Doctorate in Clinical Psychology | Lancaster University

Doctoral Thesis

Homelessness, Mental Health and Psychologically Informed Environments: Qualitative Exploration with People Experiencing Homelessness and Staff

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Statement of total word count for thesis

	Main text	**Appendices (including tables, figures and references)**	**Total**
Thesis Abstract	293		293
Section 1: Literature Review	7930	7335	15265
Section 2: Research Paper	7996	10067	18063
Section 3: Critical Appraisal	3999	745	4744
Section 4: Ethics	5150	7970	13120
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Thesis Abstract

This thesis consists of three sections: a systematic literature review (SLR), an empirical paper, and a critical appraisal. The research focuses on people experiencing homelessness (PEH), to understand experiences of accessing and engaging with mental health support, in addition to exploring psychologically informed environments (PIEs) in homelessness services.

The SLR explores the perspectives of adults who have experienced homelessness in accessing support for their mental health. A systematic literature search identified 15 papers, synthesised using a meta-ethnographic approach to develop a line of argument synthesis. The results highlight many challenges faced by PEH when accessing mental health support. Themes included the intersectionality of stigma, the importance of relationships, service pressures, and feeling connected. The review recommends that services include people with lived experience of homelessness in service design and increase integration and collaboration across the system.

The empirical paper explores what contributes to a successful PIE in a homelessness service from the perspectives of psychologists, staff, and service users. Qualitative semi-structured interviews and a grounded theory methodology captured participants' accounts and developed a model to illustrate the components of a functioning PIE, the driving forces of systemic and engagement factors, and the service user and staff experiences at the centre. The theory highlights the importance of the relationship between the different elements; when the various factors worked together, a PIE was more stable for the service users and staff at the centre. The results highlight the complexity of implementing a PIE in a homelessness service. Recommendations for services include considering the wider contextual and systemic influences surrounding homelessness.

The critical appraisal reflects on the research process and the role of the researcher at different stages of design, data collection, analysis, and interpretation. Further clinical implications and areas for future research are also explored.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from September 2020 to August 2023.

The work presented here is the author's own, except where due reference is made.

The work has not been submitted for the award of a higher degree elsewhere.

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Date: 28/03/2023

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Table of Contents

Section 1 Literature Review

Receiving Support from Mental Health Services from the Perspectives of Adults who have Experienced Homelessness: A Review of Qualitative Research.

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Abstract

The review aims to understand the perspectives of adults who have experienced homelessness in accessing support for their mental health. To explore potential facilitators and barriers to accessing support and develop recommendations for services. A systematic literature search identified 15 papers that were synthesised using a meta-ethnographic approach to develop a line of argument synthesis. The results highlight the challenges faced by people experiencing homelessness when navigating services to access mental health support. Participants experienced stigma and marginalisation related to intersecting aspects of their identities at multiple levels including individual, service, and wider society. These experiences influenced participants' abilities to access and engage with support due to being less able to build relationships with staff, further hindered by the context of high demand and service pressure surrounding services. The link between these factors reinforced barriers to access and engagement. To alleviate such barriers, it is recommended that services value the lived experience of homelessness and operate in a way that promotes integration and effective communication.

Keywords: homelessness; stigma, relationships; communication; integration

Introduction

Homelessness is a global issue, with estimates of 1.6 billion people living in inadequate housing worldwide (United Nations, 2016). In England in 2021, 282,000 people were recorded as homeless (Watts et al., 2022). Homelessness is defined as “not having a home” and includes a range of circumstances, from living in temporary accommodation to living and sleeping on the streets (Shelter, 2018). Recently, the impact of the COVID-19 pandemic has further pushed people into homelessness, with ongoing effects expected (Watts et al., 2021). Experiencing homelessness is associated with an increased likelihood of experiencing "multiple disadvantage", including substance use, mental health difficulties, and interactions with the criminal justice system (Public Health England [PHE], 2021). The co-occurrence of these difficulties contributes to increased risk to physical health and wellbeing, reduced life expectancy, and increased barriers to service access compared with the general population (Aldridge et al., 2018; McCarthy et al., 2020).

Policy

Within the United Kingdom (UK), policy to support people experiencing homelessness (PEH) includes The Homelessness Reduction Act (2017) which allocates statutory duties to local councils to prevent homelessness and support those experiencing homelessness (PHE, 2019). However, some argue that this legislation has contributed to the further marginalisation of this group by ignoring wider structural barriers to reducing homelessness (Bevan, 2022). Austerity measures in the UK and in Europe have been linked to cuts to services that aim to prevent homelessness and offer welfare support for vulnerable people (Stuckler et al., 2017). Furthermore, people with lived experience of homelessness and staff who support them highlight inadequate services, lack of resources, and high prevalence of stigma which prevents people from seeking support and furthers inequalities (Perry et al., 2021).

Homelessness and Health Inequalities

Research with PEH describes encounters with healthcare services as stigmatising and shaming which can lead to avoidance of services and worsening of health concerns (Purkey & MacKenzie, 2019). For PEH, prioritising their health needs may be influenced by having other basic needs such as shelter or food met, in addition to earlier negative experiences with healthcare professionals not understanding them which can deter them from seeking future support (Rae & Rees, 2015). To overcome such barriers outreach models offer healthcare support to people in their environments (Dorney-Smith, 2019). PEH who have received support from healthcare street outreach teams describe helpful interactions with staff that are respectful, offer choice, and a human connection (Ungpakorn & Rae, 2020).

Homelessness and Mental Health

Within the literature, both quantitative and qualitative studies have explored the links between homelessness and mental health. Longer periods of homelessness are associated with increased risks of long-term mental health difficulties due to the increased likelihood of stressful and traumatic experiences (Lippert & Lee, 2015). Qualitative interviews with PEH support this relationship with reports of traumatic experiences related to loss, abuse and violence before becoming homeless, in addition to experiencing trauma whilst homeless linked to increased vulnerability, lack of safety, and social exclusion (Gilmoor et al., 2020). Despite the need for mental health support, a large-scale quantitative study across 14 countries identified numerous barriers to access for PEH, including limited resources, restrictive exclusion criteria, and prejudicial attitudes of professionals (Canavan et al., 2012).

Within the UK, a coalition of charities reported challenges in access to statutory mental health services due to a lack of flexibility and lack of understanding of the needs of PEH, (Making Every Adult Matter [MEAM], 2021). As a result. PEH often rely on third-sector organisations however unfortunately, people still fall through the gaps in available service provision (Anderson, 2011). A survey of UK mental health trusts found variation in support for PEH and little evidence of specific staff training to support this population's needs (Lucas et al., 2018). Furthermore, only 17% of clinical commissioning groups (CCGs) in England report having specific homelessness mental health teams, suggesting that awareness of mental health needs of this population is limited (Giles et al., 2022). The National Health Service (NHS) long term plan included a commitment to increase access to specialist mental health support for people who are sleeping rough in parts of England (NHS, 2019).

Additional barriers to PEH accessing appropriate support include difficulty registering with a GP, complexities of navigating the system, and traditional models of support that lack flexibility (Moreton et al., 2022). Through qualitative interviews with service users of a homeless psychology service, Taylor (2012) highlighted that previous negative experiences with services could be a barrier to engagement, however, could be overcome by developing a therapeutic relationship with someone who understood homelessness and their individual needs. From the perspectives of staff working in homelessness, change occurs when support is at the individual's pace and offers consistent, boundaried relationships, with emphasis on the need for support to be coordinated, flexible, and persistent (Lord et al., 2021). Where such services are not available, PEH often rely on coping mechanisms such as avoidance and hiding vulnerabilities in an attempt at self-preservation whilst navigating the complexities of homelessness (Karadzhov et al., 2020).

Research with PEH has explored specific interventions that can reduce the barriers mentioned above. Continuity of care and coordination of services can facilitate access and offer immediate support from relevant teams, in addition to prioritising engagement with frequent contact to build relationships (Lamanna et al., 2018). Where specific therapeutic programmes have been created for PEH, beneficial outcomes have been reported following trauma-informed interventions (Reid et al., 2021), mindfulness-based interventions (Alhusen et al., 2017) and less traditional therapeutic methods such as an adventure therapy intervention (Shehade & Kyriakopoulos, 2021).

The current study

The available literature draws on various sources of quantitative and qualitative research, and third sector reports. Despite increased research into these issues in recent years, the evidence base is still in its infancy. Research directly with PEH about their views on accessing support from mental health services is still developing, and there are recommendations for more qualitative research to better understand these experiences (Adams et al., 2022). A recent review by Diduck et al. (2022) focused on the mental health needs of PEH in Canada, which included a section on service and systemic barriers that can limit access to mental health support. However, as this was not the focus of the review and it solely focused on Canadian studies, the current review hopes to contribute a more detailed perspective to the evidence base. The current review aims to address the lack of a comprehensive review of these issues in the literature, to support understanding and ability to make recommendations for service improvements.

Review Aim

To further explore this topic the research question was “what are the perspectives of adults who have experienced homelessness about receiving support from mental health services?”. A meta-ethnographic approach was used to review and synthesise existing qualitative literature focusing on experiences of PEH and identify any gaps in the evidence base.

Method

Approach Used

A meta-synthesis was conducted, in line with Noblit and Hare’s (1988) seven-phase meta-ethnographic approach. The process was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance (Moher et al., 2009) for identification, selection, and critical appraisal of research for analysis and synthesis, (see Figure 1).

Phase 1: Getting Started

The topic was initially identified based on researcher interests and reading literature included in the introduction. Initial scoping searches were conducted to explore the current literature; support was also sought from a university librarian to develop the review question and research protocol. Once a topic was identified, the lead researcher searched PROSPERO for current registered systematic reviews to ensure no overlap with the current study. Previous reviews have focused on the experiences of young people, less than 18 years old (Brown et al., 2016; Lapinski, 2019) or on experiences of broader health and social care services (Allen & Vottero, 2020; McNeill, 2022; Omerov et al., 2020). However, no review to the author’s knowledge has focused specifically on adults experiencing homelessness and accessing mental health services.

Phase 2: Deciding what is Relevant to the Initial Interest

Defining the focus of the synthesis

Through initial scoping searches, it was apparent that a synthesis of the voices of individuals with lived experience of homelessness was missing. Initially, numerous studies were available about experiences of mental health support, including specific programmes or qualitative aspects of randomised controlled trials (RCTs), so it was necessary to focus the scope of the research question (Noblit & Hare, 1988).

Locating relevant studies

The search strategy was developed using the SPIDER tool (Cooke et al., 2012), (see table 1). The lead researcher met with a university librarian for support in developing a comprehensive search strategy. A systematic search of PsycInfo, Medline, CINAHL, and Soc Index was completed in April 2022. The search strategy returned 1841 papers after duplicates were removed. Titles were screened and 1387 were removed, after which titles and abstracts were screened which excluded 378. Seventy-six papers were read in full and 15 were included in the review. In line with Noblit & Hare (1988), database searches were supplemented by searching reference lists of included papers. The Google Scholar 'cite forward' function was also used. No additional studies were identified through these methods. For details of the complete search strategy and inclusion decisions, see figure 1.

Inclusion decisions

Studies were included that were accessible in English Language and were peer-reviewed primary research studies. Studies were included with samples of adults (18 years+), with experiences of homelessness. Papers were included if they were solely focused on accessing support from mental health services, or the paper had an explicit focus on this in the findings, with at least one clear theme and related participant quotes. Only studies that used qualitative methodologies were included in the review. For the full inclusion and exclusion criteria, see table 2.

Quality assessment of included studies

The Critical Appraisal Skills Programme (CASP) (2018) checklist was used to critically appraise the quality of the included studies. The CASP was chosen as it is widely used in healthcare related qualitative syntheses (Long et al., 2020). The CASP questions were scored in line with Duggleby et al.'s (2010) rating scale, with a maximum score of 24. The appraisal was conducted by the lead author and five of the included papers were inter-rated by a peer for reliability. During this process, there were three discrepancies across two of the co-rated papers, the lead author and peer met to discuss the differences in score and an agreement was reached. The appraisal was to check the quality and consider the contribution of each study to the current synthesis and not as an exclusion tool (Atkins et al., 2008). The included studies ranged in quality from 13 to 22, (see table 3).

Phase 3: Reading the Studies

The 15 included papers were read and re-read, see table 4 for key information and study characteristics. The included papers ranged in date of publication from 2007 to 2022. The papers covered a range of geographical locations, with eight being from the USA, three from the UK, two from Canada, one from Australia, and one from Brazil. A range of methodologies were employed, with nine using qualitative interviews, four using focus-groups, one using a mixture of ethnographic observations and interviews, and another using interviews and focus groups. Within the included papers, eight included both male and female participants, five included solely women, with one focusing on mothers and another on veterans, and two included solely male participants.

Phase 4: Determining how the Studies are Related

Alongside the previous phase, key themes and concepts from the results sections were extracted to explore relationships between studies. In line with Britten et al. (2002) this included identifying first and second-order constructs and building third-order constructs from this. The definition of these terms was drawn from Malpass et al. (2009). First-order constructs being the views and accounts of the participants; second-order constructs being the original authors' views and interpretations; third-order constructs being the views and interpretations of the lead author of this synthesis. This phase involved reading the papers in chronological order and noting the first and second-order constructs in a Microsoft Excel document, (see table 5).

Phase 5: Translating Studies into One Another

In this phase, key concepts and themes were then mapped onto each other. Noblit and Hare (1988) describe reciprocal translation, refutational synthesis, and line of argument synthesis to determine how papers are related. In this review, a combination of reciprocal translation and line of argument synthesis was used to maximise the impact of the findings (France et al., 2019a). As no themes were identified that were contested across the papers a refutational synthesis was not conducted. In line with Malpass et al. (2009) papers were arranged chronologically to consider changes over time. This process was completed by focusing on the second-order constructs from each paper, using the original authors' words and interpretation. This facilitated translating the second-order constructs across the papers, in addition to separate notetaking for ideas about potential third-order constructs.

Phase 6: Synthesising Translations

The process of synthesising translations allowed the development of third-order interpretations and a line of argument synthesis (Noblit & Hare, 1988). These third-order concepts were developed alongside phase five as emerging third-order themes were considered across the studies and were then built upon with further interpretation. For these new interpretations alongside the original papers that contributed to the construct, (see table 6).

Epistemological Standpoint

In guidance for reporting meta-ethnography, the inclusion of reflexivity related to how the researcher may influence the process and epistemological standpoint is recommended (France et al., 2019b). A critical realist stance was adopted which assumes that an objective reality exists separate from our perceptions of it (Willig, 1999) and that knowledge and research are partially shaped by subjectivity but are not entirely subjective, and meaning is socially constructed (Forrester & Sullivan, 2018). The topic area for this review was chosen as an area of interest for the researcher. Whilst conducting the analysis and write-up of the review, the researcher began working in a psychology team in a service that supports adults experiencing homelessness. By adhering to a robust strategy for conducting the review, any potential bias in the selection of information and interpretation of results from the papers was hoped to be minimised. Furthermore, discussions with other members of the research team and keeping a reflective diary enabled the researcher to explore their position in relation to the review.

