision, poverty, trauma, healthcare access and wider structural inequality. This context is important because the barriers faced by people experiencing homelessness are rarely caused by one factor alone. Instead, difficulties in accessing mental health support often sit within broader experiences of instability, exclusion and unmet need. This section therefore draws on selected theoretical, policy and grey literature to frame the review, rather than attempting to cover all literature on homelessness. The synthesis of peer-reviewed studies identified through the systematic search is presented separately in Section 2.3.

2.1.1. Conceptualising homelessness: individual, structural and interactional explanations

Homelessness has been understood through different explanatory frameworks. Individualistic, or psychocentric, accounts locate the causes of homelessness primarily within the person, emphasising factors such as mental health difficulties, substance use, trauma histories or behavioural vulnerabilities (Dej, 2016; Horsell, 2006). Although these factors may be relevant to some people's pathways into homelessness, this perspective has been criticised for placing too much emphasis on personal agency while giving insufficient attention to the social, economic and political conditions that shape people's choices and opportunities (Fitzpatrick, 2005). From a counselling psychology perspective, this matters because overly individualised accounts can pathologise people experiencing homelessness and imply responsibility for circumstances shaped by wider marginalisation.

In contrast, structural accounts locate homelessness within wider systems of inequality, including poverty, insecure employment, housing affordability, welfare policy and the availability of social

housing (Johnson, Scutella, Tseng, & Wood, 2015; Bramley, 2021). These accounts challenge deficit-based understandings by drawing attention to the conditions that increase the risk of homelessness. For example, instability in the private rented sector, limited access to affordable housing and welfare restrictions can make it difficult for people with few economic or social resources to secure or maintain stable accommodation. A structural perspective therefore helps challenge narratives that frame homelessness as the result of individual failure.

However, structural explanations can also be limited if they obscure the lived complexity of homelessness or present individuals as passive recipients of social factors. An interactional model offers a more nuanced framework by recognising that homelessness often emerges through the relationship between structural pressures and individual circumstances (O'Flaherty, 2004; Lee, Tyler, & Wright, 2010). From this perspective, experiences such as mental health distress, substance use, domestic abuse, physical ill-health, institutional care and trauma are not treated as isolated personal deficits, but as difficulties that develop and persist within wider social, economic and service systems.

This interactional understanding is relevant to the present study because it frames barriers to mental health care as both personal and structural. The research explores how people experiencing homelessness make sense of their mental health needs and the barriers they encounter when seeking mental health support, recognising that access may be shaped by contact with wider services such as primary care, substance use support, housing services and outreach provision. This framework therefore allows individual lived experience to be considered alongside the social and service contexts that shape access to mental health care. For counselling psychology, such a position is consistent with a commitment to holistic, non-pathologising and socially situated understandings of distress (Cooper, 2009; Vera & Speight, 2003). It also provides a basis for considering the impact of homelessness at both individual and societal levels, where personal distress and health inequality are closely connected to wider systems of housing, welfare, healthcare and social support.

2.1.2. The Impact of Homelessness

The economic implications of homelessness are substantial. Local authority expenditure on homelessness services in England reached £2.44 billion in 2022/23, including over £1.6 billion spent on temporary accommodation (National Audit Office, 2024). More recent figures suggest that this pressure has continued to increase. Shelter's analysis of local government spending data found that councils in England spent £2.84 billion on temporary accommodation in 2024/25, a 25% increase from the previous year (Shelter, 2025). This financial pressure is particularly acute in London, where boroughs were reported to be spending £5.5 million per day on homelessness in 2024/25, with almost £5 million per day spent on temporary accommodation alone (London Councils, 2025). These figures suggest that the current system relies heavily on costly emergency and temporary responses, rather than sustained preventative support. For the present study, this matters because crisis-led responses may address immediate housing need without necessarily resolving the psychological distress, service exclusion and instability that shape people's longer-term access to mental health support.

At the individual level, homelessness is associated with substantial physical and psychological harm. Homeless Link's evidence indicates high levels of long-term physical health conditions and mental health difficulties among people experiencing homelessness, suggesting that housing instability is closely connected with wider health inequality rather than being only a matter of accommodation (Homeless Link, 2022, 2024). Mortality data further illustrate the severity of this inequality. The Office for National Statistics (2022) estimated that 741 deaths of people experiencing homelessness were registered in England and Wales in 2021. The mean age at death was 45.4 years for men and 43.2 years for women, markedly lower than in the general population. Drug poisoning, suicide and alcohol-specific causes were among the leading contributors to these deaths, indicating the close relationship between homelessness, mental distress, substance use and preventable harm (Office for National Statistics, 2022). More recent tracking by the Museum of Homelessness found that at least 1,611 people died while homeless across the UK in 2024, a 9% increase from the

previous year (Museum of Homelessness, 2025). Taken together, these figures position homelessness as both a housing issue and a public health concern. They also provide important context for the following section, which considers the relationship between homelessness, mental health and complex needs.

2.1.3. Homelessness, mental health and complex needs

The relationship between homelessness and mental health is complex and bidirectional. Mental health difficulties can increase vulnerability to homelessness by affecting employment, relationships, finances, self-care and help-seeking. At the same time, homelessness can intensify psychological distress through insecurity, stigma, isolation and exposure to threat (Gutwinski et al., 2021; Barry et al., 2024). Homelessness and mental health should therefore not be understood as separate or linear problems, but as experiences that can reinforce one another over time.

Access to care is further complicated by the wider adversity that often surrounds homelessness. Physical ill-health, substance use, trauma, cognitive or communication difficulties, poverty and discrimination can shape both how people understand their distress and whether support feels reachable or safe (Luchenski et al., 2018; Pluck et al., 2020). For some people, these difficulties may predate homelessness; for others, they may be intensified by housing instability itself. In both cases, psychological distress is best understood within a wider context of instability and exclusion, rather than as an isolated clinical issue.

This has important implications for mental health care. Many services are organised around assumptions of stability, including having a fixed address, reliable telephone or digital access, transport, appointment attendance and the ability to describe distress in ways that fit referral criteria. These assumptions may not reflect the circumstances of people who are rough sleeping, living in temporary accommodation, sofa surfing, moving between services or prioritising immediate survival needs (Gunner et al., 2019; O'Carroll & Wainwright, 2019). As a result, mental health need may be present but difficult to evidence, communicate or prioritise within systems designed around more settled lives.

The concept of complex need is therefore central to this study. Among people experiencing homelessness, psychological distress often exists alongside physical ill-health, substance use, trauma and social exclusion. The term “tri-morbidity” has been used to describe the co-occurrence of mental health difficulties, physical health problems and substance use among people experiencing chronic homelessness (Hewett & Halligan, 2010). However, while this term is useful, it can also reduce complexity to a set of clinical categories. In this thesis, complex need is understood more broadly as the interaction between personal distress, social adversity and service systems that are not always flexible enough to respond to the realities of homelessness.

This broader understanding of complex need leads directly to questions about how mental health care pathways are organised, and whether existing routes into support are able to respond to people whose circumstances do not fit assumptions of stability, clarity or single-service need.

2.1.4. Mental health care pathways and service exclusion

For people experiencing homelessness, access to mental health care is shaped not only by individual help-seeking, but also by the way care pathways are organised. In England, psychological and psychiatric support is commonly accessed through primary care, with the General Practitioner (GP) often acting as the route to further assessment, referral and treatment. Primary care pathways, including NHS Talking Therapies, are intended to widen access to psychological support for common mental health difficulties (NHS England, 2024). However, these pathways may be less accessible for people whose needs are unstable, multiple or difficult to categorise within standard referral criteria (Luchenski et al., 2018; Gunner et al., 2019).

For people experiencing homelessness, exclusion can occur before therapeutic support is offered. GP registration requirements, requests for identification, lack of a fixed address, limited telephone or digital access, missed correspondence and previous experiences of rejection may all prevent entry into the mental health system (Doctors of the World, 2017; Healthy London Partnership, 2021). Digital exclusion is particularly important as services increasingly rely on online systems, telephone contact and remote communication. People experiencing homelessness may lack stable internet

access, digital devices, privacy or reliable charging facilities, making digital-first pathways difficult to use. The Department of Health and Social Care's (DHSC, 2025) inclusion health policy recognises digital access as one factor shaping health inequalities among socially excluded groups. Where individuals do access primary care, they may still be redirected between services if their needs are considered too complex for primary care, but not sufficiently severe, stable or diagnostically clear for secondary care. This can create a threshold gap in which individuals are referred, redirected or discharged without receiving sustained psychological support.

Service fragmentation is particularly relevant for people with co-occurring mental health and substance use difficulties. Although policy guidance increasingly emphasises integrated care, individuals may still experience services as divided between mental health, substance use, housing, physical healthcare and social care. This can produce a circular pattern in which a person is expected to address substance use before accessing mental health support, while also needing mental health support to address substance use (Fulfilling Lives, 2020; St Mungo's, 2019). Such patterns are especially problematic when substance use is understood as a way of coping with trauma, distress or the conditions of homelessness.

Current guidance increasingly supports integrated responses to co-occurring mental health and substance use needs, rather than treating substance use as an automatic reason for exclusion from psychological support. The NHS Talking Therapies Manual states that co-existing substance use should not automatically exclude a person from NHS Talking Therapies, while policy guidance on co-occurring mental health and substance use conditions emphasises the need for coordinated care across services (NHS England, 2024; Department of Health and Social Care, 2024). NICE and CQC guidance similarly support person-centred and integrated responses to co-occurring needs (NICE, 2019; Care Quality Commission [CQC], 2024). This is important because people experiencing homelessness may otherwise be passed between services, with mental health support deferred until substance use is addressed, and substance use support limited by unaddressed psychological distress.

These issues reflect Hart's (1971) inverse care law, where those with the greatest need for healthcare are often least able to access it. For people experiencing homelessness, exclusion from mental health care may not occur through one explicit refusal, but through repeated procedural, relational and practical barriers. Understanding these barriers therefore requires attention not only to how services are organised, but also to how individuals experience and make sense of repeated attempts to seek mental health support.

2.2. Systematic Search Strategy and Review Methodology

2.2.1. Review approach

A systematic search strategy was undertaken to identify empirical literature examining how people experiencing homelessness access mental health support and the barriers they encounter when seeking care. Reporting of the review was informed by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (PRISMA; Page et al., 2021), which were used to support transparent presentation of the search, screening, eligibility assessment and final study selection process.

The review was structured using a Population, Exposure and Outcome framework, as outlined by Bettany-Saltikov (2012). This framework was appropriate because the review focused on a defined population, people experiencing homelessness, their experiences of service access processes and barriers, and outcomes associated with seeking or attempting to access mental health support. The purpose of the review was to identify, organise and critically synthesise academic literature relevant to the focus of the present study. In particular, the search sought to identify literature concerning lived experiences of homelessness, perceived barriers to accessing mental health services, the influence of individual circumstances and demographic identities, and perceptions of helpful or accessible support.

The search covered literature published between January 2000 and April 2026. This broad timeframe was selected to avoid excluding earlier empirical work that may have contributed to understandings of homelessness, mental health and service access, while also capturing

contemporary studies reflecting current health and social care contexts. Although studies from 2000 onwards were eligible, the final included studies were all published between 2022 and 2025. This suggests that the literature most closely aligned with the focus of the present study was concentrated in recent work addressing current service access, post-pandemic healthcare provision, integrated housing-health responses and lived experience of barriers to care.

The systematic search was limited to empirical academic studies that met the eligibility criteria. Older theoretical, policy and landmark literature was used separately in the contextual background where it supported conceptual framing, for example in relation to structural explanations of homelessness, the inverse care law, tri-morbidity and counselling psychology's social justice position. These sources were not counted as included studies in the formal synthesis unless they were identified through the database search and met the review eligibility criteria. This distinction was maintained to ensure clarity between contextual literature and the academic studies included in the narrative synthesis.

2.2.2. Information sources and search date

The database search was conducted on 29 April 2026 across three electronic databases: the Cochrane Library, EBSCO and PubMed. These databases were selected because they cover literature across health, psychology, public health, social care and interdisciplinary research relevant to homelessness and healthcare access.

The search identified 4,993 records in total: Cochrane Library (n = 5), EBSCO (n = 3,659), and PubMed (n = 1,329). Search results were exported into Rayyan systematic review software for deduplication, screening and record management. Rayyan was used as an organisational tool to support the review process; it was not used to make automated inclusion or exclusion decisions. Screening decisions were made manually by the researcher against the inclusion and exclusion criteria. Screening was conducted by one researcher. Records were first screened by title and abstract against the eligibility criteria, before potentially relevant articles were retrieved and assessed in full text.

2.2.3. Search strategy

The search strategy was developed using a Population, Exposure and Outcome framework (Bettany-Saltikov, 2012). Search terms were adapted for each database to account for differences in indexing, search functionality and subject headings. The core search concepts are shown in Table 1, and the full database-specific search strings are provided in Appendix J.

Table 1

Search Concepts Organised by Population, Exposure and Outcome Framework

PEO component	Search terms
Population	homeless* OR “no fixed abode” OR “sofa surf*” OR hostel* OR “temporary accommodat*” OR unhoused OR houseless OR “rough sleep*”
Exposure / context	access* OR barrier* OR “help seek*” OR engag* OR outreach OR uptake OR “support service*” OR “mental health” OR counselling OR “talking therapy” OR “psychological support” OR “psychosocial support”
Outcome / experience	access* OR barrier* OR “lived experience*” OR perspectiv* OR view* OR help seek* OR engag* OR narrative* OR qualitative OR interview*

Boolean operators were used to combine terms, with OR capturing synonyms within concept blocks and AND combining the Population, Exposure and Outcome blocks. Truncation symbols, such as *, were used to capture variations of key terms.

The search combined homelessness-related terms with terms relating to mental health or psychological support, access, barriers, engagement and lived experience. This kept the search focused on studies relevant to the present study, while still allowing broader healthcare and service-access literature to be captured where mental health-related findings were present.

Concepts such as structural explanations, interactional models, psychocentric discourses and social justice were not used as database filters or screening criteria. Instead, they informed the

contextual framing of the review and the interpretation of findings in relation to counselling psychology.

2.2.4. Eligibility criteria

Eligibility criteria were defined before screening to ensure that the review remained aligned with the aims of the present study. The review sought to identify literature concerning how people experiencing homelessness make sense of their mental health needs, how they experience access to mental health-related support, and what factors may hinder or facilitate care.

The first criterion concerned the study population. Studies were included where they focused on adults aged 18 years and above who were experiencing homelessness or housing insecurity. This included visible forms of homelessness, such as rough sleeping and hostel use, as well as less visible forms, including temporary accommodation, sofa surfing, insecure housing, imminent eviction, and inadequate or unconventional housing. Studies focusing on specific adult subgroups, such as young adults aged 18 to 24, women experiencing hidden homelessness, people experiencing severe and multiple disadvantage, or LGBTQ+ adults, were also eligible. This broad population criterion reflected the focus of the thesis on both visible and hidden homelessness, rather than rough sleeping alone.

The second criterion concerned the type of support or service being examined. Studies were included where they examined access to, engagement with, or barriers and facilitators within mental health, psychological, substance use, primary care, housing-health, or related support services. Studies did not need to focus solely on specialist mental health services, provided that they contained extractable qualitative findings relevant to psychological distress, mental health need, help-seeking, service engagement, or organisational factors affecting mental health-related care. This was important because, for people experiencing homelessness, access to mental health support is often shaped by wider systems, including primary care, substance use services, outreach, peer support and housing-related pathways.

The third criterion concerned the type of evidence. Studies were included where they provided subjective, experiential, or qualitative data relevant to access to mental health-related support.

Primary qualitative studies and mixed-methods studies with extractable qualitative findings were eligible. English-language publications dated between January 2000 and April 2026 were included. Although this timeframe was broad, the final included studies were published between 2022 and 2025 because these were the studies that met the eligibility criteria and most directly addressed contemporary access to mental health-related support for people experiencing homelessness.

Studies were excluded where they focused on children or adolescents under 18, or where findings included under-18s and adult data could not be clearly separated. Studies were also excluded where participants were stably housed with no current or recent housing insecurity, or where homelessness or housing insecurity was not part of the study population, sampling criteria, or substantive analysis. Studies focusing only on physical health, infectious disease, epidemiological prevalence, medication efficacy, or descriptive service data were excluded unless they included relevant qualitative analysis of mental health-related access, support, help-seeking, or lived experience. Editorials, opinion pieces, book reviews, non-empirical items, and purely quantitative studies without qualitative or interpretive data were also excluded.

Finally, studies from healthcare systems substantially different from the UK universal healthcare context were excluded unless they offered clear transferable relevance to universal, publicly funded, or broadly comparable healthcare access. This criterion was used because the present study is concerned with access to care in a context where healthcare is intended to be available without direct payment at the point of use. Studies in which access barriers were primarily shaped by private insurance status or ability to pay were considered less transferable to the UK context. This helped maintain the review's focus on service-access issues most relevant to the present research context, while acknowledging that some potentially useful models from non-comparable systems may not have been captured.

2.2.5. Screening and study selection

The database searches identified 4,993 records. Following deduplication in Rayyan, 2,614 duplicate records were removed, leaving 2,379 records for title and abstract screening. After title

and abstract screening, 26 articles were retained for full-text assessment. Seventeen articles were excluded at the full-text stage, resulting in nine studies being included in the final review. The study selection process is presented in Figure 1.

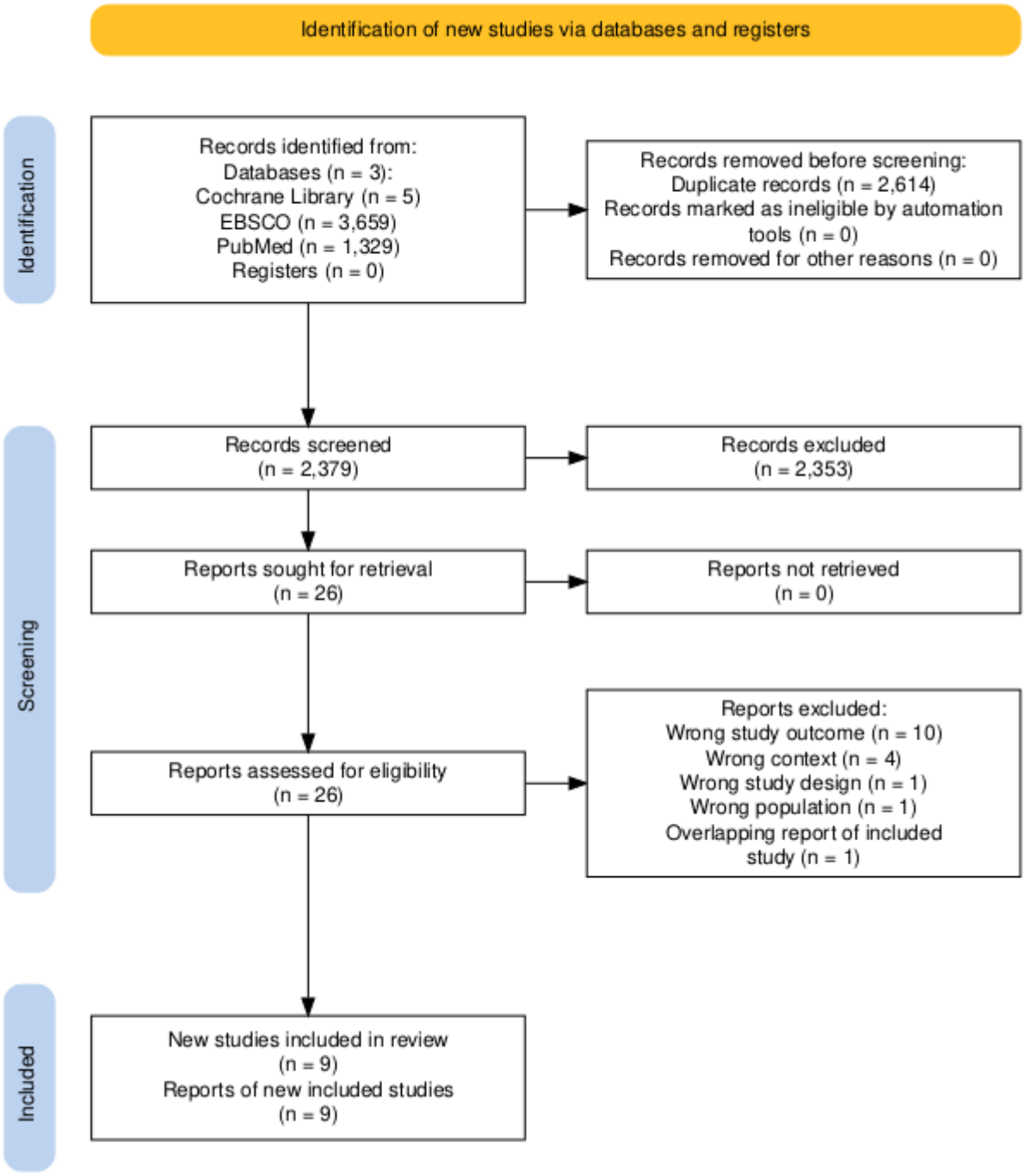

Figure 1

PRISMA 2020 flow diagram of study selection process.

Note. Adapted from the PRISMA 2020 flow diagram template (Haddaway et al., 2022).

The full-text exclusion reasons presented in the PRISMA diagram were wrong study outcome (n = 10), wrong context (n = 4), wrong study design (n = 1), wrong population (n = 1), and overlapping report of an included study (n = 1).

2.2.6. Overview of included studies

The nine contemporary studies included in the final review are presented in Table 2. Although the eligible search period extended from 2000 to 2026, all included studies were published between 2022 and 2025. Together, the studies addressed access to mental health and substance use support, general practice, peer support, integrated health and housing provision, addiction recovery, brain injury, severe and multiple disadvantage, and wider healthcare access among people experiencing homelessness or housing insecurity.

Table 2

Overview of Included Studies and Their Relevance to the Review

No.	Study	Country / Context	Design / Method	Population / Sample Focus	Main Relevance to the Review
1	Bell et al. (2024), *Healthcare and housing provision for a UK homeless community: A qualitative service evaluation*	England	Qualitative service evaluation	People with recent or current experiences of homelessness who had contact with healthcare and housing provision	Provides evidence on integrated health and housing support, service flexibility, outreach and continuity of care for people whose needs may not fit standard service pathways.
2	Potter et al. (2024), *Improving access to general practice for and with people with severe and multiple disadvantage: A qualitative study*	England	Qualitative study / collaborative service improvement	People experiencing severe and multiple disadvantage, including individuals with lived experience, alongside practice staff and support-sector stakeholders	Provides evidence on GP access, primary care barriers, administrative exclusion, co-production and inclusion-focused service design.

3	Schel et al. (2022), *What makes intentional unidirectional peer support for homeless people work? An exploratory analysis based on clients' and peer workers' perceptions*	Netherlands	Qualitative exploratory study	People experiencing homelessness receiving peer support, and peer workers providing support	Provides evidence on how peer support may facilitate trust, engagement, empowerment, relational safety and connection with services.
4	Sutherland et al. (2022), *Older women's perceptions of the impact of homelessness on their health needs and their ability to access healthcare*	Australia	Mixed-methods study with qualitative interview data	Older women experiencing homelessness in the Perth metropolitan area	Provides evidence on gendered and age-related dimensions of healthcare access, including unmet health needs, safety, stigma and the specific vulnerabilities of older women experiencing homelessness.
5	Ingram et al. (2024), *"Just a knife wound this week, nothing too painful": An ethnographic exploration of how primary care patients experiencing homelessness view their own health and healthcare*	Ireland	Ethnographic qualitative study	People experiencing homelessness attending primary care and addiction services	Provides evidence on how people experiencing homelessness understand health and healthcare in the context of survival, normalised harm, stigma and exclusion.
6	Adams et al. (2022), *A qualitative study exploring access to mental health and substance use support among individuals experiencing homelessness during COVID-19*	England	Qualitative interview study	Adults experiencing homelessness with mental health and/or substance use support needs during COVID-19	Provides evidence on access to mental health and substance use support, including service disruption, remote access, flexibility and continuity of care during the pandemic.

7	Warren et al. (2025), *Barriers and facilitators to housing and healthcare services for people experiencing homelessness with concurrent brain injury, mental health and substance use disorders: A qualitative study*	Canada	Qualitative participatory study	People experiencing homelessness with acquired brain injury and concurrent mental health and substance use disorders	Provides evidence on how cognitive difficulties, mental health, substance use and housing instability interact to create complex barriers to housing and healthcare access.
8	Jain et al. (2025), *Learnings from providing integrated health, housing and wider care for people rough sleeping during the COVID-19 pandemic: A national qualitative study of the "Everyone In" policy initiative*	England	National qualitative study	People accommodated through Everyone In, alongside providers and stakeholders involved in delivery or implementation	Provides evidence on the value and limitations of integrated, flexible health, housing and wider care responses for people rough sleeping during the COVID-19 pandemic.
9	Ingram et al. (2025), *Barriers and enablers of addiction recovery amongst people experiencing homelessness in Dublin, Ireland: A proposed conceptual framework adapted from the REC-CAP*	Ireland	Qualitative secondary analysis / conceptual framework development	People experiencing homelessness with addiction recovery needs, alongside provider perspectives	Provides evidence on addiction recovery, recovery capital, housing instability, stigma, social support and structural barriers to sustained recovery.

This overview table shows how the studies identified through the formal search relate to the literature reviewed in the following sections. Each of the nine included studies is discussed within

the narrative synthesis, although some studies are drawn on more extensively than others depending on their relevance to each theme.

2.2.7. Data extraction and narrative synthesis

Data were extracted by the researcher into a structured matrix, provided in Appendix K. To improve readability, the matrix is presented across two appendix tables. Table K1 summarises the study characteristics of the included academic studies, while Table K2 summarises key findings, methodological considerations and each study's relevance to the narrative synthesis. The matrix was developed to support transparent and consistent comparison across the included studies. The headings were informed by PRISMA 2020 reporting principles, which require study characteristics and data items to be reported, and by guidance on narrative synthesis, which emphasises the importance of comparing findings within and between studies (Page et al., 2021; Popay et al., 2006). Extracted information included author, year, country or setting, study focus, population, methodology, data collection method, key findings, methodological strengths and limitations, and relevance to the review focus. Table 1 presents a concise overview of the included studies.

Given the methodological diversity of the included literature, a narrative synthesis was considered more appropriate than meta-analysis. This approach was suitable because the included studies were qualitative or contained extractable qualitative findings, and the aim of the review was to understand experiences of access to mental health-related support rather than to calculate pooled effects (Popay et al., 2006). The synthesis was also informed by PRISMA 2020 reporting principles, particularly the need to clearly report the process used to select, extract and synthesise evidence (Page et al., 2021).

Drawing on Popay et al.'s (2006) guidance, the synthesis was conducted in three stages. First, extracted findings were reviewed to identify material relevant to lived experience, perceived barriers and facilitators, individual circumstances, and experiences of support. Second, findings were compared across studies to identify areas of similarity and difference. Third, related findings were grouped into recurring areas that appeared across the included studies and were relevant to the

focus of the present study. These areas included primary care access, administrative barriers, mistrust and stigma, fragmented services, co-occurring mental health and substance use needs, the influence of individual circumstances and demographic identities, integrated care, peer support, and factors that appeared to facilitate engagement. The purpose of this process was to critically interpret the academic literature in relation to the present study. The synthesis therefore identifies what is already known, where findings differ across studies, and where gaps remain that the current research may help to address.

2.2.8. Quality appraisal

The included studies were critically appraised using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018), with findings summarised in Appendix L. MMAT was selected because the review included methodologically diverse studies, including qualitative research, mixed-methods research, ethnographic work and qualitative service evaluations. The tool was appropriate because it provides design-specific criteria for appraising qualitative, quantitative and mixed-methods studies, while allowing a consistent approach across a methodologically diverse evidence base.

The appraisal was completed by the researcher. Each study was first considered against the two MMAT screening questions, which assess whether the study has clear research questions and whether the data collected allow those questions to be addressed. Studies were then appraised using the MMAT category most closely aligned with their design. Most studies were appraised using the qualitative criteria. Sutherland et al. (2022) was appraised as a mixed-methods study, with particular attention paid to the qualitative findings used in this review. Qualitative service evaluations were appraised using the qualitative criteria where the evidence included in the synthesis was identified through qualitative data collection and analysis.

The purpose of appraisal was not to exclude studies solely on the basis of methodological limitations, but to support critical interpretation of the evidence. Appraisal considered whether the qualitative approach was appropriate, whether data collection methods were adequate, whether findings were adequately derived from the data, whether interpretations were substantiated by the

data, and whether there was coherence between data sources, data collection, analysis and interpretation. For mixed-methods studies, attention was also paid to the clarity and relevance of the qualitative component to the present review.

In line with MMAT guidance, the appraisal was used to identify methodological strengths and limitations rather than to reduce studies to a single overall quality score. This was important because the review synthesised a relatively small body of contemporary literature concerning people experiencing homelessness and access to mental health-related support. The appraisal findings informed how each study's contribution was interpreted within the narrative synthesis. Studies with methodological limitations were retained where they provided relevant insight, but these limitations were considered when discussing the strength, transferability and overall contribution of the evidence.

The appraisal was completed by one researcher, rather than independently by multiple reviewers, and this limitation is acknowledged in Section 2.2.10. The review was not registered with PROSPERO or another review register, and a separate review protocol was not prepared. However, the search strategy, eligibility criteria, PRISMA flow diagram, overview table, data extraction matrix and quality appraisal summary were retained to support transparency.

2.2.9. Use of contextual and grey literature

Grey literature was not included in the formal synthesis of the nine academic studies. However, selected policy, statutory and third-sector sources were used in Chapter 1 and Section 2.1 to establish the wider context for the review, including the scale of homelessness, statutory definitions, hidden homelessness, service provision and barriers to care. These included government reports, parliamentary briefings, NHS and public health guidance, and relevant third-sector sources such as Shelter and St Mungo's. These sources were identified through targeted searches of relevant organisational websites rather than through the formal database search. They were used to contextualise the research problem and support the rationale for the study, but were not counted as included studies in the PRISMA flow diagram or formal narrative synthesis..

2.2.10. Limitations of review

The review process had several limitations. Screening, data extraction and quality appraisal were conducted by one researcher, which may have increased the risk of subjective judgement. To reduce this risk, predefined eligibility criteria, a structured data extraction matrix, MMAT appraisal and a PRISMA flow diagram were used to support transparency and consistency. The review was limited to English-language publications and to studies available through the selected databases, meaning that relevant studies published elsewhere may not have been identified. Excluding studies from healthcare systems that were not broadly comparable to the UK helped maintain relevance to the present research context, but may have meant that some potentially useful international service models were not included. The synthesis should therefore be understood as a focused narrative synthesis informed by a systematic search strategy and relevant to the review focus, rather than as an exhaustive review of all literature on homelessness and mental health care.

2.3. Narrative Synthesis of Included Academic Literature

The following section presents the narrative synthesis of the nine academic studies identified through the systematic search. The synthesis is organised into four recurring areas that appeared across the included studies: 1) access to primary care and administrative exclusion, 2) mistrust and relational barriers, 3) fragmented responses to complex and co-occurring needs, and 4) integrated, flexible or peer-supported approaches.

These areas provide a structure for examining how the included studies contribute to the rationale for the present study. The synthesis considers lived experience, perceived barriers to mental health-related support, the role of individual circumstances and demographic identities, and factors that may facilitate care or service improvement. It also identifies what remains unclear and how these gaps inform the present study.

2.3.1. Access to primary care and administrative exclusion

This subsection examines how the included studies present primary care and administrative systems as early points of access or exclusion for people experiencing homelessness. It is particularly

relevant to the focus of the present study concerning perceived barriers to mental health services and how services might be improved. Although the present study focuses on mental health care, the reviewed literature indicates that routes into mental health support are often shaped by wider systems, including general practice, outreach provision, referral processes and housing-health pathways. For people experiencing unstable housing, these systems may become difficult to navigate before formal mental health support is reached.

Potter et al.'s (2024) study provides a useful example of this wider access pathway through its focus on general practice access for people experiencing severe and multiple disadvantage. Although the study is not limited to people experiencing homelessness, it is relevant to this review because severe and multiple disadvantage includes overlapping experiences of homelessness, poor mental health, substance use and interpersonal violence or abuse. Using a qualitative, co-produced service improvement design with three inner-city general practices, Potter et al. (2024) drew on collaborative service improvement meetings, observations, interviews with practice staff and people with lived experience, and a focus group involving lived-experience and support-sector perspectives. This research design is a strength because it brings together professional, organisational and lived-experience perspectives, although the small lived-experience sample and focus on practices already engaged in improvement work limits transferability.

Potter et al. (2024) found that standard general practice systems can be difficult to use where services depend on conventional appointment structures, administrative communication and assumptions of stability. The co-designed changes included flexible access for patients on an inclusion patient list, continuity through a care coordinator and micro-team of clinicians, and improved information sharing. These findings are relevant because general practice commonly acts as a route into assessment, referral and wider psychological or psychiatric support. The study therefore suggests that exclusion from care can be produced by routine service design, rather than only by individual reluctance or non-attendance.

Bell et al. (2024) similarly highlight this concern with the mismatch between mainstream service organisation and the realities of homelessness. In their qualitative service evaluation of healthcare and housing provision for people experiencing homelessness, participants described complex journeys into and through homelessness, alongside difficulties engaging with mainstream systems. The nurse-led outreach service was experienced as more accessible than mainstream provision because nurses worked in community settings, visited people in situ, offered drop-in access and provided a relational bridge into healthcare. This is particularly relevant to mental health-related care because the outreach model included both mental health and general nurses, with psychological therapies and motivational interviewing forming part of the provision. Bell et al.'s findings therefore suggest that outreach can reduce the burden placed on individuals to navigate formal appointments and service thresholds.

Adams et al. (2022) illustrate this issue in the specific context of mental health and substance use support. Their qualitative study found that service location, limited availability, remote or telephone access, and difficulty accessing support outside standard service arrangements could prevent people experiencing homelessness from receiving support, even when services were technically available. This reinforces Bell et al.'s (2024) findings by showing that access depends not only on the existence of services, but also on whether services are reachable, flexible and responsive to the circumstances of homelessness.

Warren et al. (2025) further show how access barriers may be intensified for people with overlapping cognitive, mental health and substance use needs. Their study examined barriers and facilitators to housing and healthcare services for people experiencing homelessness with acquired brain injury and concurrent mental health and substance use disorders. Drawing on focus groups with people with lived experience, service providers and community stakeholders, Warren et al. identified barriers including stigma, insufficient investment, siloed systems, generalised approaches to housing and policies that did not support complex needs. The study was conducted in Canada and did not focus specifically on psychological therapy or specialist mental health services. However, it

remains relevant to the present review because access to mental health support for people experiencing homelessness is often shaped by wider healthcare, housing and support pathways, rather than by specialist mental health services alone.

Jain et al. (2025) provide a useful contrast by showing how access can improve when services become more flexible and integrated. Their national qualitative study examined the *Everyone In* initiative in England, an emergency COVID-19 response that temporarily accommodated people sleeping rough or at risk of rough sleeping, and included people accommodated through the programme alongside service providers involved in planning, delivery or implementation. The study found that flexibility in funding and resources, joined-up services, and innovative responsiveness across health, housing and wider care systems were key strengths of the initiative. Jain et al. (2025) also emphasised the importance of addressing psychosocial needs and the complexities of alcohol and substance use within homelessness strategies. This suggests that administrative exclusion is not inevitable. Rather, exclusion may be reduced when systems are flexible, integrated and able to respond to the wider determinants shaping health and help-seeking.

Taken together, these studies suggest that routes into mental health-related support are shaped by the organisation of wider care systems. General practice, referral processes, appointment structures, eligibility criteria and fragmented service pathways can either provide routes into care or become mechanisms of exclusion. The included literature identifies important systemic barriers and points towards practical improvements, including flexibility, outreach, continuity, information sharing, joined-up working and integrated provision. However, less is known about how people experiencing homelessness make sense of repeated administrative barriers within their lived experience, how these experiences shape trust, self-worth and future help-seeking, and what they believe would make services more accessible. There is also limited qualitative understanding of how these experiences may be shaped by personal circumstances and demographic factors, including gender, ethnicity, housing situation, trauma history and previous contact with services. This gap is directly relevant to the present study, which explores participants' lived experiences of barriers to

mental health care within the wider context of homelessness, and their perspectives on how access to support could be improved

2.3.2. Mistrust, stigma and relational barriers

Having considered administrative and service-level barriers, this subsection examines how relationships with services shape access to mental health-related support. This is relevant to the present study because access is not only determined by whether services are available, but also by whether support is experienced as safe, respectful and trustworthy. Across the included studies, stigma, shame, mistrust and relational safety were central to how people experiencing homelessness engaged with healthcare and mental health-related support.

Sutherland et al. (2022) highlight how stigma, shame and fear of judgement affected older women's access to healthcare. In their study of 22 older women experiencing homelessness in Western Australia, some women described feeling ashamed or embarrassed about becoming homeless, which made it harder to seek help. For some, this was linked to feeling judged by services or by people who had known them before they became homeless. The study also shows why this stigma may have been particularly painful for older women. Homelessness disrupted women's relationships with children and grandchildren, and some described feeling that they had failed as mothers or women because they could no longer provide a home or maintain their family role. These feelings sat alongside other barriers, including domestic and family violence, trauma, financial insecurity, fear of unsafe accommodation or street homelessness, and the need for female healthcare professionals to feel safe. Although conducted outside the UK, the study is relevant because it shows that stigma can be emotional and relational, shaped by gender, age, family relationships, violence and shame.

Ingram et al. (2024) similarly highlight the role of trust and recognition in healthcare access. Their ethnographic study of people attending a primary care and addiction service in Ireland found that participants' priorities included mental health, safety, relationships with children and family, purpose, physical pain and housing. Participants generally valued the drop-in primary care and harm

reduction service, particularly where staff knew them, treated them with familiarity and created a supportive social environment. However, barriers remained around mental health and addiction support, including internalised beliefs that they were beyond help, limited information about available services, and stigma within systems that treated addiction as separate from health. This indicates that engagement is shaped not only by service availability, but by whether people feel recognised, respected and able to trust the support offered. Reluctance to seek further help may therefore reflect previous experiences of stigma, shame, rejection or services that felt poorly attuned to the realities of homelessness, rather than a lack of motivation to engage.

Adams et al. (2022) develop this point in relation to mental health and substance use support. Their qualitative study with people experiencing homelessness in North East England during COVID-19 found that changes to service provision often created "inadvertent exclusion," including reduced out-of-hours support, digital exclusion, limited awareness of available services, and difficulties accessing support in safe and suitable spaces. Participants also described the emotional burden of repeatedly retelling recovery stories, feeling passed between services, and encountering support that did not always recognise the interaction between mental health, substance use and homelessness. These findings highlight the importance of trauma-informed care as a relational approach, not only a service model. Support was more likely to feel accessible when it prioritised choice, empowerment, active involvement and respect for peoples lived experience.

Schel et al. (2022) examined intentional unidirectional peer support within homeless services from the perspectives of both people receiving support and peer workers providing it. The study found that peer support could enhance self-image, support personal growth and improve engagement with needed services. These outcomes were linked to relational mechanisms such as rapport, empathy, trust, empowerment, accessibility, equality, and support with navigating professional care. This is relevant to mental health access because mistrust, shame and previous rejection may make formal services feel difficult to approach. Peer workers were valued for understanding clients' situations through shared experience, offering support that felt less

judgemental, and mediating between clients and professionals where relationships with services were difficult. Peer support therefore appears to offer more than practical advice; it may provide a relationship that feels credible, less hierarchical and emotionally safer, helping people move towards support that they might otherwise avoid.

Bell et al. (2024) also point to the importance of relational accessibility. In their qualitative service evaluation, participants valued the nurse-led outreach service not only because it was practically easier to access, but because it provided continuity, familiarity and a bridge into mental health care. This supports the idea that outreach can reduce both practical and relational distance between people experiencing homelessness and formal systems of care. In this sense, outreach and peer support are not only alternative service formats. They may also make care feel more approachable by offering consistency, respect and non-judgemental contact.

Taken together, these studies show that mistrust and stigma are central to understanding access to mental health-related support. People experiencing homelessness may approach services with expectations shaped by previous rejection, shame, trauma, fear of judgement and experiences of being dismissed. The literature also identifies relational facilitators, including peer support, outreach, continuity, compassion, choice and trauma-informed care. There remains limited understanding of how people experiencing homelessness themselves make sense of these forms of support, or how they influence future help-seeking for mental health care. This gap is directly relevant to the present study's focus on lived experience, particularly how individuals understand trust, safety and support when attempting to access mental health care while homeless.

2.3.3. Fragmented responses to complex and co-occurring needs

The previous subsections considered administrative and relational barriers to mental health-related support. This subsection considers how these barriers may be intensified when people experiencing homelessness have complex and co-occurring needs. Across the included literature, mental health was rarely presented as separate from housing insecurity, substance use, trauma, physical ill-health, cognitive difficulties or social exclusion. Instead, the studies suggest that people

experiencing homelessness often experience these difficulties as connected, while services may respond to them through separate pathways. This is relevant to the present study because it raises questions about how people make sense of mental health care when their distress is closely linked to wider instability and exclusion.

Adams et al. (2022) provide a clear example of this in relation to mental health and substance use support. Their qualitative study with people experiencing homelessness during COVID-19 found that access was affected by reduced service provision, digital exclusion, limited awareness of available support and difficulties accessing care when it was needed. The study also showed that mental health and substance use were often closely linked. For some participants, substance use was connected to trauma, distress, coping and survival. This is important because services that expect substance use and mental health to be addressed separately may not reflect how these difficulties are experienced in practice.

Ingram et al. (2024) similarly show that people experiencing homelessness may understand health through everyday survival needs rather than through separate clinical categories. Their ethnographic study of people attending a primary care and addiction service in Ireland found that participants' priorities included mental health, personal safety, family relationships, purpose, physical pain and housing. Barriers to mental health and addiction support included feeling beyond help, limited information about available services and stigma within systems that treated addiction as separate from health. Psychological distress may therefore be experienced alongside pain, fear, grief, substance use, unstable accommodation and the need for safety. A fragmented system may therefore fail to respond to the way health is actually experienced.

Warren et al. (2025) add to this by focusing on people experiencing homelessness with acquired brain injury and concurrent mental health and substance use disorders. Their study identified barriers including stigma, under-resourced services, siloed systems, general housing approaches and policies that did not adequately support complex needs. Cognitive difficulties are particularly important because they may make it harder to manage paperwork, appointments, repeated

explanations and contact with several agencies. Although the study was conducted in Canada, it offers useful insight into how systems can become inaccessible when they require stability and persistence from people whose circumstances make this difficult.

Ingram et al. (2025) further show that recovery from substance use cannot be understood separately from the wider conditions of homelessness. Their study of addiction recovery among people experiencing homelessness in Dublin found that recovery was shaped by housing, physical and psychological health, stigma, motivation, self-beliefs, social support, meaningful activity, and access to mental health, addiction, primary care and housing services. This is important because recovery was not presented as simply a matter of individual readiness or motivation. Instead, participants' ability to engage with recovery appeared to be shaped by whether they had a safe place to stay, support for unresolved psychological distress, opportunities to rebuild confidence and purpose, and services that could respond to more than one need at a time. The study therefore challenges approaches that treat substance use as an isolated problem and suggests that recovery may be more sustainable when housing, mental health, addiction and social support are addressed together.

Sutherland et al. (2022) add an important gendered and age-related perspective. Their study of older women experiencing homelessness identified interrelated concerns including safe accommodation, trauma and abuse, financial insecurity, stigma, mental health difficulties, healthcare costs, and the interaction between physical and mental health. This shows that co-occurring needs are not experienced in the same way by all people experiencing homelessness. For older women, barriers to care may be shaped by gendered experiences of safety, domestic and family violence, shame, later-life health needs and hidden homelessness.

Taken together, these studies suggest that complex need should not be understood only as a feature of the individual. It is also shaped by the way services are organised. People experiencing homelessness may be required to navigate separate systems for mental health, substance use, physical health, housing and cognitive difficulties, despite experiencing these needs as connected.

This fragmentation can lead to people being delayed, redirected or excluded when their difficulties do not fit clearly within one pathway. However, the literature says less about how people experiencing homelessness themselves make sense of these overlapping needs, or how being passed between services shapes their understanding of mental health care. This gap is relevant to the present study, which explores how individuals understand mental health need within the wider context of homelessness, instability and service exclusion.

2.3.4. Integrated, flexible and peer-supported approaches

The previous subsections focused on barriers to mental health-related support, including administrative exclusion, mistrust, stigma and fragmented responses to complex need. This final subsection considers what the included studies identify as helpful for improving access and engagement. Across the literature, effective support was not described only in terms of service availability. Instead, the studies emphasised flexibility, continuity, outreach, integration, peer support and relationships experienced as safe and respectful.

Jain et al. (2025) provide insight into integrated support through their national qualitative study of the *Everyone In* initiative in England. The study examined what worked well and less well in providing integrated health, housing and wider care for people who were rough sleeping, or at risk of rough sleeping, during the COVID-19 pandemic. It found that flexible funding and resources, joined-up services and responsive ways of working were key strengths of the initiative. These findings indicate that barriers to care may be reduced when systems can respond quickly and work across traditional service boundaries. Jain et al. also emphasised the need to address psychosocial needs and the complexities of alcohol and substance use within homelessness responses. Effective support therefore requires more than temporary accommodation or isolated healthcare input. It also requires attention to the wider conditions that shape mental health, substance use, stability and help-seeking.

Bell et al. (2024) similarly highlight the value of flexible and outreach-based provision. Their qualitative service evaluation found that people experiencing homelessness valued a nurse-led

outreach model because it was easier to access than mainstream services and brought support closer to where people were. The model included mental health and general nurses, with psychological therapies and motivational interviewing forming part of the wider provision. Participants described the nurses as a bridge into healthcare, contrasting this support with previous experiences of inflexible or unsupportive mainstream services. This shows that mental health-related support may become more accessible when services adapt to the circumstances of homelessness, rather than expecting individuals to navigate formal systems alone. Bell et al. also found that housing did not remove the need for ongoing support, challenging the assumption that accommodation alone is sufficient to resolve health and psychological need.

Peer support offers another way of reducing the distance between people experiencing homelessness and formal systems of care. Schel et al. (2022) examined intentional unidirectional peer support within homeless services from the perspectives of people receiving support and peer workers providing it. Peer support was associated with improved self-image, personal growth and engagement with services. Key mechanisms included rapport, empathy, trust, empowerment, support, guidance and mediation. These findings show that peer support may be helpful because it offers a relationship that can feel less hierarchical than some professional encounters. Peer workers may also act as a bridge between service users and formal care, particularly where mistrust, shame or previous rejection have made engagement difficult.

Potter et al. (2024) add a co-production perspective by showing how service improvement can be strengthened when people with lived experience are involved in shaping care. Their study of general practice access for people experiencing severe and multiple disadvantage identified co-designed changes such as flexible access, inclusion patient lists, continuity through care coordinators and micro-teams, and improved information sharing. Although the study was not limited to people experiencing homelessness, it demonstrates how mainstream services can be adapted for people whose needs do not fit standard models of care. The co-produced design is important because it

shifts service improvement away from professional assumptions alone and towards changes informed by those who have experienced exclusion from care.

Adams et al. (2022) identify further features that may support engagement. In their study of access to mental health and substance use support during COVID-19, participants valued support that was personalised, responsive, inclusive and trauma-informed. Choice and empowerment were particularly important, especially where people had experienced reduced autonomy and control. This finding reflects the wider pattern across the included studies: support was more likely to be experienced as helpful when it offered flexibility, respected individual circumstances and avoided positioning people as passive recipients of care.

Ingram et al. (2025) broaden this further by considering recovery and engagement in relation to wider life conditions. Their secondary qualitative analysis of provider interviews and ethnographic fieldwork with people experiencing homelessness attending a primary care and addiction service in Dublin identified barriers to addiction recovery, including limited access to housing, unaddressed physical and psychological health conditions, harmful beliefs about the self, substance use and treatment options, and societal stigma. It also identified enablers of recovery, including self-confidence, self-efficacy, autonomy, meaningful activity, social support, and access to mental health, addiction, family, primary care and housing supports. This shows that support cannot be understood only as treatment for an isolated difficulty. For people experiencing homelessness, recovery and engagement may depend on broader conditions that make change possible, including stable housing, social connection, autonomy and access to multiple forms of care.