Results

The synthesis of first and second-order constructs facilitated the development of third-order constructs and a line of argument synthesis. This addressed the question of what are the perspectives of adults who have experienced homelessness about receiving support from mental health services? Third-order themes and subthemes are described below, (see table 6). The findings from the current review highlight the challenges faced by PEH when navigating complex systems to access mental health support. Experiences of stigma and marginalisation at multiple levels for the individual, from the service or professional and in wider society appear to influence people's abilities to access and engage with support. The experience of stigma can impact the ability to build relationships with staff, which is further influenced by the context in which services are operating, with high demand and service pressures. The results of this review highlight that the relationship between these factors can reinforce barriers to access and engagement. However, this may be alleviated by creating services that value the lived experience of homelessness and operate in a way that promotes integration and effective communication.

Intersectionality of Stigma

This theme focuses on the varying impact that stigma had on participants accessing and engaging with mental health services. How participants perceived these effects differed across the studies, however there was a similar theme of the intersectionality of different aspects of participants' identities concerning the stigma they faced. For those with multiple intersecting identities, this was perceived as exacerbating experiences of stigma, which in turn increased challenges with accessing support, building relationships, and feeling able to engage with services.

In addition to experiencing homelessness, stigmatised identities included gender, race, mental health, substance use, criminal history, and being a mother. Some participants felt stigmatised through being seen to access mental health support, “You feel like a freak. [The local psychiatric hospital] is associated with all these people walking around talking to themselves…There’s no like place where you still feel kinda normal” (Kozloff et al., 2013, p. 927). For some participants their identities as mothers and views about their abilities to parent caused distress, “Ain’t nobody happy to be drug user mom... ain’t nobody here... everybody trying to get their kids out of here! And you get treated like crap everyday” (Dashora et al., 2012, p.945). Elsewhere, the intersectionality of being from ethnic minority backgrounds, being homeless, and having a criminal history was felt as notably difficult when accessing support, “They don’t want to give you a chance. Once you made a mistake... you get this label […], you’re a bad person, been in jail, it sticks to you all your life” (Leipersberger et al., 2007, p. 17). Across the papers, participants spoke of experiences of adversity and poverty that forced them into cycles of poor mental health, substance use, and homelessness due to a lack of support, “Made redundant due to mental health and not being able to keep up rent on flat” (Harland et al., 2022, p. 177).

Participants spoke of how experiencing homelessness and associated difficulties impacted views of their self-worth, "But a lot of people think... I think their self-esteem is so low, that... they feel like they’re just dirt” (Leipersberger et al., 2007, p.10). This view was thought to have been internalised from messages received from others earlier in life (La Mar et al., 2021) and often linked to barriers to asking for help in an attempt to hold on to pride. In two studies (Luhrmann et al., 2008; Huey et al., 2012), participants spoke of fears of being seen to be “crazy” and concerns around judgement from others as a barrier to accessing support, “I can’t do that; I’m not crazy” (Luhrmann et al., 2008, p. 16).

Across the papers, these internalised stigmatising views were also linked to experiences when interacting with mental health services. Participants spoke of being mistreated by professionals and “treated like a dog” (Dashora et al., 2012, p.945), and so expressed a need to be treated respectfully and empowered. Experiencing stigma and feeling labelled by professionals was experienced as emotional and furthered reluctance in asking for support, “It’s difficult for me to ask for help… I don’t want to tell people that I have mental health issues or that I have a substance abuse problem…They’re gonna think that I’m dirty” (Kozloff et al., 2013, p.927). Similarly, participants reported experiences where they were refused mental health support because of their substance use which left them feeling stigmatised and reduced motivation to seek help, “I needed to be made more aware of addiction and recovery and not judged and discriminated against” (Harland et al., 2022, p. 177).

These experiences contributed to fear of judgement from others and were associated with avoidance and distrust in services, “[People who are homeless] don’t want to be judged, they don’t know if people are actually willing to help them. I’ve been through that. It’s scary” (Li et al., 2020, p.9). “There’s been times where I wanted to go in there, like I knew I needed some sort of help, but I was a bit reluctant because they might do the same thing [not believe me], just not worry about it” (Sturman et al., 2020, p.751). In one study these feelings of rejection were also associated with feeling ashamed and guilty, which for one participant led to thoughts about suicide (La Mar et al., 2021). The perceived stigma from professionals was linked to a broken system that was failing individuals, “thanks to our crappy government our system that has treated us like crap, our recovery centres, our places that do not support us

[…] they say ‘you came from the street, eating from the garbage” (Mossato et al., 2022, p. 9702).

The Importance of Relationships

Where participants had overcome the barriers to support associated with stigma and had interacted with mental health professionals and services, a crucial factor was the type of relationship built. For many, relationships were key to supporting engagement with mental health services, particularly for people with limited support networks who saw services as an option for connection (Kerman & Sylvestre, 2019). Conversely, the absence of a supportive relationship could hinder the helping process and result in clients disengaging from services (Kozloff et al., 2013; Leipersberger et al., 2007). “They made me feel like I was wasting their time and they did not want to help or have time so I didn’t ask anymore” (Harland et al., 2022, p. 179).

Building trust

A clear theme underpinning these professional relationships was being able to develop trust. A lack of trust in professionals was linked to barriers to engaging with mental health support. Some participants expressed distrust of mental health professionals and their agendas for the work, “I don’t want no therapist because to me… therapists are like, they already know how to get you to say stuff that they want to hear… because they already know the human mind” (Hudson et al., 2008, p. 1284). For some participants, the need to build trust in professionals was linked with fears of being judged about their mental health, substance use, or experiences in their past. This was associated with concerns around confidentiality and the need to be able to trust that information shared with professionals would be kept confidential before feeling comfortable to open up (Dashora et al., 2012; Kerman & Sylvestre, 2019).

Some participants had experiences where this worked well and facilitated their engagement with the support, “She’s cool, it’s confidential, and I get an hour to just talk to someone who has actually gone through training... and might just have some options for you” (Kozloff et al., 2013, p. 926). However, unfortunately, some participants had experiences where the contents of counselling sessions were not kept confidential and were reported to professionals in other systems such as child services (Huey et al., 2012). These difficult experiences with professionals were said to further reduce trust in services and future motivation to seek support, “I felt like they didn’t care. They said I was complicated and couldn’t help as I had mental health and addiction. So why would I trust them again” (Hardland et al., 2022, p. 177). Additionally, it was common for participants to link difficulties trusting others with experiences in their personal lives, despite wanting to seek support for their mental health or experiences of trauma, “I think for most of us, (um), you just really don’t know who to trust, so everybody’s a threat at all times” (Li et al., 2020, p. 8).

Experiencing empathy

Perceiving a mental health professional as understanding and empathetic was key to building trust. When professionals had been perceived as dismissive of previous trauma and lacking in compassion, participants did not feel safe disclosing information (Huey et al., 2012). A common theme was the participants’ desire for professionals to be caring and considerate of their needs, “You have to be sensitive. If you wanna deal with the place of a mental health person, you can’t think mental health wise, ‘cause you’re not crazy […] the sensitivity should be towards the person who is ill” (Leipersberger et al., 2007, p. 14). For some participants, their preference for style of a counsellor centred around the interpersonal relationship, “I would want an advocate [counsellor] that would sit there basically would understand my side, my situation, and my story” (Dashora et al., 2012, p. 946). Participants highlighted the importance of a compassionate approach, however shared experiences where they felt interactions lacked compassion, leading to suggestions for more staff training, “I think that they should have some compassion training… ’cause I feel like they don’t really understand our situation and I really don’t feel like they particularly like us” (Li et al., 2020, p. 9).

Feeling empowered

Where participants had built positive relationships with mental health services, some noticed changes to the relationship they had with themselves, “Because I’m getting better every day. Because I can actually see the growth when we talk. I can actually see some of the things I deal with better” (La Mar et al., 2021, p. 5). Participants also desired to be actively involved in their support and empowered to make decisions, “Ask the person, ask the individual how they want to be helped, that’s the way forward for them, what help do they need” (Adams et al., 2022, p. 9). However, it was common for participants to share stories that highlighted feelings of disempowerment and a lack of choice over their support (Dashora et al., 2012; Leipersberger et al., 2007). Throughout the studies, the importance of relationships that were built on trust, empathy, and empowerment to support successful engagement was highlighted.

Service Pressures

The ability to form positive relationships was influenced by service level factors, which affected the ability to maintain therapeutic relationships and so engage meaningfully with support.

(Lack of) consistency

Participants often stated a preference for professionals to follow them through changes in life situations, however due to high staff turnover a lack of consistency was felt, “I can honestly say that... losing case managers, because case managers leaving, uh, shifting from one case manager to another has been hard on me. It has created some more mental issues” (Leipersberger et al., 2007, p. 14). Furthermore, participants expressed frustration that this disjointed support meant repeating their stories to multiple people and frequently building new relationships, “I am sick of getting new workers and having to explain again. Explaining me story to workers. You should get one worker. I’m sick. I have done this for 17 years and I can’t do it anymore” (Adams et al., 2022, p. 7). Where participants were able to receive support from a service for a considerable length of time this was described as making a difference, “It’s been a road. Ups and downs. Anxiety. But I see I can see the difference in myself. You know like, I’ll miss one session, and then the next week I’m like, “I need to get this session in” (La Mar et al., 2021, p. 4). Additionally, where services recognised the need for consistency participants spoke of positive experiences, “Just because I’m feeling good this month, it doesn’t mean that in a month or two’s time, I am still feeling great. There are constant reviews and chats and contacts and stuff, which is great” (Adams et al., 2022, p. 8).

Resources

The ability to develop positive relationships and receive consistent support from mental health providers was often linked to the availability of resources. Unfortunately, it was common for participants to attribute a lack of appropriate support to services that were inadequately resourced and had restrictive service criteria. A lack of resources and demand placed on services was felt by some participants during rushed appointments or being seen as one client in a list of many, “You don’t want to be talking with someone who is constantly looking at your watch… to let you know that your little allotted time is up. That's… it makes you wanna stop talking, you know?" (Leipersberger et al., 2007, p. 15). The demand on services was also linked with long waiting lists to access support. Participants expressed frustration and feeling discouraged by waiting times, especially after deciding to take the first step to seek support (Adams et al., 2022; Hamilton et al., 2012; McConalogue et al., 2021). Waiting for support was linked to delaying progress in an individual's recovery, "How are you going to make [accessing services] a long process? This person along the way is going to get tempted, is gonna break, is gonna get depressed – something's bound to happen" (Kozloff et al., 2013, Suppl).

In addition to resources within organisations, some participants noticed a disparity between their own resources and service requirements, "If you don't got the cash, or you don't got the things that you need, and don't know what to say to get the help you need, everybody's looking at you like you're stupid" (La Mar et al., 2021, p. 4). Participants also described a lack of financial resources to travel to appointments or pay for support (Harland et al., 2022; Leipersberger et al., 2007). During the COVID-19 pandemic and the shift to services offering remote support, some participants highlighted feeling further exclusion due to lacking adequate technology or digital skills, "I'd missed the Zoom link meeting, he rang me […] "Why haven't you joined?" I went, "Because I don't have internet, I don't have a laptop, I don't have credit on my phone to get internet to do it" (Adams et al., 2022, p. 5).

Inflexibility

Participants also spoke of experiences where their attempts to access and engage with mainstream mental health services were hindered by services not being equipped or willing to meet their needs. For some participants, mental health support was offered at inconvenient times and did not consider their individual circumstances (Huey et al., 2012). For others, strict rules on engagement and discharge policies meant that participants were often excluded before support had started, “I can’t attend appointments due to mental health and am blamed for that and isolated more and helped less” (Harland et al., 2022, p. 178). Further frustration was associated with services offering reduced appointment times and not being available when the need was greatest, which led to reliance on out-of-hours services that did not know the person or their circumstances, “I rung the Crisis team a lot. I was on the phone to them nine times in one night before they actually came out […] Crisis team is pretty much the wrong name for them I would say” (Adams et al., 2022, p. 7).

Connectedness vs Disconnectedness

Despite scarce resources and services being stretched, participants highlighted ways that services could ensure accessibility to PEH and support with navigating the complex system. Throughout the studies, a sense of feeling connected to services was important and associated with reduced feelings of discrimination or judgement, and improved relationships. This was felt when people had a mutual connection to a service, “You have to get references from people you know who’ve used the service to know which ones are more likely to help” (Kozloff et al., 2013, p. 926). This feeling of connection was also described as present in more formal settings such as peer support groups, where participants felt able to speak openly and offer mutual support to build connections (Kerman et al., 2019).

The value of lived experience

A trusted relationship with mental health professionals was facilitated when someone had similar life experiences and was able to relate to clients on a personal level to facilitate connectedness (Leipersberger et al., 2007). Many studies highlighted the importance of hiring staff with lived experience to work in mental health services, as a way to reduce the stigma and judgement often experienced. Being able to access support from someone who understood the complex needs of the clients was often cited as helpful, “Yes, it would be somebody on your own level that has actually been through alcoholism or drug use” (Adams et al., 2022, p. 8). This was particularly thought to be important when seeking support for substance use, “We need people who have the disease and have used the drug… not people that don’t use drugs telling people not to use drugs” (Hudson et al., 2008, p. 1285). Furthermore, where participants associated their identity with a particular group, having people from that group was highlighted as helpful for enabling engagement, “They need to get women veterans to work in these different positions in order to help other women veterans” (Hamilton et al., 2012, p. 59). At a service level, some participants named the need for people with lived experience to be involved in designing and creating support for PEH (Adams et al., 2022; Mossato et al., 2022), “Educate staff from front-line upwards, use people with lived experience, stop barriers which prevent those who are homeless from accessing health care” (Harland et al., 2022, p. 179).

Valuing integration

Continuing with the theme at a service level, experiencing a lack of integration and collaboration in services contributed to feelings of disconnect. A lack of coordination across services often contributed to participants feeling confused about where and how to access support to meet their needs (Hamilton et al., 2012), “You’re going to five different programs to get one thing you need” (Kozloff et al., 2013, Suppl). Participants felt strongly about support that could meet multiple needs which they viewed as inter-related, “Mental health assistance, if you’re not going to address the rest of her issues that’s going to fix that whole ugly bubble that we get stuck in out there. It has to be a package deal” (La Mar et al., 2021, p. 5). Participants reported understanding their mental health and substance use as part of the same problem, however expressed frustration when this was not the viewpoint of services and so were not able to access support (Harland et al., 2022). Furthermore, concerns were raised about having to stop substance use without having alternative coping mechanisms in place, “One thing that I disagree with, is that you can’t engage with mental health unless you’re off it [...] But the whole reason I’m drinking is because of lack of confidence as stuff like that, so it’s a double-edged sword” (McConalogue et al., 2021). For some, the COVID-19 lockdown was an example of how services can change to work collaboratively, “It was a bit of a jigsaw puzzle, everything was here, there and everywhere. [...] But since lockdown, people have really honed in on their skills and they’ve had to learn to cope with different ways of doing things” (Adams et al., 2022, p. 7).

Communication from services

As well as a lack of communication between different services, participants also spoke of a lack of communication from services about the support they offered. Being unaware of available support or lacking an understanding of service processes resulted in participants relying on their initiative to find services (Huey et al., 2012; Mossato et al., 2022). This lack of awareness was associated with exacerbating difficulties related to homelessness or mental health, “I do not believe [that] I would be homeless and going through the tremendous, tumultuous time I’ve been going through in the last 4 years had I heard a long time ago that women’s services were available for women vets” (Hamilton et al., 2012, p. 58). A suggestion to improve the accessibility of support was to adapt approaches to meet the needs of the client group “Well, I think somebody coming out and actually talking to the girls, somebody being informed that there are services out there. The key is getting out into the hostels and knocking on the doors” (Adams et al., 2022, p. 6).