Taken together, these studies indicate that support is more likely to be accessible when it is flexible, relational and integrated. The included literature points to the value of outreach, peer support, co-production, trauma-informed practice, continuity, information sharing and joined-up work across health, housing, addiction and social care systems. However, much of this literature focuses on service models, service improvement or broad accounts of what worked well. Less is known about how people experiencing homelessness themselves make sense of these forms of

support, why particular relationships or service features feel helpful, and how positive experiences of support may influence future help-seeking. This gap helps build the rationale for the present study, which focuses on the lived experience of accessing mental health care and the meanings individuals attach to barriers, support and possible change.

2.4. Synthesis of Knowledge Gaps

The narrative synthesis suggests that mental health-related support for people experiencing homelessness is shaped by administrative, relational and structural factors. The included studies show barriers can arise before specialist mental health care is reached, including through general practice systems, referral processes, appointment structures, eligibility criteria, digital requirements and fragmented service pathways. They also show that access is shaped by trust, stigma, previous rejection, trauma, shame, and whether services are experienced as safe, respectful and consistent. Across the literature, mental health need is rarely presented as separate from housing instability, substance use, physical health, cognitive difficulties, trauma or social exclusion. However, services are often organised in ways that divide these needs across separate systems.

The review also identified features of support that may improve engagement, including outreach, peer support, co-production, trauma-informed practice, continuity, information sharing, flexible service design and joined-up working across health, housing, substance use and social care. However, much of the existing literature focuses on service models, organisational barriers or broad evaluations of what appears to improve access and engagement. Less is known about how people experiencing homelessness themselves make sense of these barriers and facilitators, how repeated experiences of exclusion shape trust and future help-seeking, and how individuals understand their mental health needs within the wider context of homelessness and service fragmentation.

This gap is important because the barriers identified in the literature are not only practical or organisational. They may also carry personal meaning, shaping how individuals understand themselves, their sense of worthiness of support, and whether they believe services will respond to them. The present study therefore responds to the need for more idiographic research that explores

lived experience in depth. By focusing on how people experiencing homelessness make sense of mental health need, service barriers and helpful support, the study aims to contribute a more person-centred understanding of mental health care access in the context of homelessness.

2.5 Counselling Psychology and Social Justice

The knowledge gaps identified above are important not only as service-access issues, but also as matters of social justice. Psychology has historically been criticised for privileging intrapsychic explanations of distress, sometimes at the expense of social, political and economic contexts (Prilleltensky & Nelson, 1997; Prilleltensky et al., 2007; Wilkinson, 1997). This critique is particularly relevant to homelessness, where distress may be intensified by poverty, insecure housing, stigma, institutional exclusion and restricted access to care. If psychological distress is understood only as an individual difficulty, there is a risk of overlooking the structural and relational conditions through which suffering is produced, maintained or left unsupported.

Social justice has therefore become an important principle within counselling psychology. Miller (2001) defines social justice in relation to the fair distribution of societal goods, including income, employment, education and healthcare. Within counselling psychology, this orientation has been linked to the profession's commitment to subjective experience, holistic practice and attention to the wider systems in which distress occurs (Fouad et al., 2006; Ivey & Collins, 2003; Kagan et al., 2010; Vera & Speight, 2003). More recent work in psychological therapies has further emphasised the need to understand distress in relation to power, politics and structural inequality (Winter & Charura, 2023). The Division of Counselling Psychology has also emphasised practitioners' responsibilities to the wider world, including the need to engage with equality, fairness and social justice in psychological practice (DCoP, 2021).

From this perspective, homelessness can be understood as a significant social justice issue. Hore (2013) argues that homelessness should be conceptualised in this way within the UK context, rather than being understood only through individual deficit or pathology. This is consistent with critiques of psychocentric discourses, which risk attributing homelessness to personal failure while obscuring

structural determinants and systemic exclusion (Dej, 2016). Professional standards also require psychologists to recognise discrimination and challenge views that pathologise individuals on the basis of class, identity or social position (BPS, 2024, 2025). For counselling psychologists, overlooking these wider conditions may create clinical blind spots, particularly where psychological interventions are offered without attention to the material and relational contexts that shape distress.

The present study is therefore grounded in a social justice orientation. By foregrounding the accounts of people experiencing homelessness, it seeks to explore not only what barriers to mental health care exist, but also how those barriers are lived, understood and given meaning. This focus aligns with counselling psychology's commitment to validating subjective experience while also recognising that individual distress is socially situated. It also supports the rationale for an idiographic methodology, because understanding access to mental health care requires attention to how people make sense of exclusion, support, dignity and help-seeking within the wider context of homelessness.

2.6. Rationale for the Present Study

The reviewed literature indicates that people experiencing homelessness encounter barriers to mental health-related support across multiple levels, including service organisation, referral pathways, eligibility criteria, digital access, fragmented provision, stigma, mistrust and previous experiences of rejection. It also suggests that support may be more accessible when it is flexible, relational, integrated and informed by lived experience.

However, the existing evidence base remains limited in its idiographic understanding of how people experiencing homelessness make sense of these experiences. Much of the literature identifies service-level barriers or describes models of support, but less is known about how individuals understand these barriers in the context of their own mental health needs, housing instability and previous attempts to seek care. There is also limited understanding of how repeated experiences of exclusion may shape trust, self-worth and future help-seeking.

The present study responds to these gaps by exploring the lived experiences of people experiencing homelessness in relation to mental health care access. Interpretative Phenomenological Analysis is appropriate because it allows for detailed exploration of how individuals make sense of their experiences, while remaining attentive to the social, relational and structural contexts in which those experiences occur. This approach is consistent with counselling psychology's commitment to subjective experience, non-pathologising understandings of distress and socially situated psychological practice.

On the basis of these gaps, the present study was guided by the following research questions.

2.7. Research Questions

The questions this study aims to answer are:

Research Question 1: What are the lived experiences of individuals facing homelessness, and how do these contexts shape their perceived mental health needs?

Research Question 2: What systemic and personal barriers do people experiencing homeless perceive when attempting to access mental health services?

Research Question 3: How do different demographic identities and individual circumstances influence the experience of these barriers?

Research Question 4: What forms of current support are perceived as beneficial, and how can services be improved from a lived-experience perspective?

3. Research Methodology

In this section, I discussed the rationale for my chosen research methodology, Interpretative Phenomenological Analysis (IPA), as opposed to other potential methodologies. I explored the philosophical underpinnings of IPA and provided a reflexive account of my personal views on epistemology and ontology, highlighting how these factors ultimately shaped the research process. Finally, I described the research design and process, addressing ethical considerations in detail.

3.1 Design

3.1.1. Rationale for a Qualitative Approach

Based on a critique of the current literature, it was discovered that previous studies predominantly focused on using quantitative measures. Historically, these measures have been mediated through third-party observers, such as healthcare professionals or family members, rather than prioritizing the first-hand accounts and subjective sense-making of the individuals themselves. Key values of the counselling psychology profession included seeing the individual holistically and valuing subjective experiences (Vera & Speight, 2003). Therefore, it was felt that a qualitative approach would add rich, insightful data focused on people experiencing homelessness' subjective experience (Kaiser, 2009) in an under-researched area. A qualitative approach also aligned with the researcher's aims of exploring meaning and nuances (e.g., pauses, laughter, tone) in participants' accounts to derive a deeper and more holistic understanding of the individual (Smith & Eatough, 2007), which would not have been possible using a quantitative approach.

3.1.2. Epistemological and Ontological Position

The term "ontology" referred to a branch of philosophy initially introduced by Aristotle in 'Metaphysics' IV 1 (Cohen, 2016) and was concerned with the nature of existence and the structure of reality (Crotty, 1998). In the context of research, questions relating to ontology might have included, "What can we know?" and "What is the nature of reality?" (Guba & Lincoln, 1989). While ontology dealt with what in the world there was to know, epistemology focused on how we studied this

knowledge (Willig, 2008). Maynard (1994) stated that epistemology provided philosophical grounding to decide what types of knowledge could be gained and how reliable these measures were. During my research process, I reflected on my personal position regarding ontology and epistemology, which shaped my research design.

In the early stages of my academic career, my focus was primarily on theory and research rather than direct interaction with people. During this time, my practice was grounded in a positivist paradigm, characterized by the belief that scientific "truth" is only attainable through the rigorous measurement and control of variables. This perspective was anchored in a naive realist ontology, which posits that an objective reality exists independently of human perception and can be apprehended through detached, objective research methodologies (Guba & Lincoln, 1994). My limited understanding and experience at the time led me to view qualitative research as time-consuming and less significant than its quantitative counterpart. In hindsight, I recognize that the stability and structure offered by quantitative methods eased my anxiety as a novice researcher.

As my career progressed, I gained valuable experience working directly with individuals within the NHS. In the Accident & Emergency department of a busy hospital, I observed that patients were often reduced to objective terms on paperwork, reflecting a system that prioritized speed and efficiency in communication and patient care. Yet, in many instances, patients welcomed me into their lives, allowing me to glean the most meaningful insights by remaining open to their perspectives rather than strictly adhering to prescribed documentation.

Currently, as a Trainee Counselling Psychologist, I find myself gravitating towards objective psychometric measures, particularly when I feel less confident in my abilities. This realization has prompted me to reflect on how my personal qualities influence my approach. During therapeutic sessions as part of my training, I have been actively working on embracing the inherent uncertainty that arises in these interactions. This shift has enabled me to foster genuine connections with clients and explore their experiences more deeply, resulting in insights that might have been overlooked in a more structured setting. This experience reinforced the importance of balancing structured measures

with a more fluid, person-centred approach, allowing me to appreciate the unique complexities of each individual's experience. By embracing uncertainty and allowing the therapeutic process to unfold organically, I have facilitated richer discussions and supported my clients in a manner that aligns more closely with their needs.

My current epistemological stance aligns with Critical Realism and Phenomenological Epistemology (Guba & Lincoln, 1994). Critical realism acknowledges a realist ontology—the existence of an objective reality—while simultaneously recognizing that our knowledge of that reality is socially situated and fallible; thus, individuals perceive and make sense of these "truths" differently based on their unique contexts (Eatough & Smith, 2007). From a phenomenological perspective, I believe it is essential to prioritize firsthand accounts to uncover these subjective 'lived realities' (Giorgi, 1994). This framework allows me to move beyond the limitations of my previous positivist stance, emphasizing that while structural barriers to health are 'real,' their impact can only be fully understood through the subjective meaning-making of the individual.

3.1.3. Characteristics of IPA

In alignment with my personal epistemological stance, I chose Interpretative Phenomenological Analysis (IPA) as the research methodology. IPA has three primary theoretical underpinnings: phenomenology, hermeneutics, and idiography. Edmund Husserl was the principal founder of phenomenology, which he described as "the science of the essence of consciousness" (Husserl, 1913). Phenomenology aims to create an account of subjective lived experience that is true to the individual rather than one subscribing to pre-existing theory (Smith & Osborne, 2015). Phenomenology studies "phenomena," examining how things appear, how they were experienced, and the meaning attached to them. IPA research adhered to phenomenology's core values by paying careful attention to the individual's lived experience and encouraging participants to use their own words to portray this (Smith, Flowers & Larkin, 2009).

Hermeneutics, defined as the theory and practice of interpreting the meaning of texts (Rennie, 1999), is based on the perspectives of theorists such as Heidegger, Schleiermacher, and Gadamer.

Schleiermacher proposed that both linguistic and psychological interpretation were necessary for effective analysis and could reveal more than what the participant consciously knew (Smith, Flowers & Larkin, 2009). Heidegger expanded on this by asserting that humans were inseparable from the world around them, meaning researchers could not reveal absolute truths about lived experiences (Larkin, Watts & Clifton, 2006). This led to the IPA principle that the researcher's account would reflect the participant's lived experience rather than an objective truth. IPA research also employed a "double hermeneutic" process, coined by Smith and Osborne (2003), which described two interpretations: 1) the participant's interpretation of their lived experience, and 2) the researcher's interpretation of the participant's account.

Idiography, another fundamental aspect of IPA, emphasized the unique experiences of individuals. In IPA research, each participant's story was honoured by focusing on their lived experience before moving on to the next participant. After all participants data had been interpreted, a cross-case analysis followed, where common themes or phenomena were identified while respecting each individual's unique account (Smith & Eatough, 2006).

3.1.4. Rationale for IPA

In alignment with the researcher's epistemological stance, critical-realism was adopted as the research epistemology. IPA is theoretically rooted in critical realism (Bhaskar, 1978), and accepts that there are enduring and stable aspects of reality, or fundamental truths, that exist outside of human conceptualisation. Therefore, individuals may perceive experiences in various ways based on their personal construction of reality (Eatough & Smith, 2008).

IPA was seen as fitting toward a critical realist epistemology due to its idiographic nature, where each participant is considered a unique individual and thoroughly analysed on a case-by-case basis. A phenomenological approach will address the gap in the current knowledge base by allowing PEH to share their lived experience on their own terms, rather than from pre-existing theoretical preconceptions or from accounts from other people, as seen in past research. Based on this, critical

realism aligns with Counselling Psychology's principles, as it is highlighting the importance of exploring individual's subjective experiences, beliefs and values (BPS, 2005).

Within IPA research, both the researcher and participant are active in exploring how a participant makes sense of the world, known as the "double hermeneutic". The double hermeneutic allows researchers the advantage of being able to use their subjective judgement to offer an external understanding of the participants' experiences (Smith at al., 2009). Although IPA is idiographic in that it accounts for the individual's unique experience, it also allows for exploration of themes between several participants to better understand a concept or social phenomenon (Creswell, 2007). Common themes amongst participants may provide valuable insight for future developments in mental health services for the homeless population.

3.1.5. IPA and Other Qualitative Approaches

When considering other qualitative research methods, I found that Grounded Theory (GT) did not fit the research question due to its focus on developing explanatory theories of social processes. Thematic Analysis (TA) was also considered, but it lacked IPA's phenomenological focus, which provided richer insights into participants lived experiences. IPA's idiographic nature and its ability to highlight common patterns of social phenomena led to a deeper understanding of the homeless population's mental health needs (Smith et al., 2009).

3.2. Procedure

3.2.1. Data Collection and Recruitment

I contacted homeless centres in the Manchester area by email and enquire whether I could advertise a Recruitment Poster (Appendix A) for the study within their centre. My rationale for choosing Manchester as the location of the study was due to the Office for National Statistics (2020) report, which stated that Manchester had the highest rates of homeless deaths in 2019 in a study of 336 local authorities. Additionally, Healthwatch (2017) states that access to the mental health system in Manchester is difficult to navigate, with fragmented services.

Following Clarke's (2010) guidance, which recommends four to 10 participants for professional doctorate students conducting IPA, I attempted to recruit six to eight participants for the study (Clarke, 2010; Smith et al, 2009). However, given the challenges associated with accessing the homeless population, such as their transient lifestyle, distrust of researchers, and lack of stable contact information (Sydor, 2014; Lambert & Wiebel, 2014), I was only able to recruit four participants. Participation was voluntary, and the researchers email address and work phone number was provided if the participants wish to express interest in the study. Prior to the interview, a Participant Information Sheet (Appendix B) was provided, and the participant was required to sign a Contract Agreement (Appendix C).

I used a purposive sampling approach by recruiting individuals over the age of 18, in alignment with the research question: “What barriers do homeless adults perceive they face when trying to access mental health services?” To ensure a comprehensive scope, the study adopted the ETHOS Light framework (FEANTSA, 2007) to identify core populations who often remain invisible in statutory records. The inclusion criteria comprised individuals who self-identified as experiencing one of the following categories of homelessness:

- **Rooflessness:** Individuals without any shelter, such as those sleeping rough.
- **Houselessness:** Individuals living in temporary accommodation, such as hostels, night shelters, or bed and breakfasts.
- **Insecure Housing:** Individuals living in precarious conditions, such as those "sofa surfing" with relatives or fleeing domestic violence.
- **Inadequate Housing:** Individuals living in unfit conditions, such as extreme overcrowding or illegal campsites.

Participants were also required to have experienced a time when they needed mental health support but had difficulty accessing it despite their efforts. To participate in the study, participants were required to not be under the influence of substances during meetings with the researcher, ensuring that they had the capacity to consent at all times during the research.

3.2.2. Participants

Table 3 presents the demographic characteristics and homelessness histories of the four participants. Pseudonyms are used throughout to protect participant anonymity.

Table 3

Participant Characteristics and Homelessness History

Participant	Age	Gender	Ethnicity	Duration and Nature of Homelessness
David	57	Male	White British	12 years: Long-term roofless, experiencing periods of houselessness and insecure accommodation.
Paul	52	Male	White British	4 years: Remained continuously roofless throughout this duration.
Emma	55	Female	Black British	10 years: Experienced continuous rooflessness during this time.
Andrew	48	Male	Black British	30 years: Long-term roofless, with short periods of houselessness.

3.2.3. Materials

To ensure thorough data collection, participant engagement, and adherence to ethical standards, the following materials were utilized in this study:

Recruitment Poster: A visually engaging poster was designed to attract potential participants, providing essential information about the study, eligibility criteria, and contact details.

Participant Information Sheet: This document provided detailed information about the study's purpose, procedures, potential risks, and benefits, ensuring informed consent from all participants.

Contract Agreement: A formal agreement outlined the terms and conditions of participation, including confidentiality assurances and participants' rights.

Distress Protocol: A distress protocol (Cocking, 2008) was implemented to address any emotional or psychological distress experienced by participants during the study, ensuring their well-being and safety.

Debrief Form: A form was provided to participants at the conclusion of the study, summarizing the study's purpose, findings, and providing contact information for further questions or support.

PHQ-9 (Patient Health Questionnaire-9): A standardized questionnaire was administered to assess the severity of depressive symptoms in participants.

GAD-7 (Generalized Anxiety Disorder-7): A standardized questionnaire was administered used to evaluate the severity of generalized anxiety disorder symptoms in participants.

Interview Schedule: A structured interview schedule was developed to guide the interviews, ensuring consistency in the questions asked and allowing for comprehensive data collection on participants' experiences and perspectives.

Audio recording: Interviews were conducted face-to-face with an audio recorder to ensure accurate data capture.

3.2.4. Interviews

Face-to-face interviews took place in a private room at a homeless charity centre in Manchester, with safety protocols in place to ensure the well-being of both the researcher and participants. A lone working policy was implemented, with a staff member stationed in an adjacent room, informed of the interview's estimated duration of one hour and responsible for checking in at the end of this time. The researcher carried a panic alarm for emergencies and a code phrase was established to discreetly signal for emergency assistance if needed.

To ensure participant safety and comfort, additional protocols were introduced. Participants were fully briefed on the safety measures prior to the interview, including the presence of nearby staff for assistance if needed. They were informed that they could leave, pause, or stop the interview at any point without having to provide an explanation and were encouraged to express any concerns throughout the process. I also offered participants a warm drink and allowed them time to settle in

before beginning the interview, giving them space to feel more at ease. These measures were carefully designed to create a secure, respectful, and supportive environment for both the researcher and participants.

Smith and Osborne (2003) stated that a flexible data collection instrument was required within IPA research to analyse in detail how a participant perceived and made sense of their experience. Semi-structured interviews were chosen as the method because they allowed for richer data to be collected, aligning with IPA (Smith & Osborne, 2003). For example, semi-structured interviews provided greater flexibility in the coverage of topics discussed, meaning pertinent information was recognized instead of being overlooked due to not fitting a rigid interview schedule. Furthermore, semi-structured interviews were argued to facilitate rapport between the researcher and participant, which could lead to more information being shared (Smith & Osborne, 2003). Focus groups were considered as a method; however, individual interviews were deemed more aligned with the idiographic focus of the research and allowed the focus of the research to remain central (Smith, 2005).

The questions within the interview schedule were constructed based on a critique of the literature. Following guidance from Smith et al. (2009), six to ten open-ended questions and corresponding prompts were chosen to provide 45–90 minutes of discussion within the interview. Questions were developed in accordance with Smith and Osborne's (2008) guidance, which suggested that interviews should be conducted in a way that allowed exploration of a topic with as little influence from the researcher as possible. Therefore, the Interview Schedule (Appendix D) was developed to provide a general framework that was open to further exploration with the participant, using prompts if necessary. Questions were constructed while being mindful of avoiding value-laden questions, jargon, and closed questions (i.e. What is your opinion on the mental health support available for people experiencing homelessness?)

Interviews were recorded on an encrypted audio-recording device used solely for the research study, and participants were required to give verbal consent before audio recordings began. Audio recordings were then transcribed verbatim for analysis (Smith et al., 2009).

3.2.5. Reflexivity and the Researcher–Practitioner Position

In navigating my dual identity as both a doctoral researcher and a practicing therapist, a primary reflexive challenge arose during the recruitment and screening phase. My therapeutic training instils a proactive 'duty of care,' whereas the research role demands a degree of detachment to ensure standardized data collection. This tension became most acute when reviewing the PHQ-9 (Kroenke et al., 2001) and GAD-7 (Spitzer et al., 2006) used during participant screening. As these are validated clinical measures used to identify depression and anxiety severity, my professional background meant I could not view the resulting scores through a purely data-driven research lens. As Gabriel (2005) notes, practitioner-researchers must develop a high degree of role fluency to navigate these ethical boundaries.

The primary dilemma occurred when a potential participant's response to Item 9 of the PHQ-9 indicated thoughts of self-harm or suicidal ideation. At this ethically important moment (Guillemin & Gillam, 2004), my researcher identity, focused on assessing study eligibility, was immediately superseded by my clinical identity. This transition aligns with Finlay's (2002) assertion that reflexivity requires the researcher to acknowledge how their professional background directly shapes the research encounter. To resolve this, I implemented a 'Risk Bridge' protocol: if a screening questionnaire indicated clinical risk, I paused the research recruitment process to prioritize a clinical risk assessment and provide appropriate signposting to emergency or mental health services (Hom et al., 2017).

A further dilemma involved the risk that participants might view the administration of the PHQ-9 and GAD-7 as the start of a clinical intervention rather than a research screening process (Fleet et al., 2016). As these tools are ubiquitous in clinical settings, participants may have perceived me as an expert clinician, potentially leading to acquiescence bias or a 'good patient' persona where they reported symptoms, they felt I wanted to hear. Reflexively, I had to ensure that my responses to high scores were handled with therapeutic sensitivity without prematurely establishing a long-term therapeutic alliance. Following Etherington's (2004) guidance, I used the informed consent process to

explicitly deconstruct these roles, clarifying that while I had a duty of care to ensure their safety, our interaction was for research purposes rather than therapeutic treatment.

Finally, the act of excluding participants based on high PHQ-9 or GAD-7 scores presented an internal conflict. In a clinical setting, turning away a person in distress feels antithetical to the therapeutic ethos of accessibility. During recruitment, when a participant's scores suggested they were too vulnerable for the current study's scope, I experienced what Gabriel (2005) describes as the internal conflict of the 'relational practitioner.' This conflict manifests as the struggle to balance the objective, boundary-driven requirements of a researcher with the innate, empathetic impulse to provide immediate therapeutic containment. To mitigate this, I ensured that every individual who completed a screening questionnaire, regardless of their inclusion in the final study, was handled with clinical care and provided with a curated list of support resources, ensuring my ethical duty as a therapist was met alongside my requirements as a researcher.

3.2.6. Analysis

The data were analysed using Smith et al.'s IPA approach, following the six-stage analytic process outlined by Smith et al. (2009) while adopting the updated terminology provided in the revised guidance by Smith et al. (2022).

1. *Multiple reading*

The transcript was read several times to immerse myself in the data and stay connected to the original audio recordings (Shenton, 2004). Each line of the transcript was numbered for quick reference.

2. Initial coding

Initial coding was based on Smith et al.'s (2009) definition of three distinct categories within IPA: descriptive comments (normal font), linguistic comments (italics), and conceptual comments (bold). Annotations were made based on these categories in the left-hand margin. Smith et al (2009) state that descriptive comments focus on descriptions of the content (e.g., early life experiences and relationships). Linguistic comments were drawn upon the use of language (e.g., pauses, laughter,

repetition, tone). Conceptual comments were considered by questioning and interpreting what the client might mean regarding an explicit comment.

3. Identifying experiential statements

The transcript was analysed to identify themes based on similarities noted within the initial coding process at a higher level of abstraction, which may refer to psychological conceptualization. These themes were presented in the right-hand margin and was referred to as “experiential statements”.

4. Clustering themes in individual data

I looked for common connections within the experiential statements to identify Personal Experiential Themes and Group Experiential Themes. This was achieved through processes highlighted by Smith et al (2009), such as “abstraction” (clustering similar themes together), “subsumption” (identifying a common theme within the cluster to develop Group Experiential Themes), “numeration” (the frequency a theme is supported suggesting importance) and “function” (exploring the wider context and function of the theme in regard to the participant). Experiential statements were collated into a table with a quotation from the participant which was felt to best capture the essence of their thoughts and emotions.