Discussion

This review aimed to explore the perspectives of adults with experiences of homelessness and accessing support from mental health services. The meta-ethnographic approach synthesised existing, relevant research on this topic to highlight the complex experiences of the participants. This review extends the current evidence base by providing theoretical insights developed through the meta-ethnographic process (Noblit & Hare, 1988), and presents a line of argument related to facilitators and barriers when accessing and engaging with mental health support.

PEH face the challenge of navigating complex systems to access mental health support, whilst simultaneously experiencing adversity and disadvantage. The ability to access and engage with appropriate support was influenced by experiences and interactions with individual staff and service providers, within the context of organisational and systemic pressures. The impact of the intersectionality of stigma on the mental health of PEH and trying to access services was a key finding in the current review. Across the papers, the effects of stigmatisation and marginalisation because of aspects of participants' identities were evident at many levels. These experiences were often internalised and linked with negative views about the self and reduced self-worth. This was unfortunately reinforced through interactions with professionals or services which further stigmatised, labelled, and excluded. These experiences often led to avoidance of and distrust in services and resulted in people not receiving appropriate support for their mental health.

The current author's interpretation of the qualitative research reflects findings from previous reviews. The key finding of the intersectionality of stigma as a barrier to help-seeking, due to increased experiences of shame and a detrimental effect on people's mental health is reported elsewhere (Karadzhov et al., 2020; McCarthy et al., 2020). Furthermore, the impact of this stigma and prejudicial attitudes on a person's ability to trust a service to meet their needs and promote feelings of safety is also supported (Bhui et al., 2006; Schreiter et al., 2021). This concept is recognised by staff working in homelessness, with "intersectional societal stigma" identified as a key structural challenge whilst working with people whose realities are heavily influenced by crises in housing, underfunded mental health services, employment, and austerity (Kerman et al., 2022). The overlap in findings from previous reviews reinforces the concept of the intersectionality of stigma as a driving force in preventing PEH and multiple disadvantage from accessing and engaging with appropriate mental health support (McCarthy et al., 2020).

The importance of a therapeutic relationship based on trust, empathy, and empowerment was a clear theme from the current review, that is supported in the literature (Chaturvedi, 2016; Macdonald et al., 2022; Thompson et al., 2004). The current review argues that such relationships were developed in the absence of feeling stigmatised or judged by professionals. Where this occurred, access and engagement with mental health services was facilitated, concepts that are echoed in previous reviews (Diduck et al., 2022; Omerov et al., 2020). Furthermore, when mental health services are adapted to meet cultural needs and understand a person's cultural background, this can help to break down barriers associated with stigma and promote relationships through respect and dignity (Johnson et al., 2013).

The current review also found that participants had experienced service-level barriers when trying to access and engage with mental health support. The impact of perceived service pressures such as lack of consistency, reduced resources and inflexible rules on the ability to form positive relationships, trust staff and feel empowered are concepts supported by previous reviews (Allen & Vottero, 2020; Magwood et al., 2019). The impact of service-level barriers on the therapeutic relationship is also supported in the literature (Archard &

Murphy, 2015; Macdonald et al., 2022). Furthermore, people with previous experience of homelessness advocate for mental health services to focus less on rules and restrictions and more on offering choices to service users (Padgett et al., 2008). In practice, a specialist service for PEH based on trauma-informed approaches, that offers continuity of care and a flexible approach to missed appointments was experienced positively by service users (Clark et al., 2020).

The current review highlights the need for services to be designed to ensure accessibility to PEH and facilitate engagement, despite the various service and systemic barriers that exist. The recommendation for including staff with similar life experiences is supported in research, as support from a peer worker in the UK was described as meaningful, trusting, and persistent, elements of relationships that were said to be essential for PEH when engaging with services (Barker et al., 2018). The involvement of people with lived experience in service design and staff training to raise awareness of difficulties and challenge judgements faced by PEH is supported by a recent peer-led project (Groundswell, 2022).

The current review highlights the need for services to be better integrated and offer clear communication if they are to meet the needs of this population. This recommendation to reduce barriers to accessing services and enhance engagement with support is mirrored in the findings of previous reviews (Lapinski, 2019; Priester et al., 2016). Within the UK, recent guidance recommends an integrated health and social care approach for PEH (National Institute for Health and Care Excellence, 2022). A recent example of good practice comes from a specialist primary care service in the UK, where a service evaluation found that having an integrated multi-disciplinary team for physical health, mental health, and substance use facilitated better engagement with PEH (Clark et al., 2020). The developments in the evidence base and policy may indicate that services are developing in an integrated way.

However, the current review included papers from 2007 so may have captured experiences of previous service configurations as well as more recent, in addition to including non-UK papers.

Clinical Implications

This review highlights the significance of considering the role of stigma, the importance of relationships, and the need for integrated services. In addition to the importance of understanding how these factors are related, to support PEH effectively. As integrated services are recommended in recent guidance for supporting PEH (National Institute for Health and Care Excellence [NICE], 2022), it is hoped that services will be developed in line with this. The need for joint working between mental health and homelessness services is recommended, along with improved communication with PEH about what support is available to them (Groundswell, 2022). Recent recommendations in the UK related to substance use also advocate for services to acknowledge the co-morbidities of trauma, mental health, and addiction and for commissioners of substance use and mental health services to work together to ensure individuals do not get excluded from both (Black, 2021). In services that have developed to be more integrative, ongoing improvements requested by staff include more space for reflection and learning, in addition to service user involvement to improve service safety and quality (Clark et al., 2020). Within teams, there may be a role for psychologists to offer indirect interventions such as staff training on topics related to the findings of this review, including building relationships, displaying empathy, and communicating effectively.

The role of psychology in homelessness services is developing, with services adopting Psychologically Informed Environments (PIEs) and trauma-informed care (TIC) approaches (Homeless Link, 2017). Within these approaches, the role of psychologists to support both service users and staff at an individual, service and systemic level may overcome some of the barriers to access and engagement identified within this review (Moreton et al., 2022). Additionally, clinical psychologists working in homelessness services advocate for a role in wider societal interventions, to promote less stigmatising views of PEH by changing narratives that blame individuals rather than structures for inequalities (Xenophontos, 2020).

Within the literature, there are debates about offering psychological support to PEH. Historically, more importance was placed on meeting basic needs such as housing and physical health, before addressing emotional or psychological needs (Bhui et al., 2006). More recently, pre-treatment approaches that focus on engagement, relationships, and communication are recommended when working with PEH, to support emotional wellbeing in circumstances where basic needs such as housing are not met (Levy et al., 2018). These varied views highlight the complexity of supporting PEH and the importance of having a flexible and person-centred approach, as advocated for by participants in this review. Furthermore, the development of integrated services which offer support for primary care and mental health in one place may be a way of overcoming this disparity (Clark et al., 2020).

Strengths and Limitations

To the best of the author’s knowledge, this is the first qualitative systematic review to explore the experiences of mental health services for adults who have experienced homelessness in this way. This review adhered to guidelines for producing reviews (CASP, 2018), to ensure transparency of the research process. The aim of this review was to champion the service user voice within homelessness and mental health research to keep the individual at the centre of discussions.

A potential strength and limitation is that this review did not exclude based on specific populations of PEH. The inclusion of homeless veterans, who are disproportionally represented in the homeless population was aimed to be inclusive of varied experiences. However, the experiences and needs of homeless veterans may be considerably different from other participants in the review (Omerov et al., 2020). Furthermore, the nature of homelessness means that the participants are not a homogenous sample, and so experiences will differ in terms of substance use, experiences of domestic violence, and current homelessness status.

Further consideration of limitations is that this review employed a broad view of mental health services, therefore it included participants from a variety of settings and with experiences from different professional groups, which may limit applicability to specific services. Additionally, included studies were from a range of countries with different healthcare and welfare systems and so whilst differences in individual and service level resources were evident in studies based in the USA (Dashora et al., 2012; La Mar et al., 2021; Leipersberger et al., 2007), it was not within the remit of the review to compare geographical locations and resources in detail. Furthermore, as papers were primarily from Western countries, this may also limit generalisability to different countries and healthcare systems and impacts conclusions about resources.

Future Research

As this review highlighted a wide range of facilitators and barriers to PEH accessing and engaging with mental health support, it is recommended that future research with this population further explores what can be done to overcome the challenges faced. Additionally, as policy is changing to recommend a more integrated approach (NICE, 2022), more research evaluating services that have adapted to meet the needs of this population would be beneficial. Furthermore, as the role of psychology in homelessness services is developing, it would be beneficial to explore the experiences of staff and service users to support service development. As the value of lived experience came through in the review, it is recommended that future research is co-produced with people with lived experience of homelessness to ensure research is inclusive and accessible (Groundswell, 2022).

Conclusion

This meta-ethnography identified 15 studies that explored the perceptions of adults experiencing homelessness in accessing support for their mental health. The synthesis of the literature led to the development of themes and a line of argument to show the relationship between factors related to experiences of stigma, the importance of relationships, acknowledgements of service pressures, and a feeling of connectedness to support. The review recommends that services consider these factors when offering mental health support to PEH. Future co-produced research with people with lived experience of homelessness to understand the challenges identified in this review is also recommended. Overarching the results was a desire to be treated as a human and have individual life circumstances understood despite service pressures and demands.

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Tables and Figures

Table 1

Search Strategy

SPIDER	Search String
Sample	(DE "Homeless" OR DE "Homeless Mentally Ill") OR TI (homeless*OR houseless OR “multiple complex needs” OR ((sleep* OR liv* OR dwell*) N5 (street* OR rough*))) OR AB (homeless*OR houseless OR “multiple complex needs” OR ((sleep* OR liv* OR dwell*) N5 (street* OR rough*)))
Phenomenon of Interest	("Community Health" OR DE "Community Mental Health" OR DE "Community Mental Health" OR DE "Assertive Community Treatment" OR DE "Community Mental Health Centers" OR DE "Community Mental Health Services" OR DE "Community Counseling" OR DE "Community Psychiatry" OR DE "Community Psychology" OR DE "Community Services" OR DE "Community Mental Health Services" OR DE "Community Welfare Services" OR DE "Emergency Services" OR DE "Home Care" OR DE "Home Visiting Programs" OR DE "Public Health Services" OR DE "Community Welfare Services") OR TI (“health care access” OR “psycho-social intervention” OR “mentally ill” OR counselling OR counseling OR psychol* OR “service use” OR “mental health” OR shelter OR ((community OR outreach) N5 (service* Or clinic* OR health OR intervent*)))

	OR AB (“health care access” OR “psycho-social intervention” OR “mentally ill” OR counselling OR counseling OR psychol* OR “service use” OR “mental health” OR shelter OR ((community OR outreach) N5 (service* Or clinic* OR health OR intervent*)))
Design	DE "Qualitative Measures" OR DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" OR TI ((("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guide or guides) N3 (interview* or discussion* or questionnaire*)) OR "focus group*" or qualitative or ethnograph* or fieldwork or "field work" or "key informant" or “narrative”) OR AB ((("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guide or guides) N3 (interview* or discussion* or questionnaire*)) OR "focus group*" or qualitative or ethnograph* or fieldwork or "field work" or "key informant" OR “narrative”)
Research Type	DE "Qualitative Measures" OR DE "Qualitative Methods"

Table 2

Inclusion and Exclusion Criteria

	Inclusion	Exclusion
Language	English Language	Non-English Language
Type of study	Primary research, peer reviewed article	Secondary research, non-peer reviewed article
Population	Homeless adults (previously or currently), age 18+	Studies that only capture experiences of staff working in homeless services
Focus of study	Significant content of findings includes the experiences of homeless adults seeking mental health support/support from mental health services	Studies that do not focus on the experiences of people experiencing homelessness and seeking mental health support/support from mental health services. Studies without direct quotes with people experiencing homelessness to support results. Studies where it is not clear if findings relate to mental health service or other. Studies that are a qualitative evaluation of a specific programme or research trial
Methodology	Qualitative methodology for data collection and analysis	Studies that use mixed-methods approaches or only capture quantitative data

Table 3

Results of Quality Appraisal

Study	CASP & Duggleby et al. (2010) Ratings								
	Research Design	Recruitment Strategy	Data Collection	Reflexivity	Ethical Issues	Data Analysis	Statement of Findings	Value of Research	Total
Leipersberger* et al. (2007)	3	3	3	2	2	2	3	3	21
Hudson et al. (2008)	2	2	3	1	3	2	3	3	19
Luhrmann et al. (2008)*	3	2	2	1	1	1	2	1	13
Dashora et al. (2012)*	3	2	2	2	1	2	3	2	17
Hamilton et al. (2012)	3	2	2	1	1	2	3	3	17
Huey et al. (2012)	2	2	2	1	3	2	3	3	18
Kozloff et al. (2013)*	3	3	2	1	3	3	3	3	21

Kerman & Sylvestre (2019)	2	3	2	2	3	3	3	3	21
Li et al. (2020)	2	2	2	1	3	3	3	3	19
Sturman et al. (2020)	3	3	3	2	3	3	3	2	22
La Mar et al. (2021)	3	2	3	2	3	3	3	3	22
McConalogue et al. (2021)*	3	2	2	1	3	2	2	3	18
Adams et al. (2022)	3	3	2	1	3	2	3	3	20
Harland et al. (2022)	3	3	2	2	3	2	3	3	21
Mossato et al. (2022)	2	2	2	1	3	1	2	2	15

*Note: *Studies were inter-rated for reliability by a peer.*

Table 4

Study Characteristics

Study Number	Author (year)	Country	Topic and Aims	Study design	Participants (N, age, gender)	Method of Analysis
1	Leipersberger et al. (2007)	USA	To explore mental health consumers perspectives of the mental health system	Semi-structured interviews	Homeless adults, age 22-54, 15 female, 10 male	Grounded theory (Glaser & Strauss, 1967)
2	Hudson et al. (2008)	USA	To obtain perspectives of homeless youth about the interpersonal relationship between them and adult health care providers.	Focus groups	54 homeless people, age 18-25 (No gender provided)	Constant comparative method (Glaser, 1978)
3	Luhrmann et al. (2008)	USA	To understand a population (homeless people with MH) that is known to refuse services	Ethnography observations and semi-structured interviews	61 homeless women (no age provided)	Ethnography (no source)

4	Dashora et al. (2012)	USA	To understand the needs and intervention desires of substance-abusing homeless mothers from their own perspectives.	Interviews and focus groups	28 homeless women, mothers, age 18-40	Grounded theory (Glaser & Strauss, 1967)
5	Hamilton et al. (2012)	USA	To examine perceived proximal barriers to psychosocial services among homeless women veterans.	Focus groups	29 homeless women, veterans, age 32-68	Constant comparative approach (Boeije, 2002)
6	Huey et al. (2012)	USA	To understand trauma experiences, ability to access counselling services and consider barriers to service use.	Semi-structured interviews	79 homeless women, age 18-70	Open coding/ analysed thematically (no source)
7	Kozloff et al. (2013)	Canada	To identify factors influencing service use among this high-risk group of youths.	Focus groups	23 homeless adults, age 18-26 20 males, 3 females	Thematic content analysis (no source)

8	Kerman & Sylvestre (2019)	Canada	To explore the perspectives of people with mental health problems and histories of homelessness with regard to their capabilities. In particular, we examined how participants viewed services as affecting their well-being using a capabilities framework.	Semi-structured interviews	52 homeless adults (age 18+, mean age 41) (No gender provided)	First and second cycle coding (Saldana, 2013)
9	Li et al. (2020)	USA	To (1) investigate vulnerabilities for women, including violence, sexual assault, and human trafficking risks; (2) identify existing barriers for women, including shelters, childcare, and domestic violence resources; (3) explore the relationship between mental health and homelessness for women.	Qualitative in depth interviews	32 adults (no age provided) 15 males, 17 females	Grounded theory (Charmaz, 2006) and thematic analysis (Heydarian, 2016).

10	Sturman et al. (2020)	Australia	To explore the insider perspectives of homeless men in order to identify potential improvements in the provision of their health care.	Focus groups	20 homeless men, age 28-58.	Thematic analysis (Saldana, 2016).
11	La Mar et al. (2021)	USA	To give homeless women with SMI the opportunity to voice their own insights about barriers to mental healthcare and effective means of overcoming these barriers in order to enhance successful access and engagement in mental healthcare for this population	Semi-structured interviews	13 homeless women, age 24-54. .	Grounded theory (Corbin & Strauss, 2015)
12	McConalogue et al. (2021)	UK	To explore homeless people's experiences and perceptions of health and health services	Semi-structured interviews	28 homeless people, (no age provided) 8 female, 20 male.	Thematic analysis (Braun & Clarke, 2006)
13	Adams et al. (2022)	UK	To better understand access to community-	Semi-structured interviews	26 homeless people, age 25-71 10 women, 16 men,	Inductive reflexive thematic analysis (Braun & Clarke, 2006; 2021)

			based mental health and substance use services.			
14	Harland et al. (2022)	UK	To explore the perspectives of individuals with lived experience of MCN with regards to (i) issues leading to MCN and (ii) key intervention opportunities.	Semi-structured interviews	27 homeless people, age 22-55 14 women, 13 men,	Thematic analysis (Braun & Clarke, 2006)
15	Mossato et al. (2022)	Brazil	To study how homeless population of [place] with mental disorders deal with treatment and experiences of support	Semi-structured interviews	5 homeless men (no age provided)	Content analysis and thematic approach (Trivinos, 1992; Minayo, 1994)

Table 5

Second Order Constructs from Synthesised Papers

Study	2nd Order Constructs	Description
Leipersberger et al. (2007)	(1) Barriers within the individual	Barriers to participants accessing and using mental health services included negative self-image, pride, distrust, substance use.
	(2) Barriers within the organisation	Barriers perceived from organisations included inexperience of professionals, uncaring professionals, compassion vs money, inappropriate help if any at all.
	(3) Barriers within society	Obstacles experienced in larger society included political climate, criminal history, mental illness stigma, stigma linked to homelessness.

Hudson et al. (2008)	One-Way Communication	Perceptions that conversations were manipulated by the therapist, communication style not mutually engaging or therapeutic.
Luhrmann et al. (2008)	(1) Being strong	Being strong to ask for help and interact with professionals, strength to tell stories and reveal aspects of past.
	(2) Refused services	Refused services on grounds they were "not crazy".
Dashora et al. (2012)	(1) Counselling and connectedness needs	Need to build alliance and trust in early phases of treatment. Need assurances of confidentiality before discussing substance use or mental health.
	(2) Characteristics of an advocate/counsellor	Interpersonal relationship was primary concern, success of intervention dependent on this relationship; wanted non-judgemental, caring, supportive and understanding.

Hamilton et al. (2012)	(1) Lack of information about services	Lack of knowledge of available care and support; eligibility requirements, location, terms of use.
	(2) Limited access to services	Lack of gender appropriate care, geographic barriers, lack of long-term housing options, and restrictive entry criteria of many programs.
	(3) Lack of coordination across services	Participants experienced little coordination between services, peer led support wanted to negotiate system of care.
Huey et al. (2012)	(1) Accessing mental health services	Barriers to access included location, fear of judgement, inconvenient appointments, wanting different kind of therapy.

	(2) Consuming mental health services	The majority who had used mental health services described positive benefits, valued act of venting in a safe space. Others found support did not address route causes or focus on trauma sufficiently.
Kozloff et al. (2013)	(1) Individual factors (affecting service use)	Personal motivation, readiness for change described as mandatory for engaging in services. The relationship with service providers was a key influence.
	(2) Program factors (affecting service use)	Services were endorsed that were flexible and comprehensive to their individual needs, integration of services seen as helpful.
	(3) Systemic factors (affecting service use)	Experiences of stigma from service providers and society were barriers to engaging with support. Accessibility influenced by

		inclusivity, wait times and continuity of services.
Kerman & Sylvestre (2019)	Emotions	Services that offered opportunities to talk with supportive service providers or other service users promoted emotional expression. Barriers to opening up included confidentiality, trust and approachability.
Li et al. (2020)	Mental Health Resources	Individual resources linked to isolation, low self-esteem, hopelessness. External resources included fear of rejection, discrimination, distrust.
Sturman et al. (2020)	Inadequate acknowledgement of psychological distress	Difficulty communicating with mental health services, resisted interacting based on previous negative experiences of rejection.

La Mar et al. (2021)	(1) Needing VIP status	Beliefs about needing resources prior to obtaining mental health care.
	(2) Feeling broken	Internal obstacles inside the self that interfere with receiving mental health services.
	(3) Long road to care	The need to stick with MH services for a long time to get maximum benefit.
	(4) Questions of value	A sense of incapability can interfere with overcoming difficult circumstances, something that mental healthcare could be used to help.
	(5) Soaring above rock bottom	A facilitator to mental health care; learning to love and trust in oneself can lead to greater self-help and success in utilising mental health services.

	(6) Whole package care	A facilitator to accessing mental healthcare, services that meet every need within one facility.
	(7) Care that feels like home	Important to create a comfortable, welcoming, home-like environment within a mental healthcare facility.
McConalogue et al. (2021)	Experiences of mental health (and substance misuse) services	Accessing support was a priority, mental health and substance use seen as part of same issue for participants, but different views thought to be held by health services.
Adams et al. (2022)	(1) Inadvertent exclusion	Changes to service provision that led to exclusion included support only offered during business hours, being excluded from digital technology and lack of knowledge of available support.

	(2) Barriers to recovery	Perceptions of lack of space for recovery, services being disjointed, not feeling ready and scarce resources identified as barriers to accessing support.
	(3) Building a system responsive to needs	Services feeling disconnected and not understanding people’s needs, lack of choice and control over support.
Harland et al. (2022)	(1) Mental health, substance use and access to services	Links between mental health and substance use and experiences of feeling judged or stigmatised which reduced trust in services and led to a lack of motivation to seek support.
	(2) Support focused on mental health, finance and welfare, and housing	Mental health support was the most commonly cited intervention that would have

		prevented homelessness and issues related to multiple complex needs.
	(3) Educating workers and providing judgement-free support to enhance experiences	Perceived gap between what was being offered and what was needed, suggestions for staff training around multiple complex needs and involvement of people with lived experience.
Mossato et al. (2022)	(1) What is available for the care of people with mental disorders living on the streets: contrasts	Homeless population faced with several vulnerability factors, experiences of poor treatment and homelessness associated with moral/religious issues.
	(2) Mental health care programs and limitations to welcome homeless people: existing limitations	MH services are not created by people with experience of homelessness.

Table 6

Third Order Constructs

Third Order Constructs	**Translated Themes (from second order constructs)**	**Contributing Papers**
Intersectionality of stigma	Internal stigma, Experiences of stigma from professionals and/or services, Societal stigma	Leipersberger et al. (2007), Luhrmann et al. (2008), Dashora et al. (2012), Huey et al. (2012), Kozloff et al. (2013), Li et al. (2020), Sturman et al. (2020), La Mar et al. (2021), Harland et al. (2022), Mossato et al. (2022)
The importance of relationships	Building trust	Hudson et al. (2008), Dashora et al. (2012), Huey et al. (2012), Kozloff et al. (2013), Kerman & Sylvestre (2019), Li et al. (2020), Harland et al. (2022)
	Experiencing empathy	Leipersberger et al. (2007), Hudson et al. (2008), Huey et al. (2012), Li et al. (2020)

	Feeling empowered	Leipersberger et al. (2007), Dashora et al. (2012), La Mar et al. (2021), Adams et al. (2022)
Service pressures	(Lack of) consistency	Leipersberger et al. (2007), La Mar et al. (2021), Adams et al. (2022)
	Resources	Leipersberger et al. (2007), Hamilton et al. (2012), Huey et al. (2012), Kozloff et al. (2013), Li et al. (2020), La Mar et al. (2021), McConalogue et al. (2021), Adams et al. (2022), Mossato et al. (2022)
	Inflexibility	Leipersberger et al. (2007), Huey et al. (2012), La Mar et al. (2021), Adams et al. (2022), Harland et al. (2022)
Connectedness vs disconnectedness	The value of lived experience	Leipersberger et al. (2007), Hudson et al. (2008), Hamilton et al. (2012), Kozloff et al. (2013), Kerman & Sylvestre (2019), Adams et al. (2022), Harland et al. (2022), Mossato et al. (2022)

	Valuing integration	Leipersberger et al. (2007), Hamilton et al. (2012), Huey et al. (2012), Kozloff et al. (2013), Sturman et al. (2020), La Mar et al. (2021), McConalogue et al. (2021), Adams et al. (2022), Harland et al. (2022), Mossato et al. (2022)
	Communication from services	Hamilton et al. (2012), Huey et al. (2012), Adams et al. (2022), Mossato et al. (2022)

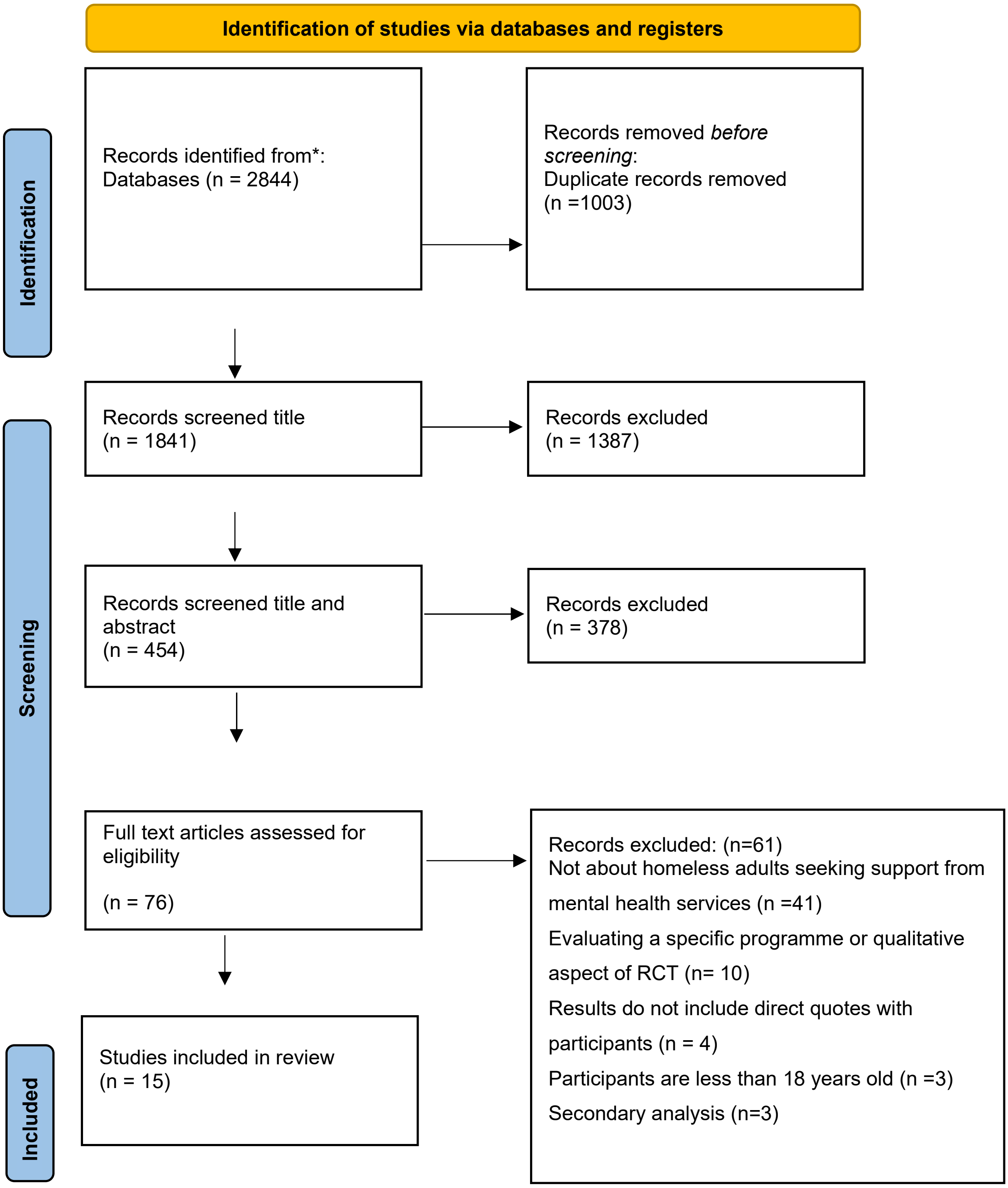

Figure 1.

Flowchart of Study Selection

Appendix 1A- Journal Guidance: Health & Social Care in the Community

I. *Health and Social Care in the community* Author Guidelines

II. 1. Submission and Peer Review Process

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Abstract

This should be non-structured and should not exceed 300 words. Where appropriate authors should cover the following areas: objective; study design; location, setting and date of data collection; selection and number of participants; interventions, instruments and outcome measures; main findings; and conclusions and implications.

What is known about this topic and what this paper adds?

Please provide up to three bullet points on what is known about this topic, and three bullet points on what the paper adds. This should be written in terms of outcome statements (what is known/added) and not process statements (what was done). For example: Authors could report a specific outcome such as “experiences of patients and carers in the community did not always concur with guideline recommendations” NOT the generic process “This qualitative study reports on experiences of patients and carers in the community”. This should be no more than 110 words (exclusive of the titles). Authors should avoid repeating sentences in the Abstract within the bullet points.

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Original Research	Reports of original research, with methods, findings and conclusions.	5000 (excluding figures, tables and the reference list)	Unstructured Abstract	Sources must be included
Empirical Research mixed methods	Reports qualitative and quantitative original research with methods findings and conclusions	6000 (excluding figures, tables and the reference list		Sources must be included
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Section 2 Research Paper

What makes a Psychologically Informed Environment (PIE) in a Homelessness Service Work? Views from Staff and Service Users.

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Abstract

Psychologically informed environments (PIEs) have been implemented in homelessness services to meet the psychological and emotional needs of service users and staff. This research aimed to explore what contributes to a successful PIE and understand the barriers to implementation. Semi-structured interviews were conducted with people with experience working within or receiving support from a PIE homelessness service. A grounded theory approach was used to develop a model based on participants' accounts, which illustrates the components of a functioning PIE, the driving forces of systemic and engagement factors, and the service user and staff experiences at the centre. This study highlights the complexity of implementing a PIE in a homelessness service and factors to consider to enhance the experiences of those at the centre. Recommendations for services include considering the wider contextual and systemic influences surrounding homelessness.