5. Repeating the process

To stay within an idiographic perspective, the previous steps of analysis began afresh with each of the participants, to ensure assumptions from the previous participant did not tarnish the interpretative process with the new participant.

6. Clustering themes across group data

The final stage of analysis involved making connections across all the participants' cases and consolidating these themes into a list. The analysis shifted from constructing themes representing the individual’s experience to themes which represented all the participants, highlighting a social phenomenon. New findings in the context of analysing the groups data may result in themes being modified. For example, Personal Experiential Themes which are not present in at least half of the transcripts were discarded (Smith et al, 2009). Furthermore, individual cases were returned to, and

the respective Group Experiential Themes was renamed to ensure cohesion. Certain themes were also dropped from the list due to reasons such as prevalence or having a weak evidential base.

These divergent perspectives provided valuable insight and were integrated into theme development through the process of polarisation, allowing for the exploration of tensions within the participant's experience (Smith et al., 2009). This aligns with IPA which accepts various versions of reality (Snelgrove, 2014) and argues there are no absolute certainties of a valid truth (Smith, 2004). The Group Experiential Themes were appropriately named to encapsulate the Personal Experiential Themes identified and listed in a final summary table.

3.2.7. Ethical Considerations

3.2.7.1. Ethical standards

The research adhered to the ethical guidelines set by the British Psychological Society (BPS, 2021) and London Metropolitan University's Research Ethics Policy and Procedures (2021). Ethical approval for this study was formally granted by the London Metropolitan University Research Ethics Committee (Appendix H). Participants were provided with comprehensive information to ensure informed consent and were assured of confidentiality. Data was protected following the Data Protection Act (2018), with interviews recorded on encrypted devices and stored securely. The potential vulnerability of people experiencing homelessness was acknowledged, and measures were taken to minimise distress and support informed participation.

3.2.7.2. Consent

According to BPS guidelines (2021), researchers were required to ensure that each participant was given sufficient information about the research to enable them to make an informed decision and to consent voluntarily before any data was recorded. Based on this guidance, a Participant Information Sheet (Appendix B) was provided to ensure full transparency of the research prior to the interview. Participants were also presented with a Contract Agreement (Appendix C) and were required to provide written consent before the interview began. The Contract Agreement (Appendix C) outlined the terms of confidentiality and anonymity, data-protection measures, and the participants' rights to

withdraw from the research. The position of power in the researcher-participant relationship was acknowledged (BPS, 2021), and individuals were given the option to read and sign these documents in their own time to ensure that they did not feel coerced into participating due to my presence. To partake in the study, participants were required to not be under the influence of substances during meetings with me to ensure that they had the capacity to consent at all times during the research.

The BPS Code of Human Research Ethics (2021) states that participants should feel free to modify their consent or to withdraw or destroy all or part of the data they had contributed to the research, within limits consensually agreed to by the researcher and participant. In adherence to these guidelines, I stated in both the Participant Information Sheet (Appendix B) and Contract Agreement (Appendix C) that participants could withdraw from the research with no questions asked and could request that their data be erased up until October 31st, 2023, when the data was amalgamated.

3.2.7.3. Confidentiality

The BPS Code of Human Research Ethics (2021) states that participants should expect their data to be treated confidentiality and not identifiable if the research was to be published. However, the duty of confidentiality is not absolute law and may be breached under certain circumstances, including if the individual was at harm to themselves or others or engaging in organised crime (BPS, 2021). The conditions of confidentiality were clearly stated in the Contract Agreement (Appendix C) for the individual to review before choosing to partake in the study.

3.2.7.4. Data protection

Interviews were recorded on an encrypted audio-recording device used solely for the research study and kept in a locked cabinet to which only the researcher had access when not in use. Participants were informed that all the data collected would be confidential unless risk was assessed based on BPS guidelines (2025). Identifiable information was anonymized directly within the transcript, and during discussions with the researcher's supervisor, pseudonyms were used. In accordance with the Data Protection Act (2018), participants' data was kept on my personal laptop in a password-protected folder. All data collected in paper format was stored in a locked cabinet to which

only I had access. Participants were informed that their data was being collected for a doctoral thesis that might result in publication; therefore, data was kept for five years in electronic format on a password-protected device.

Ethical issues were considered specifically in regard to the homeless population. People experiencing homelessness often faced stigma, social isolation, and mental health issues. Within qualitative research, there was a risk that the research could affect participants' self-esteem, personal values and beliefs, and personal relationships. Additionally, distress could be caused if sensitive or illegal information was disclosed, such as past trauma, sexual behaviour, exposure to violence, and issues relating to gender or race. In an effort to reduce any further potential feelings of marginalization that I might inadvertently contribute to, I adhered to the BPS Code of Ethics and Conduct (2021), which highlighted recognizing the "inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or any other such group-based characteristics." I followed the principle of respect (BPS, 2021) by remaining non-judgmental, empathetic, and compassionate towards participants' methods of making money, lifestyle, or appearance. A neutral approach was also adopted as an "interviewer" to avoid encouraging the concept of labelling or stereotyping people experiencing homelessnes. To achieve this, I engaged with a reflective journal and participated in personal therapy to reflect on any personal assumptions and beliefs that might emerge as a result of the research process.

In adherence to the BPS Code of Ethics and Conduct (2021), I followed the principles of respect and integrity by recognizing "issues of power" between the researcher and participants and avoiding "exploitation and conflicts of interest (including self-interest)". Since people experiencing homelessness are more likely to face financial difficulties, participants were not offered an incentive to take part in the research to prevent exploitation and acting in my own self-interest. I personally reimbursed participants for any incurred expenses due to participation in the research, such as travel costs to the centre for the interview.

Ethical consideration was also given to the recruitment of participants for the study. Although people experiencing homelessness are often in public areas, I respected the privacy (BPS, 2021) and security of participants by not intruding on their personal space. A Recruitment Poster (Appendix A) was used to invite participants to voluntarily contact me to take part in the study.

3.2.7.5. Risk Assessment and Safety Protocols

The PHQ-9 and GAD-7 (Appendix G) were conducted to assess risk. Participants who scored as "severe" on either the PHQ-9 (20-27) or GAD-7 (15-21), but were not at risk of harm to themselves, were contacted and signposted to their GP. If participants were deemed to be at risk of harming themselves, I explained that the interview would not be conducted, as the priority was the participants' safety. I then suggested that the participant present themselves to the local A&E Department and ask for the on-call psychiatric liaison team, providing details if needed (Cocking, 2008).

I ensured that interviews took place during daylight hours, between 9 AM and 5 PM. I confirmed with the organizations that there would always be at least one staff member present when I conducted interviews, to ensure I had a contact if I needed immediate support. I carried a personal alarm to alert staff in case of an emergency. I pre-prepared an excuse if I felt the need to leave the interview and developed a code phrase (e.g., "I've come for the red folder") to alert staff that I needed assistance. The interview room had a note on the door indicating that there was a "confidential meeting in process," but the room was left unlocked to ensure that the participant and I were not trapped inside and to allow other staff to access it if necessary. I also learned the locations of fire exits and escape routes within the property and informed the participant of these. I ensured that the layout of the room provided a clear route of escape for both the participant and myself, with my chair positioned closer to the door to prevent obstruction in leaving. I agreed to check in with a staff member after each interview at a specific time and to follow up if that time had expired, to ensure safety. I maintained professional boundaries at all times to discourage inappropriate behaviour. I informed a family member of my expected time of arrival at home and agreed to call the police if I had not checked

in after the expected time. I ensured that these standards were present in any future homeless organizations that might respond to my inquiry.

If an individual was suspected to be under the influence of substances before the interview, the participant was taken to a private space where they were gently reminded of the Participant Information Sheet (Appendix B) and Contract Agreement (Appendix C), which both stated that participants "must not be under the influence of substances during meetings with the researcher." I explained to the participant that this was due to safety reasons and to ensure they had the capacity to consent to participate in the research. The participant was thanked for attending and offered the opportunity to contact me to arrange an interview on another day when they were not intoxicated. They were also asked if any further support could be offered (e.g., signposting) prior to leaving.

Participants were reminded that they could terminate the interview at any point, and their levels of distress were monitored throughout using my clinical experience. If distress occurred, the Distress Protocol was referred to (Appendix E; Cocking, 2008), and the appropriate corresponding actions were taken (Cocking, 2018). For example, if a participant showed mild distress, I offered them time to pause and compose themselves, asked if they were happy to continue, and reminded them they could stop at any time they wished if they became too distressed.

If extreme distress was detected in a participant, such as verbal or physical aggression, my main aim was to maintain the safety of both myself and the participant. I referred to the Distress Protocol (Appendix E; Cocking, 2008) and suggested that the participant present themselves to the local A&E Department and ask for the on-call psychiatric liaison team (providing details of this if necessary) if I believed that either the participant or someone else was in immediate danger. I also informed the participant that they had a duty to inform any existing contacts they had with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP. If the participant was unwilling to seek immediate help and became violent, I would call the police and request that they use their powers under the Mental Health Act to detain the individual and take them to a place of safety pending psychiatric assessment. However, this last option would only be used in an extreme emergency.

3.7.2.6. Debriefing

As outlined in the Code of Ethics and Conduct (Section 3.4; BPS, 2021), *"when the research data gathering is completed, especially where any deception or withholding of information has taken place, it is important to provide an appropriate debriefing for participants. In some circumstances, the verbal description of the nature of the investigation will not be sufficient to eliminate all possibility of harmful after-effects. For example, following an experiment in which a negative mood was induced, it would be ethical to induce a happy mood state before the participant leaves the experimental setting."* Although the study involves no deception or withholding of information, it still may induce a negative mood due to the nature of the topic. For example, individuals may feel similar emotions to a time they needed but could not access mental health care, or feel hopeless about receiving mental health care in the future.

I set aside 30 minutes immediately post-study to debrief the participants. I explained the purpose of the study and their role in it in simple, jargon-free language. I informed participants that the debriefing provided an opportunity to express any feelings the study evoked and to address any questions or concerns as honestly and thoroughly as possible to improve their mood before exiting the interview. This time ensured I had ample opportunity to address any issues or allow the participant to compose themselves before returning to public spaces, if necessary. Participants were thanked for their time and reminded of the valuable contribution they made in broadening knowledge and improving mental health services for the homeless population. If any questions or concerns arose after the interview, I provided a Debrief Letter (Appendix F) with my contact information and that of my research supervisor, along with relevant signposting details. Participants were also encouraged to reach out if they wished to see the study results.

4. Findings

This chapter presents the findings from the Interpretative Phenomenological Analysis (IPA). The analysis explores how participants made sense of homelessness, mental health need, barriers to accessing support, and experiences of current support. Consistent with the idiographic and interpretative principles of IPA, the chapter attends closely to participants' individual accounts while also identifying patterns of shared meaning across the dataset.

The analysis identified three Group Experiential Themes. The first, Systemic Barriers to Support, captures participants' experiences of difficulty accessing services, including barriers linked to healthcare, housing, funding, accommodation shortages, overstretched systems and stigma. The second, Individual Barriers to Support, explores how participants' personal circumstances shaped access to care, including survival needs, travel difficulties, physical and psychological strain, digital exclusion, gendered vulnerability and trauma. The third, Benefits of Current Support, considers forms of support participants experienced as helpful, including GP involvement, charity organisations, assigned support workers and volunteering. Together, these themes show how access to mental health care was shaped by the interaction between structural conditions, individual circumstances and relational experiences of support.

The research questions this study aimed to answer were:

Research Question 1: What are the lived experiences of individuals facing homelessness, and how do these contexts shape their perceived mental health needs?

Research Question 2: What systemic and personal barriers do people experiencing homelessness perceive when attempting to access mental health services?

Research Question 3: How do different demographic identities and individual circumstances influence the experience of these barriers?

Research Question 4: What forms of current support are perceived as beneficial, and how can services be improved from a lived-experience perspective?

The findings are presented through the three Group Experiential Themes and their related Personal Experiential Themes. Direct quotations are used throughout to ground the analysis in participants' accounts and to illustrate how each theme was experienced and understood.

4.1. Group Experiential Theme 1: Systemic Barriers to Support

A consistently identified general experiential theme across participants' accounts was the presence of systemic barriers that impeded their access to, or effective engagement with, support services. These barriers often created a sense of frustration, hopelessness, and further entrenched individuals in their experiences of homelessness.

4.1.1. Accessing support

Participants articulated difficulties in understanding the convoluted landscape of available support. The sheer complexity and fragmentation of services meant that participants often felt that even when potential assistance existed, identifying its location or the appropriate access pathways proved exceptionally difficult. For instance, David recounted his experience, stating:

> "…the only reason I did get help is because I ended up in hospital. If I hadn't ended up in hospital, I wouldn't have got the help... because I didn't know where to go..." (David, lines 34-36).

This narrative suggests a loss of agency for the individual, where access to vital support is not a function of proactive seeking, but rather a consequence of reaching a severe crisis point. This sentiment was echoed by Emma, who described a frustrating bureaucratic loop:

> "So, I said 'okay how do I register as homeless?' and they said 'okay give us your name and your address' then I said 'I haven't got any address'. 'Okay well in order be able to access any help from the council, you need to register, you need to prove your identity.' So, you're back at square one. It is exhausting!" (Emma, lines 198-204).

Such narratives underscore the procedural hurdles and circular requirements that actively obstruct access for those in most need, fostering a persistent sense of powerlessness and eroding their capacity to navigate systems designed, ostensibly, to help them.

A critical aspect of this navigation difficulty was the lack of awareness regarding available support, which directly impacted participants' sense of self-efficacy in seeking help. David explained:

> "there’s not enough information out there for places like this" (David, line 47), a view corroborated by Andrew, who suggested:

> "there’s not enough information out there, there’s not enough places like this... you have to go out to people on the streets, and let them know" (Andrew, lines 85-86).

This perceived absence of proactive outreach and clear communication exacerbates the isolation faced by individuals experiencing homelessness, conveying a message that they are an afterthought, or invisible, to the very systems meant to support them.

Moreover, participants reported being turned away from essential services due to their lack of a fixed address or identity, effectively penalizing them for their homeless status. Emma's experience at a GP surgery —

> "When I went to my G.P, they asked for my address. I said, ‘I'm homeless’. ‘You're homeless. Come back when you’ve got a fixed address.’ Then where do you go?" (Emma, lines 109-111)

— exemplifies a systemic ‘Catch-22’, where the very condition of homelessness precludes access to essential care. Similarly, Emma’s struggle with proving identity meant:

> "For so long I had no identity. You asked me to prove who I was so I could get prescriptions and medical help... so there was no way I could access medical aid" (Emma, lines 116-119).

These experiences of being denied basic human dignity and fundamental services due to administrative hurdles not only impede practical access but also deeply undermine an individual's sense of worth and belonging, stripping away their identity and fostering feelings of exclusion.

Paul, who had previously experienced abuse and felt unsafe due to intimidation from an alcoholic neighbour and his friends, found this frustration with bureaucratic obstacles further compounded by a similar hurdle from the council.

> "'It's just another excuse from the council to not give you anywhere to live... because I left on my own free will. It's all a load of rubbish. There should never be a rule like that. Sometimes it's not the person themselves, it's being able to find your way in life. I always thought the it was the council's job to help, not to put another step on the ladder going down... a snake on the ladder. It's unbelievable.'"(Paul, 280-285).

The "snake on the ladder" for Paul, much like Emma's feeling of being "back at square one," powerfully encapsulates the experience of being pushed back to the starting point by seemingly arbitrary bureaucratic rules.

These challenges extended to mental health support services, with Paul recalling a distressing experience:

> "I saw a mental health team worker and spoke with him and told him the situation. And they said 'okay, we'll be in touch and let you know', took my phone number... but never contacted me. So again, I tried to take all my tablets, and I nearly succeeded" (Paul, lines 122-126).

This systemic oversight eroded trust and directly contributed to the escalation from hopeful engagement to a desperate act of self-harm. A particularly striking aspect of these access difficulties was the perception that genuine support only became available once individuals reached a "crisis point," indicating a severe lack of preventative measures. Participants frequently felt compelled into

more extreme situations to access support, as proactive interventions were notably absent before help eventually materialized. Andrew starkly articulated this systemic reactive approach, stating:

> "It took me an attempt on my own life and to get sectioned to get the help I needed" (Andrew, lines 173-175).

David echoed this sentiment, observing:

> "But it seems that... the only time people do get help, is if... you're on the verge and you have attempted to take your own life... and you end up getting sectioned" (David, lines 31-43).

Emma's experience further highlighted this systemic reactive approach, observing:

> "And when people get to the stage then the police come in and say 'oh, you're not begging' but where was the help before I got to that stage?" (Emma, lines 153-154).

This comment highlights how the absence of early, preventative support pushes individuals into crises, which then necessitate more visible and often punitive interventions. This reactive approach not only signifies avoidable suffering but also reinforces a perception of the system as unresponsive and coercive, ultimately eroding individuals' sense of agency and hope. As evidenced by Paul's account—

> "It makes you feel even worse because of that, y'know, when you ask for help… asking for help when there's nobody there to help you... I don't understand it" (Paul, lines 42-48)—

The emotional toll of navigating unhelpful or unresponsive systems cannot be overstated. The repeated pursuit of assistance, consistently met with obstacles or a lack of follow-up, significantly contributes to feelings of abandonment and exacerbates pre-existing vulnerabilities, such as mental health issues or social isolation. This directly impacts individuals' mental well-being, ultimately diminishing hope for a better future and reinforcing a pervasive sense of being trapped within their circumstances.

4.1.2. Lack of Funding

Participants connected the challenges they faced in accessing support directly to a perceived systemic underfunding of homelessness services. David's perspective highlights a pervasive sense of future hopelessness, believing that inadequate governmental financial investment creates a vicious cycle of deterioration:

> "… government funding and all that's not always there... But that needs… it does need to be an issue because it needs more funding because... it's not going to get better, it's just going to get worse... it really is" (David, lines 69-72).

This belief discourages proactive solutions and deters individuals from seeking help, ultimately allowing their circumstances to worsen unchecked, thereby undermining both hope for systemic improvement and prospects for personal recovery. He further emphasized the fundamental role of financial resources, asserting:

> "I've always said at the end of day, it does boil down to funding and social housing, which everyone knows it's not enough of. It's finding the money to fund all these projects. People want the help but there's no money to fund it" (David, lines 140-143).

This lack of systemic resources, particularly the chronic undersupply of affordable social housing, not only creates a barrier to assistance but also imposes a significant emotional burden. Individuals desire help, yet find it unattainable, fostering feelings of neglect and powerlessness, and further eroding their agency. This consistent underfunding creates a vicious cycle: insufficient upfront investment in prevention escalates homelessness, which then necessitates more expensive and reactive crisis management, ultimately trapping both individuals and the system in inadequate support.

4.1.3. Lack of Accommodation

The lack of accommodation theme was identified as a prominent systemic barrier, consistently highlighted by participants. This challenge stemmed from the national housing crisis and inherent

systemic issues within housing provision. Paul conveyed his anger and distress regarding housing unaffordability, starkly stating:

> "The rents, they need something to pull down these rents because they're killing people. They're actually killing people with these rents. Again, it's a government that's doing it. They've created all this through the interest rates charges and that's why landlords don't want to cheap rent anymore." (Paul, lines 363-367).

Paul's assertion that exorbitant rents are "killing people" transcends a mere financial grievance, signifying a perceived existential threat to an individual's very survival. This graphic language underscores the devastating impact of the housing crisis on immediate well-being. His direct attribution of this crisis to governmental action further reveals a deep sense of moral indignation and a conviction that systemic policies are not merely inadequate but are actively deleterious, pushing vulnerable individuals towards a literal precipice of harm. Paul further highlighted the high upfront costs associated with private rentals:

> "you've got to have about £1600 in your pocket that you pass over to them. They don't want pets. So that gives you another set-back" (Paul, lines 220-224).

This illustrates how conventional private rental requirements, when combined and confronted by vulnerable individuals (e.g., those with limited resources and existing responsibilities like pet ownership), quickly form insurmountable obstacles to housing access. David powerfully underscored the severity of the situation, characterizing it not merely as a "housing crisis" but as a "pandemic," which instilled a persistent sense of futility. As he articulated:

> "Everybody knows with like the housing crisis now, they call it a crisis, I call it a pandemic. Do you know what I mean? You just think to yourself, 'what's the point? I'm not going to get to where I need to be...'" (David, lines 103-106).

His evocative use of "pandemic" transcends typical crisis terminology, conveying an uncontrollable, pervasive societal affliction. This framing highlights the overwhelming scale and urgency of the housing situation, reinforcing his helplessness and the seemingly insurmountable nature of the systemic challenge. This sentiment of despair was compounded by a perceived governmental inertia. Paul directly expressed this:

> "They're not in touch with the people, are they? You know. People are telling them that there's a crisis in housing, but what are they doing about it? Nothing" (Paul, lines 382-384).

The lived reality of this crisis was further underscored by David, who recounted the direct consequence of this systemic inaction:

> "The council wouldn't help me. They could only like... put me up… temporarily... in accommodation... and then there was nowhere... no flats available or nothing available... then I was back out on the streets again" (David, lines 116-119).

This reveals a recurrent cycle where temporary solutions merely delay, rather than prevent, a return to homelessness. While temporary accommodation offers immediate shelter, its inherent transience and the lack of a clear, expedited pathway to settled housing often trap individuals in a persistent cycle of insecurity.

4.1.4. NHS overwhelmed

The perceived overwhelming of the NHS acts as a significant systemic barrier to accessing support. This often causes people experiencing homelessness to view their health needs as an undue burden, which then discourages them from seeking essential healthcare. Andrew explained this:

> "The burden on the NHS at the moment is a national atrocity. Homeless people have told me that they have got enough on their plate that they don't need my problems as well... so that's another reason people don't try to get the help. The NHS is underfunded and have got more important people to think about. You'd be surprised, even though a lot of people are homeless

and have mental health issues, they do consider other people and the NHS. But, like I say, catch-22" (Andrew, lines 393-399).

The statement demonstrates a paradoxical empathy among people experiencing homelessness for the strained healthcare system, prompting a self-imposed exclusion based on the belief that their urgent care needs are secondary to its capacity to serve the general public. This situation creates a "catch-22" where critical health issues remain unaddressed, leading to worse suffering and preventable complications.

Beyond this internalized burden, participants described challenges in accessing NHS services caused directly by systemic capacity problems. Paul recounted a distressing 16-hour wait in a hospital's A&E department, which resulted in him leaving without care:

> "I said, I do not like being in a crowded place or waiting on time because I think to have somebody waiting such a long time like, for example, in the hospital, 4-5 hours waiting and when you do get to the front of the queue, they say to you, they're changing shifts now but you'll be here half an hour and you'll see them. And he didn't turn up. I was still waiting and waiting, 11 o'clock in the morning…I'd waited from 7 o 'clock at night to 11 o' clock the next day, and it was driving me mad … I just sat there and tried to cope with it. In the end, my mind got the better of me, I just popped out. They don't take that into consideration, y'know, and the mental health team don't do anything.'" (Paul, lines 317-331).

Paul's experience illustrates how systemic capacity issues and a lack of consideration for individual vulnerabilities within overcrowded acute care settings create barriers to accessing support. His prolonged wait, exacerbated by the disorienting environment and perceived dismissiveness, ultimately forced him to abandon essential care. This highlights how current acute services are often ill-equipped to address the complex mental health needs of individuals experiencing homelessness. Similarly, David pointed out problems with mental health support, noting that the NHS often lacks:

".. the qualified staff to deal with people who have got really severe mental issues." (David, lines 192-193).

David's observation underscores a systemic strain directly related to a shortage of qualified staff equipped to handle severe mental health issues. This specific staff inadequacy, combined with the broader capacity problems exemplified by Paul's experience, leads to an inadequacy that not only misses opportunities for early intervention but also exacerbates existing mental health conditions. Consequently, this drives an unsustainable reliance on costly acute care, forcing individuals to seek help only at crisis points, as accessible preventative, community-based care remains consistently out of reach.

4.1.5. Stigma

Participants expressed that the experience of homelessness is shaped by widespread and damaging stigma. This stigma, rooted in both public attitudes and professional interactions, serves as a barrier to support and societal reintegration. For Emma, homelessness conflates with social ostracization:

"You’re a pariah!" (Emma, 98).

This stark declaration encapsulates the immediate and severe social condemnation felt by those experiencing homelessness, underscoring the intense social isolation stigma engenders. Emma further elaborates on the relentless nature of this judgment:

"you’re always on the defensive at every moment, because there’s always somebody who thinks you’re a troublemaker." (Emma, 66-68).