Keywords: homelessness; psychologically informed environments; engagement; systemic; person-centred

Introduction

The number of people experiencing homelessness (PEH) was recorded as 282,000 people in England in 2021 (Watts et al., 2022). Homelessness is defined as "not having a home" and includes a variety of circumstances such as living in temporary accommodation and living and sleeping on the streets (Shelter, 2018). An array of factors contribute to the number of people without appropriate housing, including wider societal influences such as unemployment and poverty (Giano et al., 2020) and limited affordable social housing (Fitzpatrick et al., 2019). Experiencing long-term poverty, particularly during childhood, and a lack of social support networks increases the risk of homelessness (Bramley and Fitzpatrick, 2018). The COVID-19 pandemic has also been associated with a rise in poverty and unemployment among those already experiencing disadvantage (Whitehead et al., 2021).

Homelessness and Mental Health

PEH are a vulnerable population with high rates of mental health difficulties, physical health problems, substance use, and cognitive impairments (Mackie et al., 2017; Stone et al., 2019). This population are likely to have experienced childhood trauma and complicated family relationships before becoming homeless (Homeless Link, 2017), experiences that are associated with difficulties forming relationships, trusting others, and emotional regulation in adulthood (Danquah & Berry, 2013). Being homeless also increases the risks of experiencing physical or sexual violence and a lack of physical and psychological safety (Gilmoor et al., 2020). The co-occurrence of homelessness, mental health difficulties, and experiences of trauma are associated with high levels of complexity within this population. This indicates a role for psychological intervention and trauma-informed care (TIC) based on principles of trust, safety, and empowerment (Classen & Clark, 2017). However, often PEH are excluded from mainstream mental health services due to strict service criteria and policies on engagement (Armstrong et al., 2021; Omerov et al., 2020). A study with clinical psychologists working in these settings reported beliefs that PEH do not prioritise their mental health due to other needs, concluding that homelessness is not for psychology (Xenophontos, 2020). As a result, third-sector services are often left to provide the support that meets the needs of this population, with a focus on advocacy and inclusion (Yousefzadeh, 2021).

Staff in Homelessness Services

Staff working in homelessness services describe supporting people with complex mental health and relational difficulties and managing complex behaviours such as self-harm (Benson & Brennan, 2018). Despite supporting people with a range of complex needs, staff often receive minimal training and report a lack of support for their wellbeing (Keats et al., 2012; Peters, 2019). Working in challenging circumstances and being frequently exposed to stressful events can increase stress levels, feelings of frustration, and burnout (Arslan, 2013; Kerman et al., 2022). Burnout can be in response to the pressures of the role such as unmanageable workloads and lead to feeling unsupported and experiencing emotional exhaustion (Lemieux-Cumberlege & Taylor, 2019). In a review of the emotional experiences of staff working in homelessness services, challenges included balancing the complex support needs of clients against attending to their own needs (Peters et al., 2022).

Staff also highlight the challenge of providing person-centred care whilst working in a system where resources are limited and out of their control, leading to feelings of helplessness (Johnson et al., 2012; Phipps et al., 2017). Research with support workers in homelessness services highlighted the importance of the organisational context and culture, with a need for consistency in support structures for staff (Peters, 2019). Additionally, the

COVID-19 pandemic increased the challenges faced by staff navigating services and systems around PEH (Goodwin et al., 2022).

Housing and Accommodation

Currently, in the United Kingdom (UK) there are several models of accommodation for PEH, due to the varying types of homelessness and needs of the population. This ranges from temporary accommodation such as shelters and hostels to offering individual tenancies and longer-term, permanent housing (Watts et al., 2022). One approach that has been introduced in the UK is Housing First, which prioritises quick access to housing and an offer of support based on choice and meeting individual needs (Homeless Link, 2020). Recommendations for ending homelessness in the UK include increased government support to ensure there is enough housing available, with an offer of ongoing help to support people to maintain their tenancies (Downie et al., 2018). In general, across homelessness accommodations, there is evidence that services are not always meeting the needs of PEH, due to high rates of evictions that can result in a return to rough sleeping (Keats et al., 2012).

In terms of policy, the Homelessness Reduction Act (HRA) 2017 created a statutory duty to prevent homelessness, with increased responsibilities for local authorities to assess and offer a housing plan for PEH (Ministry of Housing Communities and Local Government, 2020). However, a recent report showed inconsistent levels of support to meet individual needs and a critical housing shortage, indicating that the HRA is not working effectively (Crisis, 2021).

Psychologically Informed Environments

Alongside principles of TIC in homelessness settings, psychologically informed environments (PIEs) were developed in the UK to enhance psychological thinking within services and meet the psychological and emotional needs of service users and staff (Johnson & Haigh, 2010). Relationships are at the centre of PIEs, with a focus on communication and empowerment to move away from the culture of high rates of evictions and reliance on strict rules (Keats et al., 2012). The core features of PIEs include a focus on (1) psychological awareness, (2) staff training and support, (3) learning and enquiry, (4) spaces of opportunity and (5) rules, roles and responsiveness (PIElink, 2019a), see Appendix A. PIEs are an organisational intervention, a lens to view a service through with no required checklist of criteria, which aims to promote flexibility in implementation (PIElink, 2019a). Clinical psychologists are often involved with setting up and running aspects of PIEs. Having a clinical psychologist embedded within the service contributes to more positive views about staff support (Revolving Doors Agency, 2019), and direct engagement with service users is linked to improved outcomes and interpersonal relationships (Williamson, 2018). Recent guidelines for supporting the health and social care needs of PEH have recommended PIEs and TIC (National Institute for Health and Care Excellence [NICE], 2022).

Within the literature, there is evidence for the effectiveness of PIEs at the policy level, with reduced costs to health, social care, and criminal justice systems (Cockersell, 2011; Ritchie, 2015). They have also been linked to service level changes, including improved warning and eviction policies that reduce the short-term nature of accommodation placements (Ava, 2017; Benson & Brennan, 2018; Cockersell, 2016; Williamson, 2018). Support for the effectiveness of PIEs for staff includes enhanced confidence and improved psychological awareness (Cumming et al., 2017; Maguire et al., 2017), in addition to improved team dynamics and wellbeing following reflective practice and team formulation meetings (Buckley et al., 2021; Fulfilling lives, 2019). However, staff also report challenges of balancing usual job demands alongside additional PIE responsibilities (Fulfilling Lives, 2019; Phipps et al., 2017).

Service evaluations with staff from a PIE homelessness service (Tickle, 2020) found common helpful factors included focusing on the strengths of staff, staff training, and service culture. Barriers to PIE included staff not feeling valued, a lack of understanding of PIE throughout the service, and a lack of resources. Schneider et al. (2022) carried out an analysis of staff and client wellbeing and practice needs before the implementation of PIE. The results found that PIE principles can act as a buffer against emotional difficulties and secondary traumatic stress experienced by staff (Schneider et al., 2022). This research also recommended more qualitative investigations with staff and clients working in PIE settings (Schneider et al., 2022).

Evidence for outcomes related to PEH includes staff reports of enhanced empathy towards clients and a greater understanding of functions of behaviour (Buckley et al., 2021). Such changes are associated with improved interactions with clients and maintaining relationships (Fulfilling Lives, 2016). Service users of PIE homelessness services valued building relationships with staff and accessing support that focused on meaningful changes and improved understanding of behaviours and emotions (Phipps et al., 2017; Quinney & Richardson, 2014). An evaluation of one PIE service showed service users valued being able to access multiple agencies in one place (Tickle, 2020).

Summary of the literature

The summarised literature from a range of sources outlines that PIEs in homelessness services are effective at various levels. The qualitative literature has focused on staff, and to a lesser extent service user, experiences of working in or receiving support from a PIE homelessness service. Early research with clinical psychologists working in homelessness in the UK discussed the need for increased psychology provision due to the disparity between psychological need and available resources (Rosebert, 2000). However, the role of psychologists working in homelessness services is still new and research evidence in this area is still developing (Tickle, 2022). Furthermore, despite psychologists being recommended in service provision (Maguire & Ritchie, 2015), overarching guidelines have not been developed to support this work and homelessness is often not a specific focus of clinical psychology training (Wells, 2021; Yousefzadeh, 2021).

Rationale and Aim of the Current Study

The available qualitative evidence has focused on how PIEs are experienced, with a lack of focus on implementation and functioning from the perspectives of psychologists, staff, and service users. Research into the mechanisms of change for staff and service users in PIEs was recommended from an earlier literature review (Breedvelt, 2016). To understand how a PIE is implemented and the processes involved in it being successful, this study uses grounded theory methodology, which is designed to understand psychological and social processes. It addresses the research question: What makes a Psychologically Informed Environment (PIE) in a homelessness service work?

Method

Design

The study employed a grounded theory design, following systematic, yet flexible guidelines for qualitative data collection and analysis, to construct theory from data (Charmaz, 2014). This methodology is aligned with a constructivist approach, which assumes that theories are constructed through the research process, by collecting participants' accounts and interpretations of their experiences, the researcher develops this into a theory through further interpretation (Charmaz, 2017). The process followed an inductive, iterative approach to data collection and analysis, using comparative methods until theoretical sufficiency was reached.

Ethics

The study was approved by the Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC). The researcher considered the potentially stressful impact of taking part in research, and interviews were conducted to minimise distress. Participants were offered breaks and could stop the interview at any point. A check-in occurred after the interview, no participants reported feeling distressed by the process. Information on available support was provided verbally and within the participant information sheet. All participants gave informed consent and were aware of confidentiality procedures. During the interviews, there were no occasions when confidentiality needed to be broken concerning risk or safeguarding issues.

Participants

The participants were people with experience of a PIE homelessness service, through involvement in implementation, providing or receiving support from the service. Participants were primarily recruited from homelessness services that incorporated a PIE approach, via a homeless psychologist's network supported by the field supervisor. The research was also advertised on the social media platform Twitter. Inclusion criteria included being over the age of 18, having capacity to provide informed consent, and consenting to relevant safeguarding requirements. For full details, see table 1.

Sampling

Purposive sampling was initially employed to select participants for the study, to consider their job role or if they were a service user. Sampling in this way allowed consideration of who would contribute appropriate data at different stages in data collection and ensured the interviews captured a range of experiences. The total number of participants was dependent on theoretical sampling and data sufficiency (Charmaz, 2014). Theoretical sampling was used in later stages of data collection as categories and concepts emerged, to identify participants likely to have specific relevant experiences. Recruitment ended when analytical categories did not need to be revised and theoretical sufficiency was achieved with sufficient data to construct the theory.

Procedure

Recruitment

Following an expression of interest from a potential participant, the researcher made contact via email or telephone, depending on their preference. During this conversation, the researcher discussed the details of the study and answered any questions. Demographic information was also collected to aid theoretical sampling. If the individual agreed to participate and fit with the sampling decision, an interview was arranged. All 11 individuals who expressed an interest in the research took part. Table 2 displays the demographic characteristics of the sample.

Data collection

The interviews were conducted between February and November 2022, via a mixture of methods; face-to-face, telephone, and Microsoft Teams video software. Before the interview, the researcher revisited the details of the study and offered time for questions. Written consent for participation was obtained, for remote interviews, the consent form was emailed before the interview and participants returned a signed copy to the researcher. The interviews were semi-structured, guided by the interview topic guide which initially included open-ended questions to encourage participants to give their personal experiences and views

(Appendix B). In line with grounded theory, adaptations were made to the topic guide as recruitment progressed to become more focused and reflect emerging themes (Charmaz, 2015). Adjustments were made on an ongoing basis to explore concepts that emerged through the coding process that needed further exploration, such as the role of values, having a psychologist in the team, and manager support.

Data analysis

The analysis employed in this study followed the approach to grounded theory described by Charmaz (2014).

Coding

The analysis began with line-by-line coding of interview transcripts to build the analysis from the data (Charmaz, 2014). Focused coding followed, to group the most frequent or significant initial codes and test against extensive data. Gerunds were primarily used as codes to reflect the actions of participants (Russell, 2014). See Table 3 for a coding example. Constant comparisons were made within and between transcripts and later transcripts were coded with previous transcripts in mind, to compare data with data. This was an iterative process starting with the first three interviews which informed initial updates to the topic guide. As recruitment progressed, the process of data collection and analysis continued concurrently. The next stage of analysis was to develop the theory, which involved theoretical sorting, using diagrammatic representations, and integrating memos and categories.

Memo-writing

Memo-writing supported the analysis by recording the researcher's thought processes and decision-making (Charmaz, 2014). The development of codes to conceptual categories was supported by this process to define and elaborate on categories and inform ongoing hypotheses and ideas arising from the data, see table 4. See Appendix C for an example of memo-writing.

Quality and Reflexivity

Throughout the research, the role and influence of the researcher were considered and the researcher engaged in frequent supervision with two research supervisors, to support reflexivity and minimise bias. An interview was listened to by one supervisor to ensure quality, and during the analysis both research supervisors supported the development of the model.

A reflective diary was completed alongside memo-writing to capture the researcher's role and thoughts, including role as a trainee clinical psychologist in a team supporting PEH, and reflections on the research process and challenges encountered. For example, challenges with recruiting service users and shorter interview length of the two who participated. The researcher reflected on the balance of attaining validity of data with recognising interpersonal cues from the participant to finish the interview, see Appendix D for notes from reflective diary. Despite the shorter interviews, the data from service users is considered to contribute valuable insight to the results and overall model developed, however with more service users this would have been strengthened.

Results

This research explored what makes a PIE in a homelessness service work, from the perspectives of people involved in implementation, delivery, and receiving support. A theoretical model developed through the data analysis process represents the findings diagrammatically (Figure 1). The model shows the different factors involved in the effective working of a PIE, which was experienced as more stable when the factors worked together. A PIE could still function without some of these factors but was affected in its stability and longevity.

The conceptualisation of the model with the outer cogs highlights the factors that participants experienced as contributing to a PIE's success, with the relationship between the different elements key to a functioning PIE. These processes did not occur sequentially, implementation was described as an ongoing process with different stages occurring at the same time and overlapping. Within the wheel, the arrows illustrate the driving forces that participants discussed as powering the PIE, a combination of engagement and systemic factors. The inner processes show a working PIE focused on the experiences of service users and staff. The model illustrates that the combination of all these factors facilitates the optimal working of a PIE. In the absence of one or more factors, implementation can still occur but may be experienced as less stable for those working within and receiving support from the service.

The results will be discussed in three key themes; (1) Components of a functioning PIE; (2) Driving forces; (3) Pieces of the PIE: service user and staff experiences. See table 5 for additional participant quotes.

Components of a Functioning PIE

Throughout the interviews, the components were present in examples of working PIEs and shared across participants. Where PIEs had been successful, there was an overarching theme of understanding, in terms of the specific needs of the service, staff, and service users. Where participants felt that a PIE had worked, the psychologist involved had spent time developing an *understanding of the context* in which the PIE was being implemented. “I'm going to use terrible, terrible metaphor here, there isn't one type of PIE, there's chicken pie, there's meat pies, there's apple pies. What you've got to do is find out what your organisation or service needs.” P10, psychologist.

In examples where it had been more challenging to implement PIE, there was a sense of lacking an understanding about the service level needs and what would be possible.

> I think having a better sense of the organisation and what the capacity was erm would have been good. […] it might work better to do that kind of assessment where you really get to know the service and what it needs and what they want and then decide from that point whether or not you offer that sort of intensive erm intervention. P5, psychologist

In addition to developing a service-level understanding, it was also important to *understand the context* for staff working in the service. Both psychologists and staff agreed that understanding the challenges and demands faced by staff would support staff wellbeing and facilitate implementation.