This constant state of defensiveness illustrates how stigma forces individuals into a perpetual state of self-protection, draining emotional resources and hindering social connection. The omnipresence of this judgmental gaze is a defining feature of their daily existence, highlighting the psychological burden of social disapproval.

Participants consistently encounter deeply entrenched societal stereotypes that attribute homelessness to personal failings rather than systemic issues. Emma articulates the myriad of assumptions others have made of her:

> "Everybody thinks your mental, everyone thinks you do drugs, everyone thinks you're a slapper. As I said, I've never done any of those things, and since being homeless, I've met others who never did these things until things went downhill and there was nobody to help. People constantly judge you so you lose confidence in yourself." (Emma, 75-80).

This counter-narrative challenges the individualistic blaming often associated with homelessness, highlighting the role of systemic failures and lack of support. A particularly concerning stereotype, highlighted by Emma, is the notion that individuals "like to be homeless":

> "That's one of the main things- this feeling that you like to be homeless. Like people like to sleep in doorways... or 'you've not worked all your life'. A lot of homeless people have worked all their lives, so integrating back into society becomes a problem." (Emma, 105-108).

This misconception, which dismisses the severe suffering associated with homelessness, is met with strong rejection. Emma directly challenges this, particularly the idea of being "intentionally homeless," asserting:

> "Intentionally homeless. I don't that and I don't know where they got it from. I hate that term. When I hear it, my head goes up. Because I hate being homeless. It's not intentional. If you look at it, it's circumstances that are often out of your control that make you homeless. Like you want to stand them out in the street in the cold. No." (Emma, 124-128).

This rejection underscores a desire to reclaim agency and dignity, affirming that homelessness results from uncontrollable circumstances, not personal choice. Paul voiced his disbelief at such governmental attitudes, directly responding to then-Home Secretary Suella Braverman's widely

condemned assertion that rough sleeping is a 'lifestyle choice' (Braverman, as cited in BBC News, 2023). Paul expressed:

> "They're just laughing at us, like that one this week; 'people choose to live on the streets'. They don’t choose to live on the streets. They have to live on the streets. You know, where did they get stupid people like that… in the government? It’s so stupid… they don’t think things through." (Paul, 369-373).

This top-down attribution of blame, even from policy levels, directly fuels misperceptions that permeate society and contribute to the dehumanisation of individuals experiencing homelessness. It undermines appropriate support by shifting responsibility from systemic issues to personal failings.

The consequence of these widespread negative attitudes is that individuals like Paul face not only systemic barriers but also personal suspicion. Paul vividly describes how people approach him:

> "Then you get people coming around wondering what you’re doing there, suspecting you’re a robber or a murderer." (Paul, 58-59).

This extreme level of suspicion illustrates how homelessness strips individuals of their basic human trustworthiness, reducing them to potential threats in the public imagination.

The relentless external judgment invariably leads to significant internal consequences. Emma observes:

> “People constantly judge you so you lose confidence in yourself.” (Emma, 80).

This loss of confidence is a direct consequence of internalising negative societal perceptions, making it difficult for individuals to maintain a positive self-image. The internalisation of worthlessness is a recurrent theme, articulated by David:

> “Yeah… it’s just... you are made to feel sometimes as if you’re not worthy. It’s your own fault.” (David, 67).

This feeling of being “not worthy” is exacerbated by the internalisation of blame, where individuals begin to believe that their circumstances are solely their own responsibility. David further elaborates on the psychological toll:

> “Most people won’t come to get the help because... they feel worthless. You do feel worthless. You do. You feel like nobody’s interested; nobody really cares... you’re a burden to society.” (David, 100-103).

This feeling of worthlessness creates a vicious cycle, where the internalised stigma prevents individuals from seeking the very help that might alleviate their situation. The perception of being a “burden to society” reinforces their isolation and contributes to a sense of deep hopelessness, echoing Emma’s feeling of being “resigned to fate”:

> “There’s always a story behind the homeless. You want to tell your story to people who will listen and when you can see people judging you, you don’t want to anymore. So, because people are quick to judge and the pain that comes from being judged is so much, you’re retreating to yourself, you don’t want to discuss yourself anymore, you’re tired of being judged. It feels like you’re resigned to fate.” (Emma, 135-140).

This withdrawal functions as a self-protective mechanism, yet it also perpetuates isolation and silences the narratives of those experiencing homelessness. The psychological burden of consistent judgment ultimately leads individuals to feel like they are perceived as an object of ridicule, as articulated by Paul:

> “I think, they think I’m a joke or something like that.” (Paul, 138-139).

This diminishment of self-worth subsequently reinforces their social invisibility, hindering their recognition and inclusion within the wider community.

4.2. Group Experiential Theme 2: Individual Barriers to Support

In addition to systemic barriers, participants described personal circumstances that prevented them from accessing or effectively engaging with support. These individual factors were often inextricably linked to their experiences of homelessness, forming a self-perpetuating cycle.

4.2.1. Absolute needs

Participants expressed that the immediate and overwhelming imperative of basic survival, encompassing both physical needs and a lack of security, demanded constant vigilance and resourcefulness. Emma highlighted the inherent dangers of life on the street:

> "Being homeless is a risk, lack of security. You're out on the street all night, you don't know what's going to happen. Lots of suicide, cold, you never know what will happen" (Emma, 129-132).

Chronic environmental stress was intensified by personal vulnerability, particularly for women. Emma's words clearly captured this reality, directly linking her gender to a sense of insecurity:

> "My experience of being homeless is very, it's very daunting, because as a homeless person, especially as a woman, it's not nice to sleep in the streets, because you don't feel safe" (Emma, 4-7).

While gender-specific vulnerabilities were articulated, men also experienced feelings of personal vulnerability. Paul, for instance, recounted the fear he experienced after receiving threats while sleeping in his car:

> "Them two guys did scare me... because they had weapons... big guys as well... that was why I was telling __, I have to move around, I can't stay in one spot" (Paul, 263-267).

These experiences underscore the pervasive threat of violence, which forces constant movement and prevents stable engagement with fixed support services. This hyper-vigilance and continuous

exposure to danger contributed to cumulative trauma, making it difficult for individuals to feel secure enough to focus on accessing support.

Beyond the immediate threat to personal safety, the daily struggle to meet fundamental needs for shelter, food, and warmth consumed substantial mental and physical energy. As Emma articulated, this constant preoccupation left little room for other considerations:

> “So, from the moment you wake, you're thinking, 'how to get through the day?', and you’ve not had a good night's sleep. 'Where you going to get something to eat?', 'where am I going to stay through the day to keep warm?' especially during winter, so where I am going to stay to feel warm during the day” (Emma, 168-172).

This intense focus on survival encompassed significant challenges in maintaining basic hygiene, directly impacting personal dignity. Paul explained:

> "Difficulties that come to mind is finding somewhere to go to the toilet. Keeping myself clean - clean clothes" (Paul, 3-5).

His narrative further detailed the financial strain of his limited pension income, which barely covered food and essential, yet costly, aspects of daily life like diesel for appointments and expensive laundrette services:

> “I mean, I only get £500 a month now, so it's not a lot to live on... Most of that is going on food for me and my dog...and diesel, so I can keep my appointments. So, I can’t spend any money on clothes or anything... even the laundrettes, they’re so dear. If you take a bag of washing in, you’re talking £30 to £40 to clean it. So, it’s very, very hard” (Paul, 232-239).

For people experiencing homelessness, this overriding survival imperative—encompassing personal security, basic physiological needs, and the preservation of dignity—transforms healthcare into a structural luxury, not an accessible right. Participants' accounts consistently show that finding food, securing shelter, or ensuring safety takes precedence over seeking medical attention, particularly

for non-emergency issues. Emma clearly stated how these immediate priorities overshadow seeking any form of support:

> “Before you can access medical aid, the first thing you think of is getting through the day” (Emma, 175-176).

This demonstrates how the immediate, physical challenges of homelessness overshadow the pursuit of long-term health and well-being. Consequently, health issues are often only addressed once they escalate into an acute crisis or directly threaten immediate survival, rather than through preventative or routine care. Such intense physiological and psychological demands deplete individuals' mental bandwidth and energy, creating a significant, often invisible, barrier to accessing support.

4.2.2. Travelling

Beyond the immediate struggle for survival and its health impacts, constant mobility is a defining and exhausting dimension of participants' homelessness experiences. Driven by environmental factors, service accessibility, and safety concerns, this perpetual movement creates substantial physical, logistical, and psychological burdens.

Emma conveyed the physical toll:

> "you’ve walked so much; your legs are aching and your back" (Emma, 151-152).

This daily exertion is a core component of survival, necessitated by the absence of stable shelter. Mobility often serves as a strategic response to adversities like harsh weather. Emma, for instance, recounted traveling:

> "… two or three hours away to escape the cold and finding shelters just to feel warm for a bit" (Emma, 72-73).

Yet, even strategic travel presents challenges, particularly for accessing essential services. Paul's need to navigate between locations for medical appointments illustrated this logistical hurdle:

"it’s travelling back and forth, because I need to be in ____ for my doctor’s appointments." (Paul, 78-80).

Mobility is not always voluntary. Individuals are often compelled to move due to precarious temporary shelters, a lack of consistent safe spaces, or exclusionary practices. Emma's observations reflect this precarious existence and its psychological toll from constant vigilance:

> "I've heard nasty stories of people being walked away from bus shelters and asked not to spend the night at the bus shelters or in doorways. You’re sleeping bag gets wet, and it’s not easy, moving from one place to another... (Emma, 160-164).

This perpetual motion, driven by both immediate needs and systemic pressures, acts as a self-reinforcing barrier, intensifying physical distress, compounding logistical complexities, and escalating psychological strain, thereby exacerbating vulnerability and prolonging housing instability.

4.2.3. Mind-Body Connection

Beyond the immediate struggle for survival and safety, participants' narratives highlight the significant and interconnected degradation of mind and body in the context of homelessness. The constant physical demands of being homeless predictably lead to a decline in physical health, while the psychological toll simultaneously eradicates mental well-being. This creates a vicious cycle that fundamentally compromises an individual's capacity for engagement and recovery.

The constant physical strain of homelessness manifested in many debilitating ailments. Paul stated that his physical health challenges included:

> "Diabetic. Arthritis. At night, my back... pains in neck... my legs. Being cramped up as well, it doesn’t help, because of the blood circulation" (Paul, 102-104),

and further noted:

> "…now the winters coming... it’s cold and damp. My backs starting to hurt... I do suffer with arthritis as well, really bad." (Paul, 12-13).

Paul's dangerously high diabetes sugar level, as he stated:

> "And my nurse ___, she's the one who does my diabetes sugar levels. which was 31.5 last time she checked which is very high" (Paul, 246-247),

illustrates the challenges of managing complex medical conditions without stable housing and consistent access to care. For individuals like Paul, the lack of access to consistent healthy food options and the inability to maintain a regulated diet are virtually non-existent, exacerbating conditions such as diabetes. This reality underscores how homelessness hinders both the effective management of chronic illnesses and consistent access to essential healthcare. He also reflected on how age compounded these challenges:

> "You don't realise when you get older that you get more frail and... miss all your family that were alive" (Paul, 93-95).

Emma also described how the relentless physical toll made it difficult to even seek help:

> "I would get go to a bus stop, put my backpack down and sit her for a while, to rest my back. Even when you get to the point where your body is saying 'no, you can't carry on like this', you keep going. It takes a lot to exist like this. And because of this, homeless people have a lot of aches and pains. So, when you finally do get a G.P listening to you, then you don't even know where to start." (Emma, 176-185).

Compounding these severe physical health challenges are equally significant and deeply ingrained mental health struggles. Emma described the anxiety inherent in constant insecurity:

> "You're likely to have panic attacks because, you don't know what's going to happen the next minute" (Emma, 7-9).

Paul observed that other people experiencing homelessness were:

> "… struggling, with mental health, like myself" (Paul, 360-363),

and articulated the effects of prolonged social isolation:

> "I'm used to be on my own and I'm used to not being around people. Even here I get panic attacks, because I'm not used to the people here" (Paul, 83-85).

Emma identified the experience of repeated rejection as fundamentally destructive to one's psychological state:

> "But when you keep facing rejection, a lot rejection is a bad thing. It destroys your mindset" (Emma, 151-152).

Participants' psychological distress culminates in a debilitating erosion of self-care, directly hindering health maintenance and sustained engagement with support. Paul described this sense of hopelessness:

> "I'm supposed to get my medication every day at the chemist but... I've just not been bothered. I have given up- I've got no fight left in me now" (Paul, 29-31).

Paul's words convey a deep sense of demoralization and exhaustion, leading to resignation in dire circumstances due to a perceived lack of control and repeated, unsuccessful attempts to improve their situation. David's experience further captures this psychological disengagement, reflecting a loss of hope and disassociation from societal norms, which significantly impedes their capacity to seek or accept help:

> "because of my substance misuse, I wasn't in the right frame of mind. I was completely lost... mentally. I had given up on myself and I had given up on society, on everything" (David, 171-173).

Crucially, this despair and psychological disintegration frequently manifest as a constant internal battle against suicidal ideation, a stark and harrowing indicator of extreme psychological distress. Paul openly stated:

"I have tried to commit suicide four times now" (Paul, 7).

He further articulated this struggle:

"… you remember the good times you had and all the really bad thoughts to come rushing back to you and you keep hearing in your mind 'Do it, do it, do it, do it, do it It's time, it's time'. And I keep fighting it and trying my best to put it to the back of my mind" (Paul, 207-211).

Participant accounts reveal that homelessness profoundly elevates suicide risk factors, including chronic stress, acute social isolation, limited support networks, and overwhelming hopelessness. This creates a damaging cycle where worsening physical health weakens mental resilience, and psychological decline significantly impedes health management and the pursuit of support. Andrew's assertion emphasizes this dehumanizing effect, also revealing the human need for connection and identity beyond diagnoses:

> "Even though I have mental health problems, I am not my mental health problem. I am not my drug addiction. But what I am, is sad and lonely" (Andrew, 397-399)

4.2.4. Individual needs

Individual needs and intrinsic vulnerabilities consistently surface as challenging, deeply entrenched barriers to accessing and sustaining support. Participants' narratives reveal a complex range of unmet needs, frequently rooted in early life experiences that irrevocably shape their trajectories into and experiences of homelessness.

A central theme among participants was the impact of adverse childhood experiences, often evidenced by early exposure to abuse, neglect, and family dysfunction. David's early initiation into substance use reveals how dysfunctional coping mechanisms often take root early in development:

> "I started drinking when I was younger, smoking weed when I was about 12" (David, 8-9).

Andrew's references to childhood abuse and severe neglect in foster care exemplify the enduring psychological harm of childhood trauma:

> “I think he took advantage of me” (Andrew, 57-58).

He further elaborated on the exploitative nature of his care and its physical toll on him, stating:

> “It was awful because the only way to foster me was for the money... I was in there with severe malnutrition” (Andrew, 169-170, 173).

Paul's memories of witnessing domestic violence further underscore the occurrence of unsafe childhood environments among participants. He recounted:

> "I think that's been true with Dad. Because he… He was a drunk, always beating up on my mum. And I was only young then so I tried to stick up for her but... As I said, he was just a drunk" (Paul, 197-199).

Such experiences are more than isolated incidents; they profoundly undermine healthy development. These foundational traumas often solidify into a deep-seated mistrust of institutions and authority figures. This widespread mistrust creates obstacles to engaging with service providers and navigating bureaucratic systems designed to offer support.

Further compounding these vulnerabilities were exclusionary challenges with literacy and digital access, which acted as significant barriers to navigating contemporary support systems. Paul articulated a deep, internalized fear and practical difficulties concerning administrative tasks:

> "Because, at the time I didn't have no money at all, my money got stopped due to the fact that I just had my birthday and I didn't tell him that. I’d become a pensioner then. Apparently for three or four weeks they’d been sending letters to my brothers flat... but that’s no good anyway. Anything with spelling, reading and writing... I'm just terrified, absolutely terrified of it. Even on the phones, I can’t do texts or apps or anything. I guess that’s my own fault" (Paul, 171-178).

He further expressed concerns about the rapid shift towards digital services:

> "Again, there's another thing, there's all this technology. People like me we've got no chance. Banks are shutting down. We don't know how to do things on our phones, bank apps and things like that... I used to go to the branch; they do it all for me. Now they close them out, I've got to try and find out a way of doing it on the phone. It's not helping, you know, it's not helping at all" (Paul, 374-379).

Paul attributed his lack of digital proficiency to a limited educational background:

> "I was quite poor when I was younger and a lot of time, I was off school and I never got the education. I have to get other people to do it for me. My parents had split up, my mother lived in ___ and my dad was in ____. We were always poor, but we managed, you know. It's just been one big struggle, you know" (Paul, 181-185).

In an increasingly digitized society, this digital divide is no longer merely an inconvenience but an actively segregating determinant of social and financial exclusion, severely limiting access to essential services and exacerbating acute social isolation.

4.3. Group Experiential Theme 3: Benefits of Current Support

Despite significant barriers to accessing support, participants also highlighted valuable experiences with existing aid, detailing aspects that provided crucial assistance and fostered a sense of hope or purpose. This theme underscores the critical impact of effective and empathetic interventions.

4.3.1. G.P. Health Checks & Food Vouchers

Participants highlighted the critical role of General Practitioners (GPs) not only for health surveillance but also as unexpected sources of direct practical support, establishing themselves as a consistent point of contact in the participants' unstable circumstances. Paul, for instance, expressed surprise and gratitude for this broader scope of care:

"This is the only place I've got support from and the doctors. The doctors have been very good to me. They gave me vouchers, so I could get food, which I never knew the doctors did" (Paul, 243-245).

This demonstrates an important aspect of primary care in the context of homelessness: its capacity to address social determinants of health beyond purely medical interventions. The provision of food vouchers, therefore, represents a tangible and impactful intervention that can significantly alleviate immediate suffering and build trust in a system often perceived as inaccessible or uncaring. This practical support exemplifies a holistic approach to patient well-being, enhancing the likelihood of continued engagement with necessary healthcare services that might otherwise be deprioritized amidst acute survival needs.

4.3.2. Charity Organisations

Participants consistently praised charity organizations for providing essential practical assistance and, crucially, fostering a sense of human connection and value, thereby serving as critical buffers against the severe isolation and dehumanization of homelessness. Participants consistently underscored how these organizations offered vital lifelines, acknowledging their indispensable role in preventing further deterioration of well-being and maintaining social cohesion. Paul's words illustrate the perceived life-sustaining and community-stabilizing function of such services:

"I'm pretty sure a lot more people would be dead by now. If these places didn't exist" (Paul, 162-166).

Beyond basic survival, charity organisations often provide a diverse array of supports including clothing, hygiene facilities, and mail access, which collectively contribute to dignity and well-being. Moreover, they offer much-needed emotional sustenance. David highlighted the transformative power of a compassionate engagement with a staff member in a charity setting:

"…if you go to see someone and they really try to understand and giving you time, that really will make you feel better and want to achieve more" (David, 320-322).

Similarly, Paul appreciated the humanity shown:

> "Yeah, it's like I said, these people have been really good to me. They've told me to have a cup of tea and that, and gave me a food bank voucher. Yeah, they've been terrific. I don't really know what I could have done without them, to be honest. I might have already topped myself by now" (Paul, 89-93).

This emotional impact, stemming from feeling heard, respected, and supported, emphasizes the importance of relationship-based care in fostering trust, reducing isolation, and improving mental health outcomes among individuals experiencing homelessness. Charities' provision of basic necessities along with non-judgmental support serves as a critical foundation for re-engagement, acting as immediate crisis intervention and a crucial harm reduction strategy that provides a vital buffer against the extreme despair often associated with homelessness.

4.3.3. Assigned Support Worker

The role of the assigned support worker was central in helping participants access and navigate complex support systems, providing consistent contact and advocacy. Participants consistently viewed these workers as key facilitators, offering tailored guidance, coordinated care, and reassurance. Andrew articulated the fundamental purpose of this relationship:

> "You might have things that you want to do that you think you can't do on your own and that is really what support workers are there for" (Andrew, 559-561).

This highlights the individualized support and empowerment that effective support workers provide, helping individuals build self-efficacy and overcome bureaucratic hurdles. David's experience further exemplified this instrumental role:

> "I had a mental health support worker...and she got me to another organisation... it's a rehab" (David, 165-169).

This demonstrates how support workers act as crucial navigators and advocates, bridging gaps between different agencies and facilitating critical transitions to appropriate care, thereby overcoming fragmentation within the service landscape. Emma similarly noted the direct impact on her housing stability:

> "So, I had two support workers…so both of them made sure I got a come to a nice shelter" (Emma, 21-23).

Effective support workers mitigate the burden of independently navigating complex systems by providing essential emotional reassurance, practical assistance, and consistent advocacy. This consistent, trusting relationship forms a stable foundation, directly enhancing sustained engagement and recovery as they rebuild trust in services and advance towards personal objectives.

4.3.4. Volunteer Work

Engagement in volunteer work and community activities provided participants with a vital sense of purpose, contribution, and belonging, actively countering the dehumanization and social isolation often associated with homelessness. Andrew's eager anticipation of a volunteer opportunity underscored the therapeutic value of meaningful activity and connection for mental well-being and establishing routine:

> "I've got my boots and I'm going to start dog walking" (Andrew, 569).

Emma's account further elaborated on the significant positive impact of structured opportunities for contribution within a homeless community. She explained the initiatives designed to foster usefulness:

> "Then I got moved into ____, that's another homeless community. They make you sell to the community. Then you volunteer in one of the shops to also make you feel useful. You're also selling then, they give you half a day in the shops or just to make you feel useful, because when you're homeless, it can make you feel like the worst person in the world" (Emma, 25-29).

This insight highlights the detrimental impact of societal stigmatization and the significant psychological uplift derived from purposeful engagement with the wider community. Emma further reinforced this by stating:

> "I felt it was a purpose for me to say that I felt I was contributing to the community" (Emma, 33-35).

By offering opportunities for skill acquisition and a positive social role, these initiatives directly foster agency and social inclusion. These elements are fundamental to sustained recovery and successful reintegration, helping individuals restore a positive self-identity, bolster their self-esteem, and cultivate a sense of belonging beyond their housing status.

5. Discussion

This study explored how four people experiencing homelessness made sense of their mental health needs, their attempts to access support, and the barriers they encountered. The findings suggest that access to mental health care was shaped by the interaction between systemic barriers and personal circumstances, rather than by individual help-seeking alone. Participants described difficulties linked to service thresholds, housing instability, stigma, lack of continuity and unmet basic needs. At the same time, they identified forms of support that felt helpful, particularly where services were relational, practical, consistent and responsive to individual circumstances.

By using Interpretative Phenomenological Analysis, the study contributes an idiographic account of how barriers to care are lived and understood by people experiencing homelessness. This is important because the literature reviewed in Chapter 2 identified many organisational and service-level barriers, but less was known about how individuals make sense of these experiences in relation to their own mental health, self-worth, trust and future help-seeking. The discussion therefore considers how the findings extend existing literature and how they may inform counselling psychology practice, particularly the profession's commitment to person-centred, holistic and socially situated understandings of distress.

5.1. Systemic barriers to support

Participants' accounts suggested that barriers to support were not experienced as isolated difficulties, but as part of a wider system that was difficult to enter and sustain contact with. Across the narratives, participants described restricted service access, crisis-led responses, under-resourced services, shortages of appropriate accommodation, pressure on the NHS and experiences of stigma. These barriers appeared to shape not only whether participants could access support, but also how they understood their own position in relation to services.

A central finding was that access to basic healthcare and housing support could be obstructed by administrative requirements. Participants described difficulties linked to the absence of a fixed address, lack of identification, unclear information and complex referral processes. This reflects

wider literature showing that administrative systems can function as barriers for people experiencing homelessness, particularly where services assume stability, documentation and the capacity to navigate complex processes (Luchenski et al., 2018; Gunner et al., 2019; Thirkle et al., 2025). In this study, these barriers were not experienced as neutral procedures. They were often understood as further evidence that services were not designed around the realities of homelessness.

This was particularly evident in relation to primary care. Although general practice is often positioned as a route into wider healthcare, including mental health assessment and referral, participants' accounts suggested that mainstream systems could be difficult to access or remain engaged with. This supports evidence from the HEARTH study, which found that specialist homeless health centres offered greater continuity of care for conditions such as depression than mainstream general practice, partly because specialist services were better able to provide flexible and responsive support (Crane et al., 2023; Crane et al., 2024). This distinction is important because access is not simply about whether a service exists. It also depends on whether the model of care can accommodate instability, missed appointments, changing contact details and competing survival needs.