> Just going to say just as a you know regular housing worker for [name of organisation], you know listening to quite violent and disturbing… information about what the women have experienced in their life and then go home and have your tea. It’s kind of quite, it's a big ask. P9, staff

The third layer of *understanding the context* related to understanding the complexity of clients’ lives and their varied needs. This helped staff appreciate barriers for clients when engaging with support. “I think people didn’t wanna be, didn’t wanna feel like they were being assessed. You know? And it wasn’t about that, it was about you know working with the person about what they want to talk about.” P3, staff.

The process of understanding the context was linked to developing *a shared understanding* for all, in terms of introducing PIE at the beginning, interactions with teams, and making decisions. In the initial stages, it was important to approach changes slowly and see building relationships as essential to the intervention.

> Going out for walks with people, if someone was going to the shop, one of the staff would say oh I fancy a walk do you mind if I come with you? Any opportunity we could get to spend time with them was all we, probably pretty much all the intervention we did for six months. P4, psychologist

There were examples where both psychologists and staff were figuring out how to work in a PIE way together, which was helped by informal conversations and more formal interventions such as training. It was clear that this process was enabled by approaching this jointly, with knowledge sharing between the psychologists and staff, rather than being solely psychology led.

> The staff members you know, were you know often really, really expert at doing that work, and you know, I think I always felt that I needed to be very humble in what I was kind of, you know suggesting I could offer, you know, given their, their expertise, you know that it needed to be, I suppose a two way process. P1, psychologist

Another key focus of this *shared understanding* related to who the work is for in a PIE. Most participants felt it was important that staff understood that PIE support was also for them and their wellbeing as well as for the people they support.

> There was an opportunity for us to develop and grow and look at our own team dynamics. In particular, our strengths because you know it doesn't take long for us to all start throwing our weaknesses around at one another, but you know having time to look at our strengths, quite, quite empowering stuff really. P9, staff

One contrasting view was that the focus on staff could be misinterpreted and take the focus away from the service users.

> So, it's got a bit misinterpreted and then it's actually the focus needs to, yes, we need to be PIE around staff and give you the training and whatever, but… It's been used more about staff approaches than about members, so trying to shift that shift back. P8, staff

The PIE projects participants were involved in differed in service design and whether the psychologist was integrated within the team or based externally. The preference for the psychologist to be based in the service was echoed by psychologists, staff, and service users. Having a *psychologist based in the team* was associated with the driving forces of engagement.

> I think that just being accessible, I really loved erm the interactions with the women who lived there and just being able to work in a much more flexible way. Erm so not having to like put restrictions on people for accessing support but being able to just have a really brief chat with someone or people being able to come and find you when they need you. P5, psychologist

On occasions when the psychologist had left the team at the end of the PIE project, both staff and service users spoke of feeling a loss and sadness.

> I wish we could have a psychologist all the time and I said that to [psychologist], I was gutted when [psychologist] left. I was really, really gutted. But yeah it was dead handy, it was really handy you know. You know if you got up one day and if you felt, sorry to say, a bit shit, then you could always come in. P2, service user

One service user shared their experience of the psychologist leaving the service and the service returning to how it was pre-PIE, which was not perceived positively. In this service, some of the components of the model such as shared staff values were not felt to be present, which highlights how the absence of some elements in the model can reduce the stability of the PIE in the long term. “Yeah, really sad. When she left it was really sad, I’m getting emotional now, it was really sad, yeah because everything went back to how it was, it was horrible.” P11, service user.

Having the *support of the manager* was another key component. This was associated with practicalities that allowed PIE to be prioritised in the service and within the staff team.

> So there has to be cover, you know, so there has to be generally agency cover who were going to come in and cover those days where the full time, staff, permanent staff team go, go off and similarly with reflective practice there has to be a cover for the team to do that. P1, psychologist

The participants who were managers in a PIE service described their role as supporting how the PIE functions, focusing on supporting frontline staff and embedding PIE into the service culture.

> We're putting better support in place for the frontline workers to ensure that they're appropriately supported to, to carry out their, their job role. Erm we have like a real transparent culture of communication with the team erm and, and just kind of like having, having them themes embedded in what we deliver has really helped us. P7, staff

Having the shared understanding and support from a manager was generally thought to support the team's role in implementing and maintaining the PIE. For some, this was incorporated into recruitment processes to ensure consistency within the team.

> So, I think people who do apply for positions here, we do talk about PIE and the elastic tolerance, so people have got an idea before they get in here. I think people who work here would prefer to be in a service like this, because it's more suitable so they feel like they're getting closer to the problems, closer to the needs". P3, staff

In examples where it had been more challenging to implement PIE, participants spoke of a lack of *consistency within the team* as a barrier. "I know in the last, the last service there was at least two members of staff who... were not on board with it, couldn't get their heads round it... and one of them in particular, I think was quite disruptive." P8, staff.

Linked with consistency was a theme of *shared values* amongst staff who were implementing PIE on a day-to-day basis. Where staff values aligned with the values of PIE, this was a helpful factor in its success and continuation even with reduced psychology input.

> It definitely comes from the, just embedding that culture within the team and I gotta say, like credit to the team, you know, they're the, the people that have done it and they've, they've really taken everything on board and erm it's, it's credit to them really

> nobody else. And I think the PIE has just supported this kind of like process and journey. P7, staff

Values were described as part of an individual and not something that could be forced upon people. When staff values and PIE values did not align this was associated with friction within teams and a barrier to successfully embedding a PIE.

> You know it’s really hard because it’s very difficult to unravel people’s personalities and their professional expectations. And for the people who were very negative about the whole PIE approach not a great deal has changed within those individual people. But erm, and it's sometimes it's a little bit of that kind of you can't really train people to care. P9, staff

Driving Forces to Power the PIE

Across the interviews, participants described engagement and systemic factors as driving forces that supported the stability of a PIE. *Key engagement factors included a focus on language and communication, relationships, flexibility, and choice.* These factors were connected and drove engagement with elements of PIE. Focusing on *communication* throughout the service was thought to benefit both staff and service users.

> But language is massively important, it really is. It’s also you know you need to be clear about what you’re saying because jargon just confuses people or jargon makes people seem a little bit insincere. What we need to do is come across as being honest, honest in our approach, I think you can do that by using clear language. P3, staff

Linked with this was the focus on *building relationships* within the service. It was clear across participants that relationships were at the centre of the experience of a PIE for everyone.

> There was lots of chances for those little bits of interaction. You know, saying hello to people you know developing a relationship erm through those kinds of small interactions, erm you know hopefully building up some rapport, building up a kind of a… I suppose a erm friendly face, non-threatening face. P1, psychologist

Across participants, the importance of taking time to build the relationship slowly was key. “Yeah yeah, I mean say the first month it took me a bit to get, you know involved with her but once I got involved, I was involved then.” P2, service user. Furthermore, focusing on relationships between the psychologist and the staff team could facilitate difficult conversations and support understanding of PIE principles.

> When you've been there a little bit longer and you built those relationships because you're not just coming in for two hours in a week, you can feel a bit more erm able to approach people and just have those conversations in a really informal way. P6, psychologist

A further engagement factor was working in a way that promoted *flexibility and choice*. Participants described this as offering a different approach to other services to promote inclusion and meet individuals’ needs.

> My biggest frustration for years has been that stat[atory] services literally, they don't attend, they're off the books. We’ve referred them in, well they didn’t attend so we closed them. But they aren't gonna consistently attend three meetings unless we support them to get there, which we do do... Because they’re in a state of chaos. So, it gives us that flexibility to try and unpick things. P8, staff

The second driving force of wider *systemic factors included the organisational culture, integration, and prioritised funding*. Participants linked the success of a PIE with how it was incorporated into the *culture and values* of the organisation.

> I feel like there should be like a training package rolled out to the senior management team just to reinforce that what we're doing below and try and embed that, that culture across, across, not just the service, but across the [organisation] you know, invest in people, positive communication. P7, staff

A further factor was *integration across the sector* and whether staff felt able to navigate the system to support clients. This was particularly challenging if a psychologist was based externally and was supporting clients in services that were not PIE.

> That's where a lot of the challenges come in, in that the services we work into aren't PIE if they haven't yet sort of moved out of the hostel yet into their own tenancy. Erm so then you've almost got clash of two very different approaches which must be really confusing for the person that's at the centre of it. P4, psychologist

The final systemic factor was whether the PIE had *prioritised funding*. Across interviews, there was a shared view that PIEs need to have more time to support ongoing implementation. "It's about funding. It's about the fact that that, that services are for whatever reason, not being funded in the long term erm 'cause you know, there's ample evidence that the PIE model is effective." P1, psychologist.

Throughout interviews, there was a sense of frustration when services were unable to meet the needs of clients due to a lack of resources. Particularly when a service described itself as PIE, but staff weren't able to incorporate the principles in their practice.

> I'd say basically put enough resources into the service so that they can deliver it properly. They, don't just put a label on it to make it sound good and make it seem that that's what you're doing. Really... but a lot of that is down to commissioning and government. P8, staff

Pieces of the PIE: Service User and Staff Experiences

The centre of the model highlights the wide range of interventions discussed by participants that improved the *service user and staff experiences* within a service. Across participants, there were core interventions featured in all PIEs.

> You're always gonna be thinking around direct delivery to the residents or the people that are the clients. You're always gonna be thinking about staff training, staff support, consultation. You're always going to be thinking around erm reflective practice. You're always gonna be thinking about physical environment you're always gonna be thinking about research, policies, processes. P10, psychologist

In terms of *direct work*, both service users and staff shared that having direct psychological support was beneficial and valued.

> She helped me… she helped me lots darling. She helped me erm… erm things that had happened to me in the past. Erm I was [inaudible] all my life and things like that and then I could, I never got any help for that and erm you know she helped me you know live with that, I suppose, speak about that. P11, service user

Offering *support to staff* was another key intervention to support their wellbeing and ultimately support their work with clients. This was discussed by both psychologists and staff as helpful for effectively embedding PIE within a team.

> That was offered to all of staff that opportunity to I suppose in a way, decompress. Have all the stuff that we deal with and we've never had that in the, in the 30 plus years that I've worked here. It felt it almost felt like, wow this is lovely, this is really and, and, and in a way without like trying to you know gasp about it, it was quite nourishing. P9, staff

Developing the skills and confidence of the staff team was also important. Discussed in terms of the psychologist supporting the team through offering training, followed by a shared responsibility so managers or colleagues could support each other.

> We really invest the time in each and every one of our staff, giving them opportunities to develop, looking at the skills and attributes and erm opportunities to kind of like progress within their career as well, ensuring that we’re supporting all that work. P7, staff

It was recognised that supporting staff in this way could have a much wider reach than by solely offering direct work to clients.

> To go and work with a staff group who then work with 20 young people in the hostel and can affect change of 20 young people. I think it's using your psychology skills in a more macro way to actually affect more people than just if you were sitting in a room with one person. P10, psychologist

Another key component related to the staff and service user experience was making the *physical environment* more psychologically informed. This was linked with improved accessibility and flexibility.

> We could have like real kind of flexible chats erm so it didn't feel like an us and them situation. Which I think can very easily be done by even having, like you know your name on a door or a closed door or, you know, come and sit into my office kind of thing. P6, psychologist

The final element *co-production* was discussed in terms of involving both service users and staff at all stages of implementation to promote shared values and ownership of the PIE.

> I think have people involved from the very start of decision-making, not just the like management level, but also people who are using the service or working in the service. Erm that feels really important because I don't think that always happens. P5, psychologist

However, it was important to consider the context for clients in terms of readiness to engage with decision-making processes. This further reinforced keeping the clients at the centre of the work and understanding the specific context of the PIE.

> A lot of people they're not at that point. You know the priority is getting themselves off the streets or out of a BnB not saying, well, actually that policy would work better. They don't have the capacity, the, the, the mental cap, like resources to think about that, because ultimately they need to focus on getting themselves out of that situation. P8, staff

Discussion

Summary of Results

The participants of this study worked in or received support from PIE homelessness services that varied in their context, remit, and stage of implementation. However, there were shared experiences of what made a PIE work in practice. The model (Figure 1), derived from the data, illustrates the components associated with a functioning PIE and shows implementation as an ongoing process. The relationship between the different elements is key to the success of a PIE, when the various factors worked together a PIE was experienced as more stable for the service users and staff at the centre.

Support from the Literature

As PIEs are an organisational intervention, the components of the model describe interventions at multiple levels in the system. As with the current theory, the key to change at an organisational level is understanding the context alongside facilitating a shift in mindset of the whole system to establish a shared purpose (Plimmer & Lowe, 2019), in this case, to keep individuals at the centre. Relevant theories that share these ideas include Human Learning Systems (HLS) approaches which focus on services that are human-centred, embed ongoing implementation and learning into the culture, and engage in systemic practices (Lowe et al., 2021).

As PIE services were at different stages, there was variation in the input from a psychologist and the related benefits or challenges of this. Participants with a psychologist based in the service agreed this was a helpful facilitator for implementing a PIE, and the offer of direct psychological work was particularly valued by service users and staff. However, in guidance for PIEs, the involvement of a psychologist is not a requirement (Homeless Link, 2017), and some argue that it is not a necessity if there is shared dialogue and discussion within the service (PIElink 2019b). In participant examples where psychologists were not based in the team, it appeared important that there was manager support to prioritise investment in staff, to enable staff to take on PIE principles and values and take ownership of the implementation. The finding of psychologists and managers working together to support the team is supported in the literature, with a suggestion that psychologically informed input to staff could be provided by managers with relevant experience who had received training from psychologists (Peters, 2019). This supports the theory that not all components of the model are essential for a functioning PIE, however how they interact, and work together can influence the longevity of a PIE in a homelessness service.

Research with staff working in homelessness supports the importance of shared values across an organisation and within the team. Staff who identify more closely with their organisation report increased job satisfaction and improved workplace functioning (Ferris et al., 2016). For staff whose values may not align with the PIE model and report lower motivation to engage with PIE, recommendations include offering proactive support to highlight the relevance for their wellbeing and job role (Schneider et al., 2022). These findings illustrate a helpful interaction when staff values align with organisational values, which may protect against the challenges of the role and burnout. For support workers, feeling supported by their organisation was associated with improved coping with the demands of their role (Peters, 2019). This supports the current theory and PIE principles, that an organisation culture that promotes staff wellbeing and a safe environment to share practice without fear of consequences is more supportive for staff learning and growth (Plimmer & Lowe, 2019).

Within the literature, the driving forces of the model are well supported in terms of making organisational changes and working with PEH. Evaluations of PIEs have similarly reported the importance of engagement factors including communication, relationships, and flexibility to facilitate the success of a PIE (Phipps et al., 2017; Williamson, 2018; Quinney & Richardson, 2014). The engagement factors in the model are also in line with pre-treatment approaches that are championed when working in homelessness services to focus on building relationships, developing a common language, and facilitating change (Levy, 2021). These principles are in line with TIC when working with individuals and within systems with high levels of traumatic experiences which can affect how individuals and services interact (Levy et al., 2018). The findings further support recommendations for organisations to promote engagement and focus on relationships to break down barriers faced by PEH when accessing support (Omerov et al., 2020).

The systemic factors driving the model are also supported in the literature, with organisational culture, funding, and integration being associated with a functioning PIE (Levy et al., 2018; Tickle, 2022). The finding of wider organisation and system influences on a staff team's ability to implement a PIE is supported, alongside recommendations that staff interventions such as training need to be supported by system level intervention (Buckley & Tickle, 2020; Burge et al., 2021). This supports the theory that how the different components of the model interact and work together influences how a PIE is embedded and works in the long term. The importance of prioritised funding to support the longevity of PIE and an understanding of PIE at a commissioning level came through from the participants, particularly in PIE projects that had been funded as pilots. Plimmer & Lowe (2019) argue for the need to fund and commission in a human way, encourage the system to work together, and offer longer-term funding to share the power within the system with reduced focus on performance or outcome measures.

Key to PIEs and approaches for working with PEH is to keep the individual at the centre (Levy et al., 2018), reflected in the current model. All the PIEs that participants in the current study were associated with included some form of intervention related to direct work, staff support, and the environment. This is in line with guidance for PIEs (PIElink, 2019), and benefits to service users and staff following these interventions are well documented (Buckley et al., 2021; Cumming et al., 2017; Maguire et al., 2017; Phipps et al., 2017; Tickle, 2022). The service users in this study wanted support with their mental health and described the benefits of working with a psychologist. This contrasts with reported views of clinical psychologists in mainstream mental health services (Xenophontos, 2020). However, supports research and theory that recognises the value of therapeutic work with PEH, that focuses on the engagement factors (Keats et al., 2012; Levy, 2018).

The importance of co-production in the data came from examples where participants had used co-production effectively or reflections that acknowledged more co-production may have improved the PIE. Involving people with lived experience of homelessness is supported in research and guidance for supporting PEH (Barker & Maguire, 2017; Groundswell, 2022). Strengthening co-production has been associated with supporting a healthy system, sharing the power between stakeholders, and supporting the implementation of changes at a service and organisational level (Moreton et al., 2021; Plimmer & Lowe, 2019).

Strengths and Limitations

This research aimed to pull together learning and experiences from multiple PIE homelessness services, to include the voices of different stakeholders and service designs. This was hoped to contribute a new perspective to the literature and enhance understanding of what makes a PIE in a homelessness service work.

Limitations include the possibility of responder bias, all staff who participated shared positive views of PIEs, however, also spoke of colleagues who had different opinions. During the interviews, the challenges associated with PIEs were explored, however the findings may not represent a balanced view. Furthermore, the field supervisor supported recruitment and was known to some participants, therefore this may have influenced how comfortable participants were to share opposing views. However, by ensuring participants understood the principles of anonymity and confidentiality, it is hoped this effect was minimised. A further limitation relates to fewer service users taking part than professionals due to recruitment difficulties and the limited time nature of the project, which reduced the opportunity to recruit more widely. Additionally, both service user interviews were considerably shorter than staff interviews, which may indicate less rich data gained from service users. It is acknowledged that with more service users or longer service user interviews, richer data may have been gained to contribute more insight from service users to the model. As a result, the model is based more on staff responses and experiences than was intended during study design.

Clinical Implications and Future Research

The theory developed may support ongoing understanding of how a PIE works in a homelessness service, offering new insights for services that are currently implementing or will implement PIE in the future. The service users who participated provided helpful insights into their experiences of being supported by a PIE homelessness service. However, they were unsure of how the principles of PIE were operating within the service. This may support the need for more co-production and involvement in decision-making to ensure individuals are kept at the centre and power is shared (Albert et al., 2023). At the start of the project involving people with lived experience of homelessness was explored, however this was not possible due to time constraints. Future research would be improved by including people with lived experience throughout the process (Albert et al., 2023; Groundswell, 2022).

For frontline staff working in homelessness services, the challenges of their roles alongside low pay, long hours, and high staff turnover impact their emotional wellbeing (Peters et al., 2022). Staff support is a key element of PIEs and homelessness organisations are increasingly focusing on interventions for staff support (Homeless Link, 2017; Keats et al., 2012). The current research highlights the importance of a supportive organisation and culture to facilitate the different interventions that target staff support, such as training. By considering the different aspects of the model it is hoped that organisations will be able to implement PIEs in a way that promotes ongoing learning and facilitates positive change for the people at the centre.

Throughout the interviews with psychologists, there was a theme of the profession still finding its way into homelessness services, something that is supported in the literature (Tickle, 2022; Wells, 2021). Some participants also highlighted difficulties in recruiting qualified psychologists in homelessness. This points to the need for clinical psychology training programmes to do more to support the development of knowledge and skills relevant to working in homelessness (Xenophontos, 2020). It is also an area for future research to explore potential barriers to qualified psychologists taking up these roles.

Conclusion

This study interviewed 11 people who had been involved with a PIE homelessness service to explore the factors that support a PIE to work in practice. Participants shared a variety of experiences which highlights the complexity of factors to consider when implementing a PIE. The resulting model illustrates that implementing PIE is an ongoing process, when the different components work together the PIEs were experienced as more stable in the long term by the people at the centre. Clinical implications for services include to consider the wider contextual and systemic influences surrounding homelessness. Future research that is co-produced with people with lived experience of homelessness is recommended.

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Tables and figures

Table 1

Inclusion and Exclusion Criteria

Role	Inclusion Criteria	Exclusion Criteria
Service user	Service user receiving support from a PIE homelessness service. Consent to key worker being contacted regarding any risk issues. Capacity to provide informed consent to participate in the research.	Under the age of 18
Staff	Staff involved with PIE in a homelessness service. Consent to line manager being contacted regarding any practice issues. Capacity to provide informed consent to participate in the research.	Under the age of 18

Table 2

Participant Demographic Information

Participant number	Role	Age	Gender	Ethnicity	Location Based	Time Working in PIE Approach	Mode of Interview	Interview Length (minutes)
1	Clinical psychologist	40	Female	Irish	Accommodation	2 years	Video	62
2	Service user	51	Male	White British	Accommodation	N/A	Face to face	22
3	Staff	47	Female	Mixed white British & Caribbean	Accommodation	3-5 years	Face to face	48
4	Clinical psychologist	30	Female	White British	Psychology team	4 years	Video	66
5	Clinical psychologist	38	Female	White British	Accommodation	2 years	Video	38
6	Clinical psychologist	37	Female	Indian	Accommodation	1 year 8 months	Video	55

7	Staff	37	Male	White British	Outreach team	6 years	Video	73
8	Staff	46	Female	White British	Outreach team	3 years	Video	66
9	Staff	59	Female	Irish	Accommodation	5 years	Phone	64
10	Clinical psychologist	46	Female	White British	Psychology team	3.5 years	Video	45
11	Service user	40	Female	White British	Accommodation	N/A	Face to face	16

Table 3

Example of Coding Process

Transcription	Line by Line Coding	Focused Coding
I: And have you kind of, you know, learned ways or what was the way of getting that management buy in?		
P: I think it would. There was some		
scepticism initially or erm… about my role,	Experiencing scepticism in beginning	
and I suppose not enough, not a great		
understanding of, of the role, and I suppose	Lacking understanding of psychology role	
you know I was feeling out the role as well,		
so you know, I didn't have a huge amount of	Developing own understanding of role	Developing understanding of PIE
clarity about what it was I was going to do.		
Especially the early, the early parts of it, I	Conducting assessment in beginning	
suppose were like an assessment phase I		
guess, and so then I think there was an		
understandable kind of, erm, maybe fear	Perceiving a fear of change from staff	
about change, and I think the biggest fear,		Understanding staff demands
was about… not necessarily the financial		
commitment, but I suppose the, the effort	Understanding fear	
would be for the manager and the team to		
change their ways of working. You know,		
and I suppose in a stressed environment how		
much more… effort they would have to put	Understanding staff demands of their role	
into their jobs, which are already quite, you		
know. Effortful, so erm I think once there		Seeing PIE work in practice
was a, you know a sense of kind of it being	Needing some evidence for PIE elements	

evidenced that it was worthwhile. You know evidence that reflective practice was being appreciated by the staff team. Evidence that the staff team you know were, felt that it was	Showing that reflective practice was valued	
helpful to have me in the premises when clients needed someone to talk to, you know,	Feeling that role was helpful to staff	
and for staff to go to so once, but I think once there was evidence that that was helpful	Feeling that role was helpful to clients	Having “buy in” of manager to enable PIE
building up then manager, the manager, was much more, you know on board. But I think	Finding that evidence builds up	
there was an initial period of scepticism. Erm I also think that what I learned as well is that, erm well first of all, I think that that there was	Experiencing initial scepticism	
probably, I don't know I 'cause I wasn't involved in the kind of setting up phase in terms of the choice of the particular hostel. That decision had kind of been made before I	Not being involved in choice around implementation	Making decisions about implementing PIE in service
came on board. So I'm not sure how much the hostel manager themselves was, was involved erm I think it might have been their manager who had kind of nominated them, so I think perhaps you know in advising someone to go	Being uncertain about manager involvement in set up pre PIE	
through this process in the future, I would think you would need to get the actual service manager whose you know on the ground	Needing to involve service manager in decision making	Having “buy in” of manager to enable PIE
involved from the earliest point possible, erm… 'cause they're gonna be the ones who	Having manager support for practicalities	
are, I suppose having to kind of you know, do the day-to-day work around you know changing shift patterns, allocating rooms, you know, doing all of that, doing all of that stuff to make it a success. And I think whilst their,	Perceiving managers as contributing to success	

their superiors may think it's a great idea, they may not have that kind of I suppose, they may have lost some of that everyday connection with what it means for their for the building or the service to implement it.	Understanding hierarchy of involvement in decision making	Perceiving managers as contributing to success

Table 4

Development of a Conceptual Category: how focused codes led to development of conceptual category of staff values.

Participant	Quote	Line by Line Coding	Focused Coding
1	“Because of the so many systemic and societal you know issues in homelessness erm and I suppose the job, then shifts into, well, how you, you become more politicised I think, you have to kind of think about this job as being, I suppose, being about, you know what your values are as a person”. psychologist	Recognising systemic factors Understanding social issues Becoming politicised Considering own values	Recognising value of work Aligning with PIE values
3	“I think the investment from the team, I think the team wanted it to work as well. Because they recognised like I say with this particular client group, you do need to have a different way of working. The old style, supported housing and bail hostels just not gonna work with this, with this culture and this client group. Because it’s kind of like what’s gone wrong for them before and it’s not worked, whereas this way, people do respond better, because erm I think it’s more about erm taking a chance on the person and believing in them, you know we believe in you, we believe that we can get past this. I think as whereas before they were never given that opportunity to change.”, staff member	Team wanting PIE to work Changing culture of homelessness/client group Believing in PIE Giving clients hope Giving clients opportunities to make changes	Recognising team role in delivering PIE Adopting PIE values
5	“Mmhmm, because a lot of it is probably quite natural, like if it flows out of like compassion and you know, yeah, values really, like value driven erm and you can't force that on people, you can't force	Seeing values as natural	Adopting PIE values

	them to feel or have those things. But erm yeah, interesting…" psychologist	Values can't be forced on to staff	
6	"So, you don't have to have a psychological background to be working from a psychologically informed erm perspective. So, it was really important to involve erm security staff in that, were involved, you know in that as well because they've got that interaction daily more so than anybody else probably thinking about the time that people are there. Erm, you know, making sure that all people that are volunteering are involved in that and everybody's just coming from a space where you're working together to support service users and staff.", psychologist	Involving all staff in PIE Valuing all staff Joint working Having a shared understanding of PIE values	Recognising team role in delivering PIE Adopting PIE values
7	"And for me it was really useful for me to have the reflective practice sessions and the PIE training because it helped me reflect on my journey as a manager and as a leader and reinforce kind of erm what I'm doing is kind of right because they're not that, you know, the, the, the PIE, the PIE kind of like ethos and, and values and the, the approach, the psychologically informed approach is, is, is definitely ingrained in me and it has been for a long time." , staff member	Valuing RP and training Using self-reflection Working in line with values Believing in PIE	Valuing PIE interventions Aligning with PIE values
8	"Like, no, I'm not evicting them, we need to sit down with them and speak to them and understand what it is that, why they're behaving that way, what's, what's triggering them. Erm… what we can do to support that and help them look at what they	Working within elastic tolerance Wanting to understand behaviours	Valuing PIE interventions

	need to help them change their behaviour and the way they react to things. So, like I used to do that years ago. Because I, I always, services I managed the number of evictions used to reduce dramatically because I would, just wouldn't unless there was major serious risk or threats, people being hurt. So, I think I used to think like that more so than I'd say staff would. Before knowing anything really about PIE. But since I know about PIE erm and it's being introduced, it makes me think, actually I didn't think as much as I used to think I thought. If that makes sense?", staff member	Working in line with PIE in previous roles Working in line with values (pre PIE) Learning about PIE	Aligning with PIE values Adopting PIE values
9	"Yeah, you know, certainly for myself it felt a little bit like validation. It felt a little bit like, you know, erm what was that… it felt a bit like the, the fishing rod and the fish thing, you know, give somebody a fish and then they don't be hungry anymore. But give them a rod and they can fish all day long for themselves and it felt a wee bit like that. It was, it was a… a way of thinking that was accepted within the, the, the, the institution for want of a better word that, that I work in. Even though a lot of workers were already working in that way anyways. But suddenly there was validation for why we worked the way we worked. And that, that was incredibly empowering for a lot of staff", staff member	Feeling validated by PIE Learning about PIE Accepting PIE Working in line with values (pre PIE) Feeling empowered by PIE	Aligning with PIE values Adopting PIE values Service adopting PIE values

10	“I come from a working-class background so you know it didn't align with my values to go into private practice. So, I felt very stuck in the NHS, so, to be able to go and deliver psychology and PIE into a charity very much aligned with my values. And I'll be honest gave me a real boost of energy when I knew I was burnt out and was done in the NHS. And charities are very aligned to many psychology values of course they are”, psychologist	Considering own values Values not aligning with private practice Working in line with values Recognising own values in work	Recognising value of work Aligning with PIE values

Table 5

Supplementary Quotes from Participants

Theme and Subtheme	Description	Quote
Components of a Functioning PIE		
	Understanding service context	"I think that you know, it's, it's an organisational intervention, and so we probably should be looking at organisational models. Not just kind of, you know, individual intrapsychic models of mental health. We need to be thinking about organisational models erm, and, erm… so thinking about that organisation and assessing that organisation, erm and different organisations will be different and you will, you know also learn different things at different stages." P1, psychologist
	Understanding context for staff	"I also think we need to see it from the challenges from staff perspective that aren't solely coming back to the service user and build more of that understanding of PIE from the way I see it anyway, is that it's, the support from staff for staff, as well." P6, psychologist