From a counselling psychology perspective, this challenges interpretations of non-attendance or disengagement as individual reluctance. Participants' accounts suggest that disengagement may be better understood as a relational and structural outcome, produced when services require forms of stability that homelessness itself undermines. Where access depends on fixed appointments, digital registration, documentation or repeated self-advocacy, the burden of adaptation is placed on the person experiencing homelessness rather than on the service. This risks reproducing exclusion while framing the individual as difficult to engage.

Participants also described support as becoming available only at a point of crisis. This finding suggests that services were often experienced as reactive rather than preventative, with help becoming accessible only when distress, risk or need had escalated. Such accounts are important because they show how crisis-led systems may intensify the very difficulties they are intended to

address. When people are required to deteriorate before support is offered, opportunities for earlier intervention, continuity and relational trust may be missed.

For some participants, emergency services appeared to become a default route into care. However, the Emergency Department is not designed to provide sustained psychological support or the relational safety associated with trauma-informed care. This is particularly relevant for people experiencing homelessness, whose needs may include mental health difficulties, physical health problems, substance use, trauma and social exclusion. Inclusion health literature has similarly argued that mainstream services often struggle to respond to people with multiple and overlapping forms of disadvantage (Luchenski et al., 2018; NHS England, 2024). In this context, participants' accounts of long waits, repeated presentations and limited follow-up suggest that emergency care may provide temporary containment without addressing the wider conditions that maintain distress.

Overall, this theme suggests that systemic barriers were not only practical obstacles, but experiences that could reinforce exclusion, mistrust and reduced expectations of care. Participants' difficulties accessing support were shaped by service design, resource limitations and the mismatch between mainstream pathways and the realities of homelessness. This finding extends the literature by showing how these barriers were personally interpreted: not simply as service inefficiencies, but as experiences that shaped participants' sense of whether help was available, safe or intended for them.

Chronic underfunding consistently was identified as a key driver of inadequate support, with participants attributing systemic failings to persistent financial constraints. This aligns with academic discourse that underscores the detrimental impact of austerity measures and budgetary reductions on homelessness services. Studies by Alexiou et al. (2021) and Heaslip et al. (2022) link cuts in welfare and housing budgets to heightened rates of homelessness and worsened health outcomes. Participants' observation that "it boils down to funding and social housing" echoes the recent evidence provided by Dellar (2025) and the joint report by the Centre for Homelessness Impact and the Institute for Government (2025), as well as the critical policy reviews of scholars such as Massey

and Roberts (2025). These sources collectively argue for a fundamental shift in governmental investment toward preventative care and social housing, rather than the current model of reactive crisis management. The joint report (CHI & IfG, 2025) specifically notes that while real terms spending on homelessness has more than doubled since 2010, the majority of these funds are now diverted into temporary accommodation. This creates a financially unsustainable system that fails to address the root causes of housing instability, effectively prioritizing crisis response over long term prevention. The cumulative effects of underfunding are evident in reduced shelter capacity, diminished outreach provision, and prolonged waiting periods for mental health treatments and housing assessments- factors that perpetuate a cycle of unmet need and systemic exclusion. From a critically reflexive standpoint, this persistent underfunding is not merely a fiscal oversight but a sociopolitical choice that reflects whose needs are prioritized within the welfare state. By allowing outreach and preventative services to diminish, the system effectively "outsources" the management of homelessness to acute, high-cost crisis services. For PEH, this creates an environment of institutional abandonment, where the lack of funding is experienced as a message from society that their stabilization is not a worthy investment. As a counselling psychologist, this necessitates viewing non-engagement not as a client deficit, but as a rational response to a system that has demonstrably withdrawn its support.

The acute shortage of suitable accommodation, compounded by a national housing crisis was identified as a significant barrier. Participants expressed frustration with unaffordable private rents and challenges in securing tenancies, often due to prohibitive upfront costs or restrictive policies, such as limitations around pets. Recent reports by the Ministry of Housing, Communities and Local Government (2025) and UK Parliament (2024) consistently underscore the shortage of affordable social housing and the growing reliance on temporary accommodation. Fitzpatrick et al. (2020) emphasize that insufficient access to secure, affordable housing perpetuates homelessness, entrapping individuals in persistent precarity. Furthermore, the National Housing Federation (2023, 2025) documents the stark disparity between housing demand and available supply, which creates

significant barriers for individuals attempting to exit homelessness. This structural “bottleneck” is exacerbated by the precarity of the Private Rented Sector (PRS), where the rise in Assured Shorthold Tenancy terminations, accounting for 23% of households seeking relief (NAO, 2024), functions as a primary driver of housing instability. For the participants in this study, the threat of “no-fault” evictions and the financial inaccessibility of the PRS reinforce a state of chronic psychological insecurity, which even the Renters’ Rights Act 2025 seeks to address by providing greater legislative stability.

Reflecting Allen et al.’s (2023) characterization of inadequate temporary accommodation, participants described a state of prolonged residential instability where the lack of tenure security and poor living conditions created a cycle of profound uncertainty. This transience functions as a structural barrier that not only extends the duration of homelessness but also obstructs an individual's capacity to achieve domestic stability, maintain consistent employment, and access continuous healthcare. Furthermore, Allen et al., (2023) contend that the environmental stressors inherent in these settings do not merely prolong housing insecurity but actively undermine the psychological work of recovery by depriving residents of the environmental safety and predictability required for therapeutic progress. Without a secure base, as articulated through participants' distress over prohibitive costs and pet restrictions, the ability to engage in long-term therapy is severely compromised. This highlights the limitation of individualistic psychological interventions in the absence of structural security. If the discipline of counselling psychology is to truly value the individual holistically, we must acknowledge that a client cannot manage internal trauma while simultaneously navigating the existential threat of returning to rough sleeping. This finding demands a shift toward supporting Housing First models as a clinical prerequisite rather than just a social service outcome. National implementation of ‘Housing First’ frameworks is supported by robust evidence from the UK pilots, which demonstrate tenancy retention rates reaching 92% after one year (MHCLG, 2024). Furthermore, by shifting care from acute crisis services to stable residential support, the model offers significant long-term cost offsets for the NHS and the broader welfare state,

providing a more sustainable alternative to the £2.7 billion currently spent annually on temporary accommodation (Crisis, 2025).

The internalisation of health needs as a burden was identified as a prominent theme, reflecting the psychological attrition caused by a system characterised by perceived neglect and prolonged waiting periods. This sense of being a burden is not merely a personal sentiment but a response to the systemic strain documented across the healthcare landscape. Research by Gilbody et al. (2020) and Hiscock et al. (2023) suggests that when NHS resources are overstretched, the resulting delay in care necessitates an over reliance on the ED, which is fundamentally ill equipped to manage the complex, chronic health profiles typical of this population. These backlogs, which NHS England (2025) data show disproportionately impact vulnerable cohorts, are further complicated by the fragmented service pathways identified by Srinivasan and Watts (2020). For the individual experiencing homelessness, these structural failures, manifesting as workforce shortages and administrative barriers to continuity (Aldridge et al., 2021; Care Quality Commission, 2024), create a cumulative vulnerability. Consequently, the absence of a stable environment for recovery, coupled with inaccessible medical records and missed follow up appointments, transforms manageable health conditions into entrenched crises. This lack of coordinated and consistent care intensifies chronic conditions, as the clinical environment fails to provide the requisite safety and predictability essential for therapeutic progress. Critically, the internalisation of being a "burden" suggests that systemic inefficiency does not just delay treatment but actively erodes the individual's sense of entitlement to health as a human right. This psychological disengagement is a rational response to a system that routinely prioritizes others, effectively sending a message to PEH that their survival is a secondary concern.

The life expectancy gap for people experiencing homelessness remains one of the starkest indicators of systemic failure. Research by Aldridge et al. (2019) and Fazel et al. (2021) reveals that people experiencing homelessness die on average 20 to 30 years earlier than the general population, with a median age of death around 51 years. Crucially, many of these deaths result from treatable

conditions, such as cardiovascular disease, tuberculosis, and gastric ulcers, underscoring how barriers to timely care and systemic neglect turn otherwise manageable health issues into life limiting outcomes. From a social justice perspective, this amenable mortality is an indictment of a healthcare model that remains reactive rather than inclusive. It highlights that for the homeless population, the right to health is often a theoretical construct rather than a lived reality, as systemic gatekeeping transforms manageable illnesses into terminal ones. Beyond the immediate clinical impact, Roy et al. (2025) and Zampini and Fazel (2021) argue that the disproportionate reliance on acute hospital care for ongoing health concerns is both inefficient and symptomatic of deeper failures in primary and preventative care. This trend indicates a structural neglect within the healthcare system, where the absence of accessible, community-based support forces individuals into high pressure emergency environments. Such a model effectively prioritizes reactive intervention over the sustained, relational care necessary to address the complex needs of the homeless population (Roy et al., 2024; Zampini & Fazel, 2021). Additionally, Cookson et al. (2017) trace systemic health inequities to underlying socioeconomic determinants, linking these to poorer outcomes and elevated rates of amenable mortality.

The pervasive stigma experienced by participants, manifesting as social ostracization, stereotypes, and institutional prejudice, is a critical finding aligned with research. Emma's feeling of being a "pariah" reflects social exclusion documented by Guise et al. (2023) and Rea (2022), who explore the dehumanizing impact of public judgment. Attributing homelessness to personal failings is a common stereotype identified by Patterson and Clarke (2019) and Widdowfield (2016). Paul’s strong reaction to the “lifestyle choice” assertion by Suella Braverman (cited in BBC News, 2023) indicates how political rhetoric fuels societal misconceptions and blames individuals rather than systemic issues. Critically, such rhetoric serves as a contemporary extension of the psychocentric discourse discussed in the Literature Review. By framing rough sleeping as a personal choice, this political narrative pathologizes the individual and obscures the structural explanations, such as the housing crisis and austerity measures, that the participants identify as the true causal factors of their predicament.

When healthcare professionals internalize these narratives, gatekeeping shifts from a neutral clinical assessment to a form of moral judgment. This necessitates that healthcare professionals move beyond a purely intrapsychic approach and adopt a role as systemic advocates who challenge the socio-political environments and discriminatory rhetoric that perpetuate this marginalization.

Recent literature suggests that reducing stigma requires action at more than one level, including public attitudes, service design, professional training and policy (Guerrero et al., 2023; Lachaud et al., 2024). This is relevant to the present findings because participants described stigma not only as something encountered in public spaces, but also as something embedded within services. Institutional stigma can occur when health and social care systems are experienced as judgemental, neglectful or procedurally punitive (Canham et al., 2022; Guise et al., 2023; Wen et al., 2017). Paul's account of missed appointments being interpreted as irresponsibility, rather than understood in relation to unstable living conditions, illustrates how routine procedures may be experienced as blaming. In this context, policies intended to manage attendance or service capacity may unintentionally reproduce exclusion for people whose lives are shaped by instability, survival needs and limited control over time or resources.

From a counselling psychology perspective, this finding invites careful reflection on the power relationship between professional and service user. Paul's account suggests that rigid attendance expectations can communicate judgement, even where this is not the intention of the service. This does not mean that boundaries or service structures are unimportant, but it does suggest that they need to be applied with sensitivity to context. A more relationally flexible approach may involve active re-engagement after missed appointments, clearer communication, choice in appointment formats and recognition that non-attendance may reflect structural barriers rather than lack of motivation. Such practice would be consistent with a non-pathologising approach that understands behaviour within the person's wider social and material circumstances.

The findings also suggest that stigma may be gendered. David's account indicated that masculine norms around self-reliance and emotional control may make it harder to disclose distress or seek

psychological support. This is consistent with literature suggesting that men may experience particular barriers to help-seeking where vulnerability is associated with weakness or failure (Pfeiffer & In-Albon, 2023). In the context of homelessness, these pressures may be intensified by the need to appear resilient, cope with threat and maintain a sense of control in unsafe or unpredictable environments. Services therefore need to be attentive to how gendered expectations may shape engagement, disclosure and willingness to accept support.

Andrew's account further complicated deficit-based understandings of substance use. His description of substance use as a way of managing emotional pain suggests that addiction cannot be understood only as an individual behavioural problem. Instead, it may also function as a coping strategy in the context of trauma, distress, homelessness and limited access to alternative forms of support. This interpretation aligns with trauma-informed approaches, which emphasise safety, collaboration, trustworthiness and the importance of understanding behaviour in relation to previous and ongoing adversity (Mahon, 2024; Saunders et al., 2023).

For counselling psychology, this supports a shift away from purely intrapsychic or deficit-oriented explanations of distress. Understanding substance use as a survival strategy does not minimise its harms, but it places those harms within a wider context of exclusion, trauma and unmet need. This has implications for practice because people experiencing homelessness may be less able to engage with psychological support when services require substance use to be resolved first, or when substance use is treated as evidence of unwillingness to change. A trauma-informed and socially situated response would instead recognise substance use, mistrust and withdrawal as potentially meaningful responses to adversity, while still supporting safety, agency and access to care.

5.2 Individual Barriers to Support

Beyond systemic barriers, participants also described individual barriers that shaped their ability to seek and sustain support. These included immediate survival needs, physical exhaustion, cognitive strain, limited digital access, gendered vulnerability and the long-term impact of trauma. However, these barriers were not simply individual characteristics. Participants' accounts suggested that

personal difficulties were often produced or intensified by the wider conditions of homelessness, including insecurity, exposure to threat, service fragmentation and lack of stable support. This theme therefore complicates any simple distinction between “systemic” and “individual” barriers, as the individual difficulties participants described were closely tied to the environments and systems in which they were trying to survive.

Daily efforts to secure food, warmth and safety often meant that healthcare became a secondary concern. Participants described how immediate survival needs could take priority over appointments, paperwork or longer-term health planning. This can be understood in relation to Maslow’s hierarchy of needs, which suggests that basic physiological and safety needs may take precedence over higher-order goals when they remain unmet (Maslow, 1943). However, in the context of homelessness, this should not be read as a purely individual motivational issue. Rather, participants’ accounts suggest that unmet basic needs were produced by material insecurity and service exclusion, reducing the cognitive and emotional capacity required to navigate complex support systems (Anderson et al., 2024; Ford et al., 2020). In this sense, prioritising survival was not a failure to engage with services, but a response to immediate and competing demands.

Participants also described the physical toll of homelessness. Accounts of pain, exhaustion, poor sleep, chronic health conditions and the demands of constant movement suggested a close connection between bodily distress and psychological strain. The concept of allostatic load, which refers to the cumulative physiological impact of chronic stress, offers one way of understanding these accounts (McEwen & Stellar, 1993; McEwen, 1998). Participants’ experiences suggested that physical health difficulties were not separate from homelessness, but were often intensified by unsafe sleeping environments, limited rest, inconsistent healthcare and ongoing psychological stress. This is important because services may require individuals to be organised, alert and able to communicate their needs clearly, while homelessness itself may deplete the physical and cognitive resources needed to do so.

The mind-body connection identified in participants' accounts therefore has implications for how barriers to care are understood. Physical exhaustion, pain and cognitive strain may function as barriers in their own right. For counselling psychology, this supports a holistic understanding of the person, in which psychological distress is considered alongside the material and embodied realities of homelessness. It also challenges interpretations that locate difficulty solely within the individual. Participants' accounts suggest that what may appear as disengagement, disorganisation or limited motivation may instead reflect the cumulative effects of stress, poor health and survival demands. This is especially important when services interpret missed appointments or limited follow-through as evidence of unwillingness, rather than as possible indicators that the person's capacity has been overwhelmed.

Digital exclusion was also identified as a significant barrier. Paul described confusion and helplessness when attempting to navigate digital platforms, highlighting how limited digital literacy and access could restrict engagement with essential services. His account suggested that digital exclusion was not only practical, but also psychological, contributing to a wider sense of being left behind or unable to access systems that others may take for granted. This aligns with research on the digital divide, which shows that increasing reliance on online systems can disproportionately affect people experiencing homelessness, particularly where access to devices, connectivity, literacy support or privacy is limited (Alden et al., 2020; Seet et al., 2021).

Paul also described the closure of banks and other high-street institutions as part of this wider shift away from accessible, face-to-face support. For individuals without stable housing, identification documents, digital literacy or reliable internet access, online services may not offer a realistic alternative. The loss of in-person services may therefore reduce not only practical access, but also opportunities for guidance, reassurance and human contact. This is relevant to counselling psychology because psychological and healthcare services are also increasingly shaped by digital systems. While online access can improve flexibility for some, participants' accounts suggest that digital-first pathways may exclude those who lack the technological resources or confidence to use

them. Maintaining face-to-face, telephone and outreach options is therefore important for equitable access. This does not mean rejecting digital provision, but recognising that digital access cannot be assumed, particularly for people whose daily lives are marked by instability and limited resources.

Gendered vulnerability was also evident in participants' narratives. Emma described feeling unsafe while sleeping rough, including experiences of harassment and the need for constant vigilance. Her account illustrates how homelessness can expose individuals to physical precarity while also intensifying fear, psychological strain and the need to manage threat. This reflects literature showing that women experiencing homelessness face heightened risks of gender-based violence, trauma and exploitation (Kirwan & McLaughlin, 2024; Milaney et al., 2020; Shelter, 2021). For Emma, the barrier to support was not only the availability of services, but the conditions of fear and vigilance in which she was trying to survive.

Emma's account also highlights the importance of recognising hidden homelessness. Women may be more likely to avoid visible rough sleeping by staying temporarily with others, sofa surfing or remaining in unsafe accommodation, often as a way of managing risk (Hess et al., 2025). This can make women less visible in official data and less likely to encounter services designed around visible rough sleeping. For counselling psychology, this reinforces the need for gender-sensitive and intersectional practice. Homelessness should not be understood as a single or uniform experience. Gender, trauma, safety, poverty and service visibility may interact to shape whether support feels accessible, safe or relevant. This is particularly important when service models are implicitly based on more visible forms of homelessness, which may not reflect the ways women manage risk or seek safety.

Early-life adversity also appeared to shape participants' experiences of support. Several participants reflected on histories of neglect, abuse, parental substance misuse or institutional betrayal. These accounts are consistent with literature linking Adverse Childhood Experiences to later mental health difficulties, reduced emotional regulation and increased vulnerability to homelessness (Landa-Blanco et al., 2024; Lorenc et al., 2020). Participants did not use ACEs terminology

themselves, but their narratives suggested that early trauma could shape later mistrust, avoidance of formal services and difficulty forming supportive relationships. This is important because help-seeking does not occur in isolation from previous experiences of care, authority or rejection.

For example, Paul's description of feeling "terrified" by paperwork suggested that administrative processes could carry meanings beyond their practical demands. For someone with previous experiences of trauma or institutional harm, forms, assessments and surveillance may be experienced as threatening rather than neutral. This is consistent with research suggesting that people with significant trauma histories may find it difficult to trust services, particularly where systems feel impersonal, punitive or difficult to understand (Cronley et al., 2020; Liu et al., 2021). From a counselling psychology perspective, this requires caution in how behaviours such as avoidance, mistrust or non-attendance are interpreted. These responses may represent attempts to manage threat and preserve safety, rather than simple resistance to help.

These findings reinforce the importance of trauma-informed care. Trauma-informed approaches emphasise safety, choice, collaboration, trustworthiness and empowerment, all of which are particularly relevant when working with people who have experienced both interpersonal trauma and systemic exclusion (Bransford & Cole, 2019; Kirwan & McLaughlin, 2024). For people experiencing homelessness, trauma-informed practice cannot be limited to the therapy room. It also requires services to consider how their procedures, environments and communication practices may either reduce or reproduce threat. In this sense, individual barriers to support are inseparable from the systems in which people attempt to seek care.

Taken together, this theme suggests that individual barriers were deeply connected to structural conditions. Survival needs, physical exhaustion, digital exclusion, gendered vulnerability and trauma all shaped participants' ability to access support. However, these difficulties were not simply located within participants themselves. They were produced and intensified by unstable housing, limited resources, service design and previous experiences of harm. This finding supports the need for mental health services that are flexible, trauma-informed, digitally inclusive and responsive to the

embodied realities of homelessness. It also reinforces the importance of counselling psychology's holistic stance, in which distress is understood not only through symptoms or behaviour, but through the person's wider context, history and conditions of living.

5.3. Benefits of Current Support

Despite the barriers described above, participants also identified forms of support that were experienced as helpful. These included support from GPs, charity organisations, assigned support workers and opportunities for volunteer work. Although these forms of support did not remove the wider structural barriers participants faced, they appeared to offer practical assistance, relational connection and a sense of being recognised as a person rather than only as someone in need.

Participants described GPs as important where primary care offered practical as well as medical support. For example, the provision of food vouchers suggested that primary care could function as more than a route into clinical treatment. It could also become a point of connection to wider social support. This aligns with integrated care approaches, which recognise that health needs are often inseparable from social needs, particularly for people experiencing homelessness (Bywaters et al., 2022; Schmitz et al., 2021; Luchenski et al., 2021). However, the significance of this support also highlights a tension. When people rely on individual practitioners to bridge gaps in wider systems, access may depend on professional discretion rather than consistent service design.

Charity organisations were also described as important sources of support. Participants valued charities not only for practical resources such as food, clothing, advice or signposting, but also for the human contact they provided. This is important because several participants described feeling ignored, judged or dehumanised in other contexts. In contrast, charity staff and volunteers could offer moments of dignity, familiarity and recognition. This finding is consistent with literature highlighting the role of the voluntary and third sector in providing flexible, relational and practical support for people experiencing homelessness (Cronley et al., 2020; Doherty et al., 2021; Pinfold et al., 2023).

From a counselling psychology perspective, the value participants placed on charity support can be understood relationally. The experience of being listened to, remembered or treated with kindness appeared to carry psychological significance, particularly where participants had previously felt like a burden or a "pariah." This resonates with counselling psychology's emphasis on the therapeutic importance of authentic human connection and relational depth (Mearns & Cooper, 2018). In this context, helpful support was not only about the provision of resources. It was also about whether interactions communicated respect, care and worth.

At the same time, the reliance on charity support raises questions about gaps in statutory provision. The fact that charities were experienced as lifelines suggests that essential forms of practical and relational support may not be sufficiently embedded within mainstream services. This does not diminish the importance of the third sector, but it highlights the need for statutory services to learn from the flexibility, accessibility and relational quality that participants valued in charitable settings. For counselling psychology, this suggests that relational care should not be treated as an optional extra, but as central to engagement and psychological safety.

Assigned support workers were also experienced as helpful where they acted as consistent points of contact and helped participants navigate fragmented systems. Participants' accounts suggested that support workers could provide advocacy, information, encouragement and continuity in contexts where services otherwise felt difficult to understand or access. This reflects wider evidence on the importance of case management and relational continuity for people experiencing homelessness, particularly where multiple services are involved (Kroon et al., 2021). Consistent and empathetic relationships may help build trust, support autonomy and reduce the burden placed on individuals to coordinate their own care across disconnected systems (D'Cunha & Watson, 2021).

Finally, volunteer work appeared to offer participants a sense of purpose, belonging and contribution. This was significant because homelessness was often associated with isolation, stigma and reduced opportunities to feel valued. Volunteering provided a way to reconnect with others and experience oneself as capable, useful and socially connected. This aligns with research suggesting

that meaningful occupation and structured activity can support wellbeing, self-esteem and social inclusion among people experiencing homelessness (Alvi et al., 2022; Davidson et al., 2023; Giddens et al., 2021). It also reflects strengths-based approaches within counselling psychology, which attend to resilience, agency and capacity for growth rather than focusing only on pathology or deficit (Wagener et al., 2022).

However, the value of volunteering should be interpreted carefully. Purposeful activity can support dignity and connection, but it should not become a substitute for secure housing, mental health care or structural change. Participants' experiences suggest that contribution and belonging matter deeply, but their worth should not depend on being seen as productive or useful. For counselling psychology, this creates a dual task: to support agency, meaning and strengths, while also challenging social conditions that restrict dignity, care and belonging for people experiencing homelessness.

5.4. Critical Analysis and Implications

The IPA approach used in this study allowed attention to be given to how participants made sense of homelessness, mental health need and access to support in their own terms. This complements broader quantitative and policy evidence by showing how systemic barriers are lived, interpreted and absorbed into participants' expectations of care. The findings suggest that barriers such as fragmented services, digital exclusion, stigma and crisis-led thresholds were not experienced only as practical obstacles. They also shaped participants' sense of trust, worth and whether support was likely to be available to them.

This is an important contribution because people experiencing homelessness are often represented through statistics, service categories or risk profiles. While such data are necessary, they can obscure the personal meaning of repeated exclusion. By foregrounding participants' accounts, this study offers a more humanised understanding of barriers to mental health care. It shows how service systems can become part of the lived experience of homelessness, particularly when

individuals are required to repeatedly explain their circumstances, navigate unclear pathways, or wait until crisis before support becomes available.

The findings also support the need to move away from reactive, crisis-led models of intervention. Participants' accounts suggested that support was often accessed only once distress, risk or housing need had escalated. This reflects wider concerns that fragmented and under-resourced systems can produce piecemeal responses rather than sustained support (Phillips & Bennington, 2022; Seet et al., 2021). A more preventative approach would require earlier identification of need, continuity across services and targeted support during vulnerable transitions, such as leaving care, hospital, prison or temporary accommodation. Such approaches are not only more humane, but may also reduce reliance on high-cost emergency responses over time.

The role of the third sector was also important. Participants described charities as essential sources of practical help, dignity and relational support. However, the prominence of charitable provision also raises questions about gaps in statutory services. While voluntary organisations can provide flexible and compassionate support, they should not be expected to compensate for failures in housing, healthcare or welfare provision. This distinction matters because homelessness should not be framed primarily as a charitable issue, but as a structural and social justice concern requiring coordinated statutory responsibility.

For counselling psychology, these findings reinforce the importance of person-centred, holistic and relational practice. Participants valued support where they felt listened to, remembered, respected and helped in practical ways. This suggests that relational quality is not secondary to service access; it may be central to whether support feels safe enough to use. Positive experiences with GPs, support workers and charity staff demonstrate the importance of consistent, empathetic and non-judgemental relationships, particularly for individuals who have experienced repeated rejection or institutional mistrust.

The findings also underline the need for advocacy within counselling psychology. Stigma was evident in participants' accounts, both through public attitudes and through institutional practices

that could feel blaming or punitive. Addressing this requires more than individual therapeutic work. It requires attention to service cultures, referral criteria, attendance policies, communication practices and the assumptions professionals may hold about homelessness. Anti-stigma training, lived-experience involvement and reflective practice may help frontline staff recognise how judgement, fear or procedural rigidity can shape interactions with people experiencing homelessness. Structured interventions such as the READ programme may be useful here, where they support empathy, reduce anxiety and improve communication among healthcare professionals (Potts et al., 2022).

Early trauma and digital exclusion also have important implications for practice. Participants' accounts suggested that difficulties with paperwork, online systems or service navigation should not be understood simply as practical skills deficits. For some, these tasks were connected to trauma, mistrust or fear of institutional scrutiny. For others, digital exclusion reflected lack of access to devices, connectivity, privacy or support. Interventions therefore need to avoid locating the problem solely within the individual. A more inclusive approach would adapt services to people's circumstances, rather than requiring people in survival mode to fit systems designed around stability, literacy and digital access.

Overall, the findings suggest that effective support for people experiencing homelessness must be integrated, flexible, trauma-informed and relationally consistent. Counselling psychology has a contribution to make not only through therapeutic work with individuals, but also through advocacy, consultation, service design and the challenge of deficit-based narratives. This requires holding together two commitments: validating individual subjective experience, and recognising the social and structural conditions that shape distress, help-seeking and access to care.

5.7. Strengths and Limitations

A key strength of this study is its use of Interpretative Phenomenological Analysis, which enabled an in-depth exploration of participants' subjective experiences. This approach identified qualitative data that captured the emotional complexity and lived nuance of homelessness and mental health care access, including aspects that may be less visible in broader quantitative or service-level research. IPA's double hermeneutic allowed attention to be given to how participants made sense of their experiences, while also allowing the researcher to interpret these accounts in relation to wider psychological, relational and social contexts. The use of direct quotations strengthened the analysis by grounding interpretations in participants' own words.

This methodological approach aligns with counselling psychology's commitment to understanding subjective experience and the meanings individuals attach to distress, support and change. It was particularly appropriate for the present study because the research did not seek to measure the prevalence of barriers, but to understand how these barriers were experienced and interpreted by participants. In this sense, the study contributes context-rich knowledge about homelessness, mental health need and service access from the perspective of those directly affected.

The findings are not statistically generalisable, nor was this the aim of the research. The small sample size was appropriate for IPA, but it means that the findings cannot be assumed to represent the experiences of all people experiencing homelessness. Participants' accounts were shaped by their particular histories, circumstances and service contexts, and other groups may have different experiences. Nevertheless, the idiographic depth of the analysis may support transferability, allowing practitioners, researchers and service providers to consider where the findings resonate with similar populations or settings (Vaughn & Jacquez, 2020).

As with all self-reported data, the findings may be shaped by memory, emotional state and the interpersonal context of the interview. Participants may have recalled some experiences more clearly than others, or may have chosen to disclose certain aspects of their lives while withholding others. To support openness, the interviews used open-ended questioning, a sensitive interview style and

attention to psychological safety. However, the accounts should still be understood as situated narratives rather than complete or objective records of experience.

A further limitation is that data collection was cross-sectional. The interviews captured participants' experiences at one point in time, while homelessness and service access are often fluid and changeable. Future research could use longitudinal qualitative designs to explore how barriers, trust, psychological responses and engagement with services develop over time. This may be particularly useful for understanding whether positive experiences of support influence later help-seeking, or whether repeated exclusion deepens mistrust and withdrawal.

Demographic variation was also not a targeted focus of the study. Although participants' accounts included differences relating to gender, age, health, trauma and individual circumstances, the sample was too small to draw conclusions about specific subgroups of people experiencing homelessness. Future research could explore how experiences of mental health care access are shaped by gender, ethnicity, sexuality, age, disability, migration status or institutional histories. This would be particularly important given the literature indicating that homelessness is experienced unevenly across different social groups.

Reflexivity was maintained throughout the research through journaling, supervision and ongoing attention to my own assumptions and positioning. This was important because I approached the research as a trainee counselling psychologist who had not personally experienced homelessness and who occupied a position of relative socio-economic stability. I therefore needed to remain attentive to the power imbalance between researcher and participant, and to the risk of interpreting participants' accounts through professional, medicalised or classed assumptions. Reflexive practice helped me to consider how my values, emotional responses and professional identity may have shaped the interview process and analysis.

This reflexive stance supported the credibility and ethical sensitivity of the study. Rather than attempting to remove the researcher from the analysis, reflexivity allowed my interpretative role to be acknowledged and critically examined. This is consistent with qualitative research in counselling

psychology, where transparency about the researcher's position is central to rigour, accountability and ethical practice (Finlay, 2021; Kelly et al., 2020).

5.8 Recommendations for Policy

The findings support policy approaches that move beyond reactive, crisis-led responses and place greater emphasis on prevention, continuity and earlier support. Participants' accounts suggested that mental health needs were often intensified by unstable accommodation, uncertainty and repeated difficulty accessing timely help. This aligns with wider evidence that homelessness, mental health need and service exclusion are interconnected rather than separate problems (Luchenski et al., 2018; Thirkle et al., 2025). Policy responses should therefore recognise that secure accommodation and mental health support are closely connected, rather than treating housing and psychological care as separate issues.

The findings also support the relevance of housing-led approaches, such as Housing First, where secure accommodation is provided alongside flexible support rather than being conditional on prior stability, sobriety or treatment readiness. This is important because participants' accounts suggested that psychological engagement was difficult where immediate needs such as safety, shelter and stability remained unresolved. From this perspective, stable housing may be understood not only as a social outcome, but also as a condition that can make sustained psychological support more possible. Existing evidence on Housing First indicates strong housing retention and potential cost benefits, although implementation requires careful attention to local service context, funding and ongoing support provision (MHCLG, 2024; Crisis, 2025).

Policy should also address the administrative and relational barriers that prevent people experiencing homelessness from accessing support. In practical terms, this could include national guidance requiring services to offer non-digital access routes, flexible registration procedures for people without fixed addresses or identification, and integrated pathways between housing, mental health, substance use and primary care services. This includes ensuring that local services do not rely solely on digital access, fixed addresses, telephone contact or rigid appointment systems. Where

digital systems are used, alternative face-to-face routes should remain available. Policy guidance should also promote trauma-informed and stigma-aware training for frontline staff, particularly in services that act as entry points into mental health care, housing support, primary care and emergency services. Such training should aim to reduce procedural gatekeeping and challenge assumptions that frame homelessness as an individual lifestyle choice rather than as a complex interaction between personal circumstances, structural inequality and service exclusion (Canham et al., 2022).

5.9. Recommendations for Research

Further research is needed to explore how people experiencing homelessness make sense of mental health care access over time. This study captured in-depth accounts from four participants, but longitudinal qualitative research could examine how experiences of exclusion, trust, support and help-seeking develop across different stages of homelessness, housing transition and recovery. For example, future studies could follow individuals as they move between rough sleeping, temporary accommodation, supported housing and more stable accommodation, examining how these transitions affect mental health need, service engagement and perceptions of safety.

Ethnographic approaches may also be useful for understanding how barriers are encountered in everyday interactions with services. This could include observing how people navigate GP registration, referral processes, drop-in services, emergency departments, housing appointments and digital access systems. Such work would be valuable because homelessness and service engagement are often fluid rather than static, and barriers may emerge through ordinary interactions rather than through formal service refusal alone.

Future research should also examine how demographic identities and individual circumstances shape access to mental health support. The present study suggests that barriers are not experienced uniformly, and the literature reviewed in Chapter 2 highlights the importance of age, gender, race, sexuality, cognitive difficulties, substance use and hidden homelessness. Research using

intersectional and participatory approaches would help develop a more detailed understanding of how these factors influence help-seeking, engagement and perceptions of support.

There is also a need for further evaluation of integrated and flexible service models. Research should examine not only whether services improve access, but also how people experiencing homelessness experience those services, what makes support feel safe or useful, and whether positive encounters influence future engagement with mental health care. This could include evaluation of outreach-based psychological support, co-located mental health provision within homelessness services, peer-support models, flexible GP pathways and integrated housing-health initiatives.

Further research could also explore the acceptability and usefulness of different therapeutic approaches for people experiencing homelessness. Although the present study did not evaluate specific interventions, participants' accounts highlighted shame, trauma, mistrust, cognitive fatigue and the importance of feeling heard. This suggests that future research could examine how different relational, narrative, body-based or trauma-informed approaches are experienced by people experiencing homelessness, particularly when delivered in flexible and community-based settings.

5.10. Recommendations for Practice

For counselling psychologists and allied professionals, the findings highlight the importance of flexible, relational and trauma-informed practice. Participants' accounts suggested that people experiencing homelessness may approach services with mistrust, shame or expectations of rejection. Practitioners should therefore prioritise consistency, transparency, choice and collaboration when offering support. These relational conditions may be especially important for individuals who have repeatedly encountered systems as dismissive, punitive or difficult to access.

Services should consider how practical barriers affect psychological engagement. In practice, this may involve flexible appointment formats, active re-engagement after missed appointments, simplified referral processes, outreach or drop-in provision, and closer collaboration with housing, addiction, primary care and voluntary-sector services. Rigid appointment systems, complex referral

processes, digital-only contact and strict non-attendance policies may unintentionally exclude people whose lives are shaped by instability, survival needs or limited resources. More accessible practice may include flexible appointment arrangements, outreach provision, drop-in options, reminder systems and opportunities to re-engage after missed appointments without punitive consequences. Embedding psychological support within trusted community settings, primary care, homelessness services or drop-in centres may also help reduce the distance between people experiencing homelessness and formal mental health provision (Walters et al., 2023).

The findings do not indicate a single preferred therapeutic model. However, they suggest that psychological support should be trauma-informed, relationally consistent and flexible enough to accommodate shame, mistrust, cognitive fatigue and survival pressures. Counselling psychologists may be well placed to work alongside housing services, primary care, addiction services, peer-support workers and voluntary-sector organisations. This does not mean diluting psychological work, but recognising that mental health support may be more accessible when it is connected to the practical and relational contexts in which people experiencing homelessness are already seeking help. Strengths-based and socially situated practice may also support individuals to reconnect with agency, belonging and meaningful activity, particularly where homelessness has contributed to isolation, loss of identity or reduced self-worth.

5.11. Post-Study Reflexive Statement

Now that the analysis is complete, I find myself reflecting not only on the experiences shared by participants, but on the emotional and ethical terrain I encountered throughout the research process. Conducting this study during the winter months, amid freezing conditions and snowfall, heightened my awareness of the precarity faced by those I was privileged to meet. I remember leaving the homeless drop-in centre on certain days feeling deeply unsettled, wondering how participants would fare that night, whether they were safe or simply trying to survive the cold. These concerns lingered beyond the boundaries of fieldwork and found their way into personal therapy, where I allowed myself space to process the emotional weight of bearing witness to such resilience and vulnerability.

Alongside these internal reflections, the drop-in centre offered a communal context for the research. The offer of a cup of tea from service users blurred the boundaries between researcher and guest. It grounded me in shared humanity rather than institutional role, reminding me that empathy must precede inquiry. During my time there, I also engaged with other professionals, including a housing officer who spoke candidly about the moral strain of his role amidst a worsening housing crisis. His reflections deepened my understanding of how systemic barriers affect not only those seeking support, but also those tasked with delivering it.

What remained with me most powerfully were the moments of strength participants revealed, whether in humour, in hope for a different future, or in their continued efforts to contribute to community despite systemic exclusion. These expressions did not erase the pain they spoke of, but they counterbalanced it with grace. In many ways, the research not only amplified their voices but reshaped my own. It reaffirmed my commitment to advocacy, reinforced the ethical imperative of compassion, and challenged me to remain accountable to those whose stories I was entrusted to hold. I carry these stories forward not as data points, but as enduring relational commitments; to remain accountable to lived experience, to pursue justice through proximity, and to safeguard the human connection that must remain at the heart of ethical research and compassionate practice.

6. Conclusion

This study explored how four people experiencing homelessness made sense of their mental health needs, their attempts to access support, and the barriers they encountered. The findings suggest that access to mental health care was shaped by the interaction between structural conditions, service organisation and individual circumstances. Participants described barriers linked to housing instability, administrative requirements, fragmented services, stigma, digital exclusion, physical exhaustion, trauma and mistrust. These barriers were not experienced only as practical obstacles, but also as experiences that shaped participants' sense of safety, worth, trust and expectations of care.

Alongside these difficulties, participants also identified forms of support that felt helpful. GPs, charities, support workers and volunteering opportunities were valued where they offered practical assistance, consistency, dignity, relational connection and a sense of purpose. These findings highlight the importance of flexible, trauma-informed and person-centred support that recognises people experiencing homelessness as whole individuals situated within personal, relational and social contexts.

Overall, the study contributes to counselling psychology by foregrounding lived experience and showing how barriers to mental health care are understood by those directly affected. It reinforces the need for responses that move beyond crisis-led and fragmented provision towards integrated, relational and socially just approaches. By attending to the voices of people experiencing homelessness, this research supports the development of services that are not only more accessible, but also more humane, respectful and responsive to the realities of homelessness.

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8. Appendices

Appendix A
Recruitment Poster

Appendix B
Participant Information Sheet

Dear Sir or Madam,

I am a trainee counselling psychologist at London Metropolitan University and I am currently carrying out research to discover more about homeless adult's barriers to accessing mental health care from a lived experience.

Little is known about the topic from the perspective of people experiencing homelessness; therefore, this research aims to provide valuable insight which could raise awareness of the difficulties homeless people face when trying to access mental health support. This insight would be beneficial in order to improve mental health services, individual treatment outcomes and aid future government policy.

I am writing in the hope that you will be interested in helping me in this endeavour and share your experience of the barriers you faced when attempting to access mental health services by participating in an interview.

Who can take part?
Participation is entirely voluntary. To participate, individuals must **over the age of 18** and identify as homeless based on the following definitions:

- Rooflessness (without shelter, e.g., "sleeping rough")
- Houselessness (temporary accommodation, e.g., hostels, night shelters, B&B's)
- Insecure accommodation (e.g., in cases of domestic violence or "sofa- surfing" with relatives)
- Living in inadequate housing (e.g., living in illegal campsites or extreme overcrowding)

Participants must also have an experience of a time they needed mental health support whilst being homeless and had difficulty accessing this despite efforts being made.

To partake in the study, participants **must not** be under the influence of substances during meetings with the researcher, to ensure participants have capacity to consent at all times during the research.

How long will the interview last?
The interview would last approximately 40 minutes- 1 hour and will be audio-recorded. There will also be an allocated 30 minutes post interview for a debriefing session.

How will the data be used?
Data from your interview will be used for my Doctoral level counselling psychology research project and may result in publication to a journal.

Will the information I share be private?
Interviews will be audio recorded and strictly confidential. All recordings will be kept securely and destroyed once the project is completed.

Can I withdraw from the study if I change my mind?
If you choose to participate you are free to withdraw without any questions until July 31st, 2023, when the data will be amalgamated.

How long will my data be stored for?
Data from the research is being collected for a doctoral thesis which may result in publication; therefore, data will be kept up for five years in an electronic format on a password-protected device.

Before you decide to participate it is more important that you understand that the interview will be discussing a very emotive topic and therefore may evoke some distressing and difficult feelings for you. In line with this, I will be monitoring your distress throughout the interview, and you will be given a chance to ask any questions you may have. if you feel the need to stop the interview, I will be respectful of this and end the interview with no questions asked.

Therefore, please take your time in deciding whether or not you wish to take part. You will have the opportunity to discuss any feelings evoked at length post interview with myself and be given information on sources of support.

If you have any further queries, complaints, comments, regarding the research process, please do not hesitate to contact myself either by phone: 07378607360 or email: chd0660@my.londonmet.ac.uk. You can also contact my research supervisor, Dr Raffaello Antonino, by email: r.antonino1@londonmet.ac.uk.

Thank you for your time.

Yours sincerely,

Charlotte Davey (BSc, MSc)
Professional Doctorate in Counselling Psychology
London Metropolitan University

Appendix C
Contract Agreement

Title of research: Homeless people's experience of barriers when seeking mental health care: An Interpretive Phenomenological Analysis.

Description of procedure: In this research you will be asked a number of questions regarding your experience of the barriers you faced when trying to access mental health support. You will participate in an audio recorded interview for the duration of 40 minutes- 1 hour.

The following list highlights your rights within the study:

- I understand the procedures to be used.
- I understand the interview will be audio recorded.
- I understand I am free to withdraw and my data erased at any point until the 31st July, 2024, where the data will be amalgamated.
- I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g., address, friend's names) will be changed prior to transcription. There are limits to confidentiality however; confidentiality will be breached if any information is disclosed that indicates a risk to safety of yourself and others or indicates an involvement in organised crime.
- I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (minus explicit identifying information) may be used within the study.
- I understand that I may find this interview upsetting and that it may evoke a number of difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings at length post interview with the researcher. The researcher will also provide information on further support available if required.
- I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debriefing form.
- I understand that the data will be destroyed once the study has been assessed.
- I understand I must not be under the influence of substances during meetings with the researcher, to ensure participants have capacity to consent at all times during the research.

Signature of participant: ……..

Print name: ……

Date: ……

Signature of researcher: ……..

Print name: ……

Date: ……

Appendix D
Interview Schedule

Interview Questions

1. Could you describe your experiences with mental health difficulties?
   Prompts: emotions, thoughts, behaviours

2. When did these mental health difficulties begin?
   Prompts: before vs after homelessness, age, critical life events

3. How have these difficulties affected your life since becoming homeless?
   Prompts: mental/physical health, performing tasks, hope for the future, problem-solving, coping mechanisms

4. What are your feelings towards mental health support?
   Prompts: negative/ positive views, have views changed over time, differences amongst sectors

5. What is your opinion on the mental health support available for homeless people?
   Prompts: accessible, suitable, effective

6. Can you tell me about a time you tried to access mental health support based on your difficulties?
   Prompts: critical incident, negatives/ positives of experience, success vs barriers faced

7. What impact did your experience with mental health support have on your life?
   Prompts: negative/positive, improve mental/physical health, improve situation

8. What do you recommend in order to improve the experience of accessing mental health support for homeless people?
   Prompts: staff development, accessibility, suitability, practicality

Appendix E
Distress Protocol

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the present research study on homeless people's experience of facing barriers when trying to seek mental health support. Many homeless people have mental health difficulties and experienced trauma, therefore not being able to source mental health support may prove to be distressing.

Charlotte Davey is a trainee counselling psychologist at London Metropolitan University and has experience in managing situations where distress occurs. There follows below a three-step protocol detailing signs of distress that the researcher will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because most of the participants will have accessed professional services within which there will usually be an existing structure set up to deal with extreme distress which professionals can implement. However, it is included in the protocol, in case of emergencies where such professionals cannot be reached in time.

Mild distress:

Signs to look out for:

1. Tearfulness
2. Voice becomes choked with emotion/ difficulty speaking
3. Participant becomes distracted/ restless

Action to take:

1. Ask participant if they are happy to continue
2. Offer them time to pause and compose themselves
3. Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1. Uncontrolled crying/ wailing, inability to talk coherently
2. Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3. Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1. The researcher will intervene to terminate the interview/experiment.
2. The debrief will begin immediately
3. Relaxation techniques will be suggested to regulate breathing/ reduce agitation
4. The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal and distressing events.

5. If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6. Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1. Severe agitation and possible verbal or physical aggression
2. In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

1. Maintain safety of participant and researcher
2. If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3. If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
4. If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

(Cocking, 2008)

Appendix F
Debriefing statement

Thank you for taking part in this research study. This is part of a Doctoral project that the researcher is conducting and your time and support is greatly appreciated.

This study aims to shed light on homeless adults' first-hand accounts of barriers they faced when trying to access mental health services. The results of the study can provide great potential scope for future developments in mental health care for the homeless population, by providing valuable insight into how access to mental health services can be improved to reduce the negative impact on both the individual and society as a whole.

I would also like to reassure you that your data will be data will be kept on the researcher's personal laptop and in a password protected folder. All data will be kept confidential and identifiable information anonymised. Please also be reminded that you can withdraw from the study at any time and your data will be immediately destroyed.

If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on the following email address: chd0660@my.londonmet.ac.uk. Emails will be checked regularly.

If you have any complaints regarding any aspect of the way you have been treated during the course of the study, please contact my research supervisor Dr Amanda Visick, by email: a.visick@londonmet.ac.uk.

Support in your area

If you feel you need support following the interview, a number of organisations can provide advice and support in confidence. These can be found below:

Shelter is a registered homeless charity who offer one-to-one support to homeless people. You can contact them on 0808 800 4444 or by their website https://england.shelter.org.uk/get_help.

Samaritans is a charity aimed at providing emotional support to anybody experiencing distress. You can contact them on 116 123 or email jo@samaritans.org.uk.

Citizens Advice is an independent organisation specialising in confidential information and advice to assist people with legal, debt, consumer, housing and other problems. You can contact them on 0800 144 8848 or online or speak to an adviser https://www.citizensadvice.org.uk/.

Cheshire Without Abuse can support you if you are experiencing domestic abuse and must flee your home to a place of safety. You can contact them on 0300 123 5101 or email info@mycwa.org.uk.

Street Support Network has useful information and advice related to homelessness in your area: https://streetsupport.net/manchester/advice/

In an emergency, always call the emergency services on 999.

Appendix G

PHQ-9 and GAD-7

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Appendix H

Ethical Approval Letter from London Metropolitan University

Date of approval	27July2023
NB: The Researcher should be notified of the review outcome within two weeks of the submission of the application. If the outcome is re-submission of the application because of requests for further information or suggested adjustments of the project, a further two weeks from receipt of the re-submitted application applies, and so on. A copy should be sent to research@londonmet.ac.uk.	
Signature of RERP chair	

Ethics_ProfDocCounsellingPs...
Saved to OneDrive

Dear Charlotte
I am happy to let you know that your ethics application has been approved and you may now go ahead.
If there are any changes to the research, please get in touch with me as vice-chair of the SSSP Research Ethics Review Panel.
I wish you good luck with your research.

Best wishes
Chris

Professor Chris Chandler
School of Social Sciences and Professions - Psychology (room TM1-58)
London Metropolitan University
166-220 Holloway Road
London, N7 8DB
Tel: 020 7133 2535
email: chandler@staff.londonmet.ac.uk

Appendix I

Prisma 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Thesis title and Chapter 2. The review is identified in Chapter 2 as a systematic search strategy and narrative synthesis.
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Thesis abstract. Not applicable as a standalone systematic review abstract, as the abstract reports the thesis as a whole.
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Section 2.1, Contextual and Conceptual Background; Section 2.4, Synthesis of Knowledge Gaps; Section 2.6, Rationale for the Present Study
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Section 2.2.1, Review Approach; Section 2.6, Rationale for the Present Study; Section 2.7, Research Questions.
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Section 2.2.4, Eligibility Criteria. Study grouping for the synthesis is described in Section 2.2.7 and Section 2.3.

Section and Topic	Item #	Checklist item	Location where item is reported
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Section 2.2.2, Information Sources and Search Date; Appendix J, Database Search History.
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Section 2.2.3, Search Strategy; Appendix J, Database Search History.
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Section 2.2.2, Information Sources and Search Date; Section 2.2.5, Screening and Study Selection. Rayyan use and manual screening by one researcher are reported.
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Section 2.2.7, Data Extraction and Narrative Synthesis; Appendix K, Data Extraction Matrix. Data extraction was completed by one researcher.
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Section 2.2.7 and Appendix K. Data sought included findings relevant to lived experience, perceived barriers and facilitators, mental health-related support, service access, engagement and support needs.
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Section 2.2.7 and Appendix K. Extracted variables included author, year, country or

Section and Topic	Item #	Checklist item	Location where item is reported
			setting, study focus, population, methodology, data collection method, analysis, key findings, methodological strengths and limitations, and relevance to the review.
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Section 2.2.8, Quality Appraisal; Appendix L, MMAT Quality Appraisal Summary. Quality appraisal was completed by one researcher using MMAT.
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Not applicable. No meta-analysis or quantitative effect synthesis was conducted.
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Section 2.2.7 and Section 2.3. Studies were grouped into four recurring areas identified across the included literature.
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Section 2.2.7 and Appendix K. Data were extracted into a structured matrix and grouped narratively. No statistical data conversion was undertaken.
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Table 1, Search Concepts; Table 2, Overview of Included Studies; Figure 1, PRISMA Flow Diagram;

Section and Topic	Item #	Checklist item	Location where item is reported
			Appendix K, Data Extraction Matrix; Appendix L, MMAT Quality Appraisal Summary.
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Section 2.2.7, Data Extraction and Narrative Synthesis; Section 2.3, Narrative Synthesis of Included Academic Literature. Narrative synthesis was informed by Popay et al. (2006).
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Not applicable in statistical form. Differences across study contexts, populations and designs were considered narratively in Section 2.3.
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Not applicable. No statistical synthesis or sensitivity analyses were conducted.
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Not applicable. No formal reporting-bias assessment was conducted. This was a focused narrative synthesis of qualitative and mixed-methods evidence rather than a statistical synthesis of intervention effects.
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Not applicable. No GRADE or GRADE-CERQual

Section and Topic	Item #	Checklist item	Location where item is reported
			assessment was conducted. Methodological quality and contribution to the synthesis were considered through MMAT in Section 2.2.8 and Appendix L.
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Section 2.2.5, Screening and Study Selection; Figure 1, PRISMA 2020 Flow Diagram.
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Section 2.2.5 and Figure 1. Full-text exclusion reasons are reported. Full-Text Articles Excluded at Eligibility Stage, if included.
Study characteristics	17	Cite each included study and present its characteristics.	Section 2.2.6, Overview of Included Studies; Table 1; Appendix K, Data Extraction Matrix.
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Section 2.2.8, Quality Appraisal; Appendix L, MMAT Quality Appraisal Summary.
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Table 1; Appendix K; Section 2.3. Not applicable in statistical effect-estimate form because the review synthesised qualitative and mixed-methods findings narratively.

Section and Topic	Item #	Checklist item	Location where item is reported
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Section 2.3, Narrative Synthesis of Included Academic Literature; Section 2.4, Synthesis of Knowledge Gaps; Appendix L.
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Not applicable. No meta-analysis or statistical synthesis was conducted.
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Not applicable in statistical form. Differences across studies are considered narratively in Section 2.3.
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Not applicable. No sensitivity analyses were conducted.
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Not applicable. No formal reporting-bias assessment was conducted.
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Not applicable. No formal certainty assessment was conducted. Methodological strengths and limitations were considered through MMAT in Section 2.2.8 and Appendix L.
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Section 2.4, Synthesis of Knowledge Gaps; Section 2.5, Rationale for the Present Study.

Section and Topic	Item #	Checklist item	Location where item is reported
	23b	Discuss any limitations of the evidence included in the review.	Section 2.2.8, Quality Appraisal; Appendix L; Section 2.2.10, Limitations of Review.
	23c	Discuss any limitations of the review processes used.	Section 2.2.10, Limitations of Review.
	23d	Discuss implications of the results for practice, policy, and future research.	Section 2.4, Synthesis of Knowledge Gaps; Section 2.6, Rationale for the Present Study. Further implications are discussed in the thesis Discussion chapter.
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Section 2.2.8, Quality Appraisal. The review was not registered.
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Section 2.2.8, Quality Appraisal. A separate review protocol was not prepared.
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Not applicable. No protocol was prepared.
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Acknowledgements / declaration section. No specific funding was reported for the review.
Competing interests	26	Declare any competing interests of review authors.	Declaration Statement (Page 2)
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Appendices J, K, L where included. Search strings, extracted data, quality appraisal summary and full-

Section and Topic	Item #	Checklist item	Location where item is reported
			text exclusion table are provided in appendices. No analytic code was used.

Appendix J
Database Search History

Database	Search string	Records identified
Cochrane Library	(homeless* OR "no fixed abode" OR "rough sleep*" OR "sofa surf*" OR "temporary accommodat*" OR unhoused) AND ("mental health" OR counselling OR "talking therapy" OR "psychological support" OR "psychosocial support") AND ("lived experience*" OR narrative* OR perspective* OR stigma OR barrier* OR qualitative OR interview*)	5
EBSCO	(TI (homeless* OR "no fixed abode" OR "rough sleep*" OR "sofa surf*" OR "temporary accommodat*" OR unhoused) OR AB (homeless* OR "no fixed abode" OR "rough sleep*" OR "sofa surf*" OR "temporary accommodat*" OR unhoused)) AND (TI ("mental health" OR counselling OR "talking therapy" OR "psychological support" OR "psychosocial support") OR AB ("mental health" OR counselling OR "talking therapy" OR "psychological support" OR "psychosocial support")) AND (TI ("lived experience*" OR narrative* OR perspective* OR stigma OR barrier* OR qualitative OR interview*) OR AB ("lived experience*" OR narrative* OR perspective* OR stigma OR barrier* OR qualitative OR interview*))	3,659
PubMed	((homeless persons[MeSH Terms] OR homeless*[Title/Abstract] OR "rough sleep*"[Title/Abstract] OR "sofa surf*"[Title/Abstract] OR "temporary accommodat*"[Title/Abstract] OR unhoused[Title/Abstract])) AND (mental health services[MeSH Terms] OR "mental health"[Title/Abstract] OR counselling[Title/Abstract] OR "talking therapy"[Title/Abstract] OR "psychosocial support"[Title/Abstract] OR "psychological support"[Title/Abstract]) AND (qualitative research[MeSH Terms] OR "lived experience*"[Title/Abstract] OR narrative*[Title/Abstract] OR perspective*[Title/Abstract] OR interview*[Title/Abstract] OR qualitative[Title/Abstract] OR barrier*[Title/Abstract])	1,329
Total		**4,993**

Appendix K
Data Extraction Matrix

Table K1

Study Characteristics of Included Papers

Study	Country / setting	Aim / focus	Sample	Method / data collection	Analysis
Bell et al. (2024)	Warwickshire, England	Explored experiences of a nurse-led outreach healthcare service and housing journeys among people experiencing homelessness.	18 adults with current or recent experience of homelessness.	Qualitative service evaluation using face-to-face narrative storytelling interviews in community settings.	Reflexive thematic analysis.
Potter et al. (2024)	England, inner-city general practice context	Explored how access to general practice could be improved for people experiencing severe and multiple disadvantage.	Practice staff, women with lived experience of severe and multiple disadvantage, and support-sector stakeholders across three inner-city practices.	Qualitative study linked to collaborative service improvement. Data included service improvement meetings, observations, interviews and a focus group.	Thematic analysis using inductive and deductive approaches.
Schel et al. (2022)	Netherlands	Examined perceived outcomes, critical elements and mechanisms of intentional unidirectional peer support within homeless services.	10 people experiencing homelessness and 10 peer workers involved in peer support.	Qualitative exploratory study using semi-structured interviews.	Qualitative coding and comparison of client and peer worker accounts.

Study	Country / setting	Aim / focus	Sample	Method / data collection	Analysis
Sutherland et al. (2022)	Perth, Western Australia	Explored healthcare needs and barriers to health service access among older women experiencing homelessness.	22 older women experiencing homelessness.	Mixed-methods study using questionnaires and semi-structured interviews.	Descriptive statistics and thematic analysis.
Ingram et al. (2024)	Dublin, Ireland	Explored how people experiencing homelessness attending an urban primary care and addiction service understood their health and healthcare needs.	People experiencing homelessness attending a drop-in primary care and addiction service.	Ethnographic qualitative study using observation, informal conversations and field notes.	Inductive thematic analysis.
Adams et al. (2022)	North East England	Explored experiences of accessing community-based mental health and substance use support during COVID-19.	26 adults experiencing homelessness, aged 25 to 71.	Qualitative interview study using telephone interviews, with participatory input from people with lived experience.	Inductive reflexive thematic analysis.
Warren et al. (2025)	British Columbia, Canada	Explored barriers and facilitators to housing and healthcare services for people experiencing homelessness with concurrent brain injury, mental health and	Stakeholders including people with lived experience, service providers, researchers, policymakers, healthcare workers, family members and brain injury organisations.	Qualitative participatory action research using in-person and online focus group-style discussions.	Manifest content analysis guided by an access-to-healthcare framework.

Study	Country / setting	Aim / focus	Sample	Method / data collection	Analysis
		substance use difficulties.			
Jain et al. (2025)	England	Explored learning from the Everyone In initiative for integrated health, housing and wider care for people rough sleeping during COVID-19.	25 people accommodated through Everyone In and 43 service providers.	National qualitative study using interviews and focus groups.	Framework analysis and case study analysis.
Ingram et al. (2025)	Dublin, Ireland	Identified barriers and enablers of addiction recovery among people experiencing homelessness and proposed a framework adapted from REC-CAP.	Secondary analysis of two qualitative data sources, including interviews with 19 providers and ethnographic fieldwork with 40 homeless clients.	Secondary qualitative analysis using provider interviews and ethnographic fieldwork.	Secondary qualitative analysis using REC-CAP as a conceptual framework.

Table K2

Key Findings, Methodological Considerations and Relevance to the Narrative Synthesis

Study	Key findings relevant to the review	Methodological strengths / limitations	Relevance to research questions and synthesis
Bell et al. (2024)	Participants described complex routes into homelessness, stigma, difficulty accessing mainstream systems and the importance of outreach healthcare. Nurse-led outreach was experienced as accessible and supportive because care was taken to people rather than requiring them to navigate standard appointments. Housing alone did not remove the need for ongoing support.	Strengths include direct accounts from people experiencing homelessness, a flexible narrative method and attention to both housing and healthcare. Limitations include a local sample, opportunistic recruitment and relatively short interviews.	Relevant to lived experience, perceived barriers and helpful forms of support. Contributes to the synthesis areas on integrated, flexible approaches, relational barriers and administrative exclusion.
Potter et al. (2024)	The study identified practical ways to improve access to general practice, including flexible appointments, inclusion patient lists, continuity through care coordinators or micro-teams, and improved information sharing. It also showed the value of collaboration between general practice, support organisations and people with lived experience.	Strengths include co-production, inclusion of lived experience and detailed attention to general practice as an access point. Limitations include a small sample and focus on motivated practices, which may limit transferability.	Relevant to perceived systemic barriers, particularly GP access, administrative exclusion, continuity, trust and service improvement. Contributes mainly to access to primary care and administrative exclusion.
Schel et al. (2022)	Peer support was associated with improved self-image, personal growth and engagement with services. Key mechanisms included rapport, empathy, trust, empowerment, guidance and mediation. Peer workers appeared to provide a relational bridge between	Strengths include inclusion of both service-user and peer-worker perspectives and attention to mechanisms of support. Limitations include a Dutch service context and exclusion of some potential participants judged unable to provide reliable	Relevant to helpful support, lived experience of engagement, trust, empowerment and relational safety. Contributes mainly to integrated, flexible or peer-supported approaches, and to

Study	Key findings relevant to the review	Methodological strengths / limitations	Relevance to research questions and synthesis
	service users and formal support.	information, which may have reduced representation of people in acute distress.	mistrust and relational barriers.
Sutherland et al. (2022)	Older women described complex and interrelated health needs, including safe accommodation, financial insecurity, trauma and abuse, stigma, fear of judgement, mental health difficulties, healthcare costs and the need for ongoing psychosocial and healthcare support once housed.	Strengths include focus on an often hidden and under-researched subgroup and attention to gendered experiences. Limitations include a small sample and an Australian healthcare and housing context, which may limit direct transferability to England.	Relevant to demographic identity, gender, age, hidden homelessness, perceived barriers and ongoing support needs. Contributes to mistrust, stigma and relational barriers, and to individual circumstances shaping access.
Ingram et al. (2024)	Health was often understood through immediate survival, pain, loss, relationships, substance use and access to services. Mental health needs were closely tied to grief, trauma, precarious housing and self-medication. The study highlighted how people understood and prioritised health and healthcare in the context of homelessness.	Strengths include ethnographic fieldwork, attention to informal accounts, reflexivity and community-partner feedback. Limitations include reliance on field notes rather than audio recording, which may have missed nuance or introduced recall bias.	Relevant to lived experience, meaning-making, mental health needs and perceived barriers. Contributes to fragmented responses to complex and co-occurring needs, and to mistrust and relational barriers.
Adams et al. (2022)	Service changes during COVID-19 often produced inadvertent exclusion. Barriers included service location, limited availability, repeated telling of recovery stories, readiness to engage and difficulty accessing support outside standard hours. Participants valued choice, empowerment, responsiveness and trauma-informed support.	Strengths include direct relevance to mental health and substance use access, involvement of people with lived experience and focus on pandemic-related service change. Limitations include telephone data collection, a regional sample and a pandemic context that may differ from routine service conditions.	Highly relevant to perceived barriers and facilitators, mental health and substance use needs, and service improvement from a lived-experience perspective. Contributes to fragmented responses to complex and co-occurring needs, and integrated or flexible approaches.

Study	Key findings relevant to the review	Methodological strengths / limitations	Relevance to research questions and synthesis
Warren et al. (2025)	Findings highlighted siloed systems, inadequate investment, technical barriers, complex paperwork, diagnosis-dependent eligibility, long waits, restrictive policies and limited accommodation of brain injury. Facilitators included government commitment, organisational collaboration, community-based services, outreach, peer and family support.	Strengths include participatory design, inclusion of varied stakeholder perspectives and attention to complex co-occurring needs. Limitations include group-level data, which may reduce depth of individual lived experience, and Canadian transferability considerations.	Relevant to individual circumstances, complex need, systemic barriers, service fragmentation and facilitators to care. Contributes to fragmented responses to complex and co-occurring needs, and integrated or flexible approaches.
Jain et al. (2025)	The Everyone In initiative showed the value of flexible funding, joined-up services, cross-sector working and rapid responsiveness. Trusted relationships, support workers, co-location and integrated provision improved access to health and social care support. Long-term learning included the need to address psychosocial needs, alcohol and substance use, and holistic support.	Strengths include national scope, inclusion of service users and providers, and analysis of policy implementation across settings. Limitations include retrospective accounts and a COVID-19 policy context that may not fully reflect usual service conditions.	Relevant to helpful support, service improvement, integrated care, mental health-related access and structural facilitators. Contributes mainly to integrated, flexible or peer-supported approaches.
Ingram et al. (2025)	Recovery was shaped by housing, physical and psychological health, stigma, self-beliefs, treatment beliefs, motivation, stability, self-efficacy, autonomy, meaningful activity, social support and access to mental health, addiction, family, primary care and housing supports. Safe and stable	Strengths include integration of provider and ethnographic data and attention to recovery capital in the context of homelessness. Limitations include secondary analysis and overlap with prior ethnographic work, meaning it should be interpreted as related but distinct evidence.	Relevant to co-occurring substance use, mental health support, facilitators, housing stability and recovery-oriented service improvement. Contributes to fragmented responses to complex and co-occurring needs, and integrated or flexible approaches.

Study	Key findings relevant to the review	Methodological strengths / limitations	Relevance to research questions and synthesis
	housing was identified as crucial for sustaining recovery.		

Appendix L
MMAT Quality Appraisal Summary

Appendix L

MMAT Quality Appraisal Summary

Note. The included studies were appraised using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). Each study was first considered against the two MMAT screening questions and then appraised using the MMAT category most closely aligned with its design. Judgements were recorded narratively rather than as overall numerical scores, in line with MMAT guidance. Most studies were appraised using the qualitative criteria. Sutherland et al. (2022) was appraised as a mixed-methods study, with particular attention paid to the qualitative component used in this review. Qualitative service evaluations were appraised using the qualitative criteria where the included evidence was identified through qualitative data collection and analysis.

Study	MMAT category	Screening questions	MMAT criteria judgement	Key strengths	Key limitations	Implication for synthesis
Bell et al. (2024)	Qualitative study / qualitative service evaluation	Clear evaluative focus and appropriate qualitative data.	Met most qualitative criteria. The qualitative approach and narrative interviews were appropriate for exploring service-user experience. Findings were linked to participant accounts and interpreted in relation to service provision, although depth was limited in some interviews.	Direct accounts from people with current or recent experience of homelessness. Flexible narrative approach. Clear relevance to outreach, integrated care, mental health-related support and service flexibility.	Local service-evaluation context may limit transferability. Opportunistic recruitment may have excluded people less engaged with services. Some interviews were relatively brief.	Retained as relevant evidence on outreach, flexible healthcare, relational support and the role of nurse-led provision in reducing barriers to care. Findings were interpreted with attention to the local service context.
Potter et al. (2024)	Qualitative study / co-	Clear research focus and data appropriate	Met most qualitative	Co-produced design.	Small lived-experience	Retained as important

Study	MMAT category	Screening questions	MMAT criteria judgement	Key strengths	Key limitations	Implication for synthesis
	produced service improvement study	to the service improvement aim.	criteria. The design brought together meetings, observations, interviews and a focus group. Findings were coherent and linked to practical service changes, although the lived-experience sample was small.	Inclusion of lived-experience contributors, practice staff and support-sector perspectives. Strong relevance to primary care access, administrative exclusion, continuity and inclusive service design.	sample. Participating practices were already engaged in improvement work. Study focused on severe and multiple disadvantage rather than homelessness specifically.	evidence on general practice access and service adaptation. Findings were interpreted as relevant to homelessness-related access barriers, rather than as direct evidence of all people experiencing homelessness.
Schel et al. (2022)	Qualitative study	Clear research questions and appropriate interview data.	Met most qualitative criteria. Interviews with people receiving peer support and peer workers were appropriate for exploring perceived mechanisms of support. Findings were coherently linked to	Inclusion of both people receiving peer support and peer workers. Clear focus on relational mechanisms. Strong relevance to trust, engagement, empowerment and peer-supported access.	Conducted in the Netherlands, so transferability to the UK context requires consideration. Some potential participants were excluded because they were judged unable to provide	Retained as relevant evidence on peer support, relational safety, trust and engagement. Findings mainly informed discussion of facilitators to care and the relational conditions that may

Study	MMAT category	Screening questions	MMAT criteria judgement	Key strengths	Key limitations	Implication for synthesis
			trust, empowerment, guidance and mediation.		reliable information, which may have reduced representation of people in more acute distress or instability.	support access.
Sutherland et al. (2022)	Mixed-methods study with qualitative component	Clear research focus and appropriate questionnaire/interview data.	Partially met mixed-methods and qualitative criteria. The qualitative component was relevant and thematically analysed. For this review, the experiential findings were most relevant. Integration of qualitative and quantitative components was less central to the present synthesis.	Focus on an under-researched group. Provides insight into gendered and age-related barriers, hidden homelessness, stigma, trauma, healthcare access and the interaction between physical and mental health.	Small sample size. Australian healthcare and housing context may limit direct transferability to England. The paper was broader than mental health care specifically, so findings were used where they related to mental health, psychosocial support, stigma and access.	Retained as relevant evidence on demographic and relational dimensions of access. Findings contributed to the synthesis on stigma, hidden homelessness, gender, age and complex need.
Ingram et al. (2024)	Qualitative ethnographic study	Clear aim and appropriate ethnographic data.	Met most qualitative criteria. Ethnographic	Strong relevance to lived experience	Reliance on field notes rather than audio-	Retained as strong evidence on how people

Study	MMAT category	Screening questions	MMAT criteria judgement	Key strengths	Key limitations	Implication for synthesis
			observation and informal conversations were appropriate for exploring situated understandings of health and healthcare. Findings were coherently derived through inductive thematic analysis.	and meaning-making. Captured informal and contextualised accounts that may be missed in formal interview designs. Reflexivity and community feedback strengthened credibility.	recorded interviews may have limited detail and introduced interpretation at the point of recording. Conducted in one Irish primary care and addiction service context.	experiencing homelessness understand health, mental health, substance use, survival, stigma and engagement with care. Findings informed themes on lived experience, relational barriers and complex need.
Adams et al. (2022)	Qualitative study	Clear research aim and appropriate interview data.	Met qualitative criteria. The qualitative interview design was appropriate for exploring barriers and facilitators to mental health and substance use support. Reflexive thematic analysis and lived-experience	Directly relevant to mental health and substance use support. Included lived-experience input. Strong evidence on service disruption, trauma-informed care, choice and empowerment.	Telephone interviews may have excluded people without stable phone access or those less able to engage remotely. The pandemic context may limit transferability to routine	Retained as highly relevant evidence on barriers and facilitators to mental health and substance use support. Findings informed themes on administrative exclusion, fragmented care, relational safety and

Study	MMAT category	Screening questions	MMAT criteria judgement	Key strengths	Key limitations	Implication for synthesis
			input strengthened interpretation.		service conditions.	flexible support.
Warren et al. (2025)	Qualitative participatory study	Clear aim and appropriate participatory qualitative data.	Met most qualitative criteria. The participatory design and access-to-healthcare framework were appropriate for examining barriers and facilitators across systems. Group-based data may limit idiographic depth.	Strong focus on acquired brain injury, mental health, substance use and homelessness. Included varied stakeholder perspectives, including lived experience, service providers, researchers, policymakers and family members.	Canadian context requires consideration when applying findings to the UK. Broad stakeholder sample and group-based methods may mean service-level perspectives are more prominent than individual lived experience.	Retained as relevant evidence on complex need, cognitive barriers, fragmented systems and service-level facilitators. Findings supported interpretation of structural and organisational barriers for people with overlapping needs.
Jain et al. (2025)	Qualitative study	Clear research focus and appropriate interview/focus group data.	Met most qualitative criteria. Interviews and focus groups were appropriate for exploring learning from the Everyone In initiative. Framework and case-study	National scope across several English regions. Included people accommodated through Everyone In and service providers. Strong relevance to	Retrospective accounts may be affected by recall. The COVID-19 emergency policy context may not reflect usual service conditions. Provider perspectives	Retained as important evidence on integrated, flexible and cross-sector support. Findings were interpreted as service and policy-level evidence,

Study	MMAT category	Screening questions	MMAT criteria judgement	Key strengths	Key limitations	Implication for synthesis
			analysis supported interpretation across multiple settings.	integrated care, flexible support, joined-up working and policy-level service change.	may be more prominent than idiographic lived experience.	with relevance to mental health-related access and wider support needs.
Ingram et al. (2025)	Qualitative secondary analysis / conceptual framework development	Clear focus and appropriate secondary qualitative data.	Met most qualitative criteria, with limitations linked to secondary analysis. Provider interviews and ethnographic data were suitable for exploring addiction recovery, and REC-CAP provided a coherent conceptual frame.	Integrated provider and ethnographic data. Strong relevance to addiction recovery, housing instability, psychological health, stigma, autonomy, social support and access to multiple forms of care. Provided a useful framework for understanding recovery beyond individual motivation.	Data were not originally identified solely for the specific focus of this review. Some overlap with earlier ethnographic work means findings should be interpreted as related, but not entirely independent, evidence.	Retained as relevant evidence on co-occurring substance use, recovery, mental health-related support, housing stability and facilitators to engagement. Findings informed synthesis on complex need and integrated support.