	Understanding context for clients	“So we look at being trauma informed and get to know someone and build a relationship up and take time to really like, understand that person's experiences and, and their journey to where they are rather than just jumping in and, and kind of saying oh, we can get you into accommodation and you know a lot of people have been let down by services, you know in the past and feel like they haven't been represented well.” P7, staff
Shared understanding	Understanding across organisation	“I was trying to influence and say all the senior managers should have it because there's no point us having a service that’s working that way if we're not. That’s the whole point of of it, that it's throughout the organisation and how can I effectively manage the staff team to deliver a service in certain way if I have not had that training.” P8, staff
	Staff understanding in the beginning	“At first, I was like how the hell are we gonna, you know what’s gonna go on and you know how, I think there’s was a lot of fear at the beginning. Because you know psychologically informed environment sounds very very nice and very very, you know like something to promote. But when you’re actually having to deliver it a lot of work goes into it, a lot more work than what you think really.” P3, staff
Psychologist in the team	Benefits to having a psychologist in the team	“They've had training on autism but having then that training followed up by being able to sort of access

		supervision and consultation and that kind of stuff really has embedded the knowledge. So, I think, that's the key difference between having like a psychologist that's just commissioned in to do something to having someone in the service as well.” P4, psychologist
	Positive input from external psychologist	“So yeah, that was, that was really beneficial I feel erm you know and again I'd like to say like credit to, to [name of Trust] and [name of psychologist]’s team because they've been really flexible and patient. Erm the sessions have been really supportive and informative erm and, and that kind of includes the training and the, the, the, the PIE the erm reflective practice.” P7, staff
Manager support	Felt absence of manager support	“…like the management would cancel trainings last minute and they would not provide the resources they'd say they would for things or not allow staff to come to supervision or you know, lots of things that actually without the support of the management, there's only so much an outside person can do so.” P5, psychologist
Consistent ways of working	Having different views in the team	“There was definitely a voice or some voices of erm… maybe they may come from the camp of tough love. Erm and that it was a bit wet and a bit liberal and I think a waste of time.” P9, staff

Staff values	Valuing transparency	“But transparency is such a key part of PIE and not kind of wanting to withhold information. So even having conversations where that can be difficult for people, for staff is an important part of the values because I think for me what I found is that a staff didn't realise that the PIE support was equally for them as it was for service users.” P6, psychologist
Driving Forces		
Engagement		
	Language and communication	“It is for the service users, the way we communicate, but that's gotta run right through our service. Erm if it doesn't, then there's just blockages and barriers because if one part, part of the service isn't psychologically informed, how are we expecting people on the front lines to do it.” P7, staff
	Relationships	“It's a universal model that applies to all of us. So, it also helped us when we were thinking about staff relationships as well, what staff are bringing into the interaction.” P10, psychologist
	Flexibility and choice	“Built support, so mutually agreeable times for meetings. Where do you want your meetings as well. It’s a case of getting the right setting for the meeting rather than, “you can come here at this time and this day and you will meet in the main office”. It’s not like that, it’s more a case of “do you want to sit in the

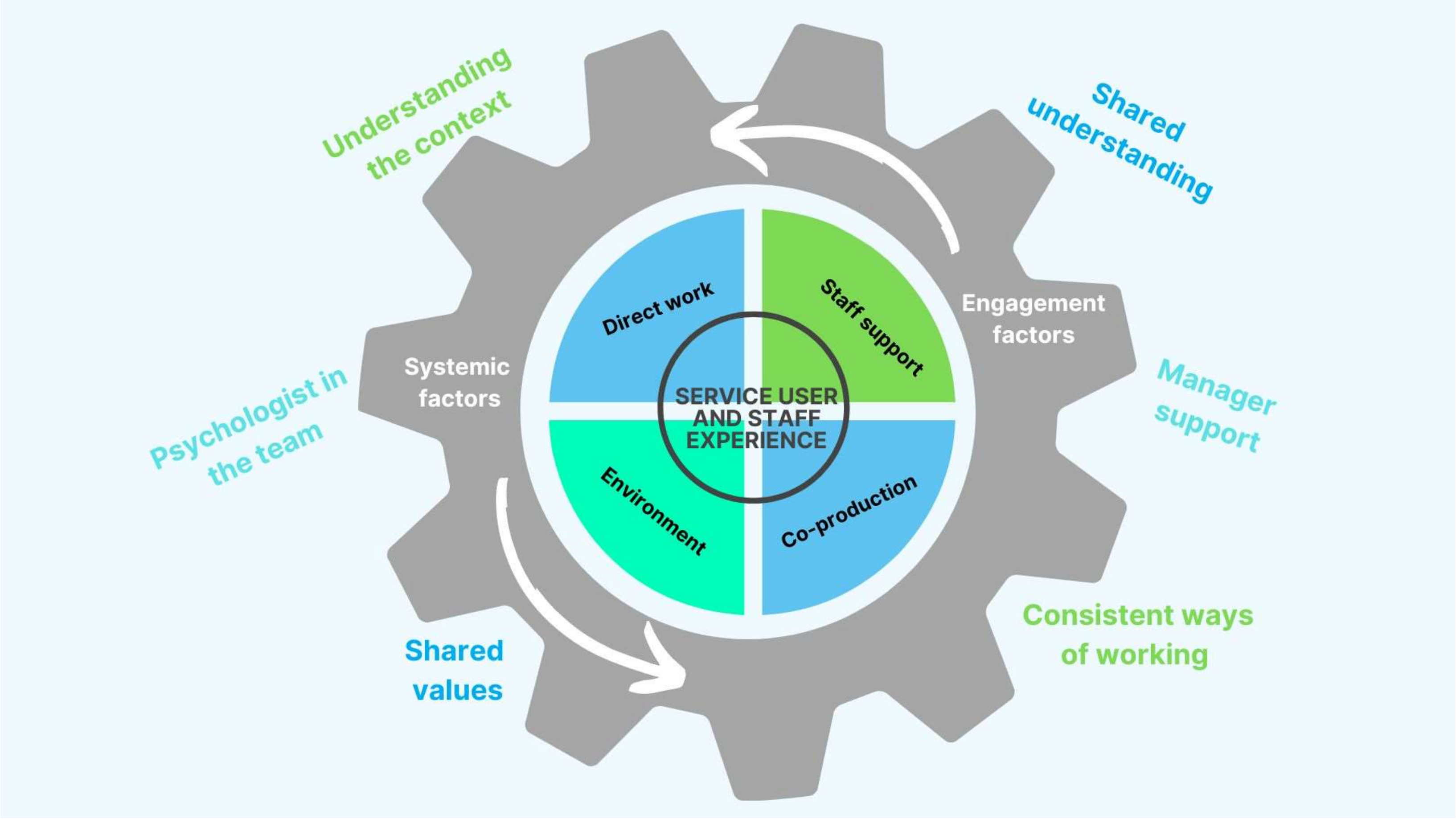
		lounge? Do you want to go out for hot chocolate?" You know, "what do you wanna do?" P3, staff
Systemic Factors	Organisational culture	"Erm because it feels nice to say you want to be more PIE but then when it comes to it, are you willing to have difficult conversations with staff or erm like invest in staff being supervised properly or, you know, all the things that it takes for that sort of environment to grow so?" P5, psychologist
	Integration across the sector	"I had a magic wand, I would want to change the interaction between third sector and statutory services. I think there's still huge problems there with you know from everything from information sharing to access to the resources" P10, psychologist
	Prioritised funding	"But we still see women on a regular basis who are very vulnerable, who fall outside of that almost by definition because it kicked off at another project or they don't have any recourse to public funds. And you know, there's we, we are constantly identifying gaps in the service […] it doesn't capture all the, the vulnerable women that use the service with needs." P9, staff
Pieces of the PIE: Service User and Staff Experience		
	Direct work	"I think my biggest thing was erm meeting, wanting to work with people that either hadn't had access to

		therapy or psychological support because it wasn't set up in a way in services that I guess even allowed for people that had other difficulties and housing being one of them, to access it." P6, psychologist
	Staff support	"So, I did lots of kind of listening and just being around and trying to work out what people wanted and what was needed and that came up a lot that erm staff didn't feel supported and didn't feel valued and actually it was a very challenging job they had to face a lot of crises. Erm and a lot of very harrowing things, but didn't really feel like they had the skills or the like backup in doing that, so staff support definitely was the biggest thing" P5, psychologist
		"It's really interesting to see how staff will refer to bits of CAT and bits of CFT and, naturally now as part of that, I came in and I was like I can't believe this it's amazing. And we were like, we always said, we need to stick to one because it would be confusing. Whereas actually a lot of the staff, they have bits of all sorts, you know" P4, psychologist
	Physical environment	"I think in psychologically informed environment I think the actual bricks and mortar environment just you know why can't homeless women [inaudible] why can't you expect kind of hotel services for where you can be whilst you're in crisis. And have staff that

		are informed and trained and skilled enough to support you out of that crisis.” P9, staff
	Co-production	“Erm… it’s good to talk, it’s good to talk, it’s good to have co-production with the customers. Because I feel as though people should have say in where they live and how it’s run. Erm obviously there has to be things in place to keep everything safe, but I think in the main just keep conversations going.” P3, staff

Figure 1.

Model of how a Psychologically Informed Environment (PIE) Works in Homelessness Services.



Appendices

Appendix A- Guidance on Psychologically Informed Environments (PIElink, 2019)

PIElink (2019a): PIEs 2.0

Key elements of a PIE	Details
Psychological awareness	Developing more 'psychological awareness' of the needs of service users: emotional awareness, psychological techniques, psychological models
Training and support for staff	Valuing training and support for staff (and volunteers) as well as service users to understand psychological and emotional trauma
Learning and enquiry	Creating a service culture of constant learning and enquiry: an attitude and atmosphere of learning, reflective practice, evidence generating practice
Spaces of opportunity	Creating and/or working with 'spaces of opportunity': the built environment and its ‘social spaces’, local surroundings and networks, referral pathways and systems
The Three Rs: rules, roles and responsiveness	Fine-tuning the 3 Rs 1. the rules of the service, that govern the day-to-day operations. 2. the roles that are available - for both staff and users. 3. the ways in which the service works - the responses or responsiveness to events.

Appendix B: Interview Topic Guides

Staff interviews: welcome and general introduction

1. Questions about general experience of homeless services (length of time working, different types).
2. Questions about current service
    a. When was PIE implemented within the service?
    b. How did PIE come to be implemented?
    c. What was the service like prior to PIE?
    d. What was it like starting to work in a PIE way?
        i. Was it easy? Why/ why not?
    e. What are the key components of PIE in your service?
3. Questions about role in PIE
    a. What was your role in set up?
    b. What is your role in delivery?
    c. What does your day-to-day role look like?
    d. Is there anything you think should have been done differently/ would have worked better?
4. What works well and what needs to change.
    a. What do you like about working in a PIE way?
    b. What would you like to change?
    c. What would your recommendations be for others thinking about setting up a PIE in a homeless service?
    d. What would improve the service where you currently work?

Service user interviews: welcome and general introduction

1. Questions about general experience of homeless services (length of time in services, different types).
2. Questions about current service
    a. What do you understand about PIE?
    b. How does the service compare with others you've experienced?
    c. Thoughts about PIE principles e.g.- focus on trauma/relationships, contact with psychologist?

3. Questions about role in PIE
    a. Involved in any decisions at service?
4. What works well and what needs to change.
    a. What do you like about the PIE service?
    b. What would you like to change?
    c. What would your recommendations be for others thinking about getting support from a PIE homeless service?
    d. What would improve the service?

Appendix C- Memo-writing

Excerpt from memos after interview 7

Psychologist in the team
Participant is based in team that does not have a psychologist, PIE support is from external psychologist. This is first staff member to not have had a psychologist in the team but be very positive about PIE. Something about the role of the manager (his role) in supporting the implementation of PIE without a psychologist in the team and also supporting the staff to do the same.

Values
Something about this participant’s own values really came through (similar to 1,5,6). He spoke positively of PIE and how it fits with how he wants to work. He spoke of developing understanding and empathy and the way this trickles down: manager-staff, staff-staff, staff-service user. Would be interesting to speak to frontline staff as well as managers?

Systemic factors/organisational culture
He recognised the organisational nature of PIE and also spoke of PIE needing to be embedded across the service for managers above him (similar to 1,4,5). Lots of use of the word “culture” and changing cultures, example of a team that has been supported to make positive changes in team culture through PIE (less turnover, better team dynamics).

Relationships
Participant spoke a lot about TIC principles, particularly building up relationships and taking time to develop trust with clients as something the team focus on following PIE. Linked this understanding specifically to training and RP delivered by external psychologist. Also spoke about focusing on relationships in the team, investing in staff and prioritising his team’s wellbeing which was linked to improved team culture.

Appendix D- Reflective diary

After first service user interview:

“Noticed I was very aware of pace and the language I was using, wasn’t as familiar with PIE term as staff but could talk around changes they noticed.”

“It was key not to go too much into personal details, try to keep to the topic guides and respect shorter answers and wanting to finish quicker than previous interviews. Contributing on a voluntary basis so had that in mind with how far to go.”

After coding first service user interview:

“Unsure if we were a bit ambitious in expecting clients to be involved in/understand processes with PIE. Obviously only spoken to one so far but this was more about their experiences than how things worked? Although they did mention open door policy and the flexibility etc that they felt helped it to work.”

After second service user interview:

“Felt very aware that I didn’t want to take up too much of their time, felt very grateful for what they gave me.”

“Hopefully some valuable stuff, can see links with other service user interview in valuing psychology support and being sad when it finished, but also themes of not being involved in PIE/decisions.”

After coding second service user interview:

“Noticing the harm that could be done by a short-term intervention, offering support but then taking it away. Doesn’t feel fair and considerate of the service user”.

“Client experiences of staff negative interactions before and after PIE. How to make changes sustainable? Something about individual workers who make a difference when on the whole staff/services not supporting/ meeting needs.”

General reflective comments

“Disappointed only managed to recruit two service users, worried earlier on that might have been ambitious to try to include but now coded interviews can see really valuable points that would have been missed if just focused on staff.”

Appendix E- Journal guidance: Housing Care & Support

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Format	Article files should be provided in Microsoft Word format. While you are welcome to submit a PDF of the document alongside the Word file, PDFs alone are not acceptable. LaTeX files can also be used but only if an accompanying PDF document is provided. Acceptable figure file types are listed further below.
Article length / word count	Articles should be between 3000 and 6000 words in length. This includes all text, for example, the structured abstract, references, all text in tables, and figures and appendices. Please allow 350 words for each figure or table.
Article title	A concisely worded title should be provided.
Author details	The names of all contributing authors should be added to the ScholarOne submission; please list them in the order in which you'd like them to be published. Each contributing author will need their own ScholarOne author account, from which we will extract the following details: • Author email address (institutional preferred). • Author name. We will reproduce it exactly, so any middle names and/or initials they want featured must be included. • Author affiliation. This should be where they were based when the research for the paper was conducted. In multi-authored papers, it's important that ALL authors that have made a significant contribution to the paper are listed. Those who have provided support but have not contributed to the research should be featured in an acknowledgements section. You should never include people who have not contributed to the paper or who don't want to be associated with the research. Read about our research ethics for authorship.
Biographies and acknowledgements	If you want to include these items, save them in a separate Microsoft Word document and upload the file with your submission. Where they are included, a brief professional biography of not more than 100 words should be supplied for each named author.
Research funding	Your article must reference all sources of external research funding in the acknowledgements section. You should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.

Structured abstract	All submissions must include a structured abstract, following the format outlined below. These four sub-headings and their accompanying explanations must always be included: • Purpose • Design/methodology/approach • Findings • Originality The following three sub-headings are optional and can be included, if applicable: • Research limitations/implications • Practical implications • Social implications You can find some useful tips in our write an article abstract how-to guide. The maximum length of your abstract should be 250 words in total, including keywords and article classification (see the sections below).
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Section 3 Critical Appraisal

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Lancaster University

Doctorate in Clinical Psychology

Introduction

The critical appraisal will summarise the research findings from the systematic literature review (SLR) and empirical paper. This will be followed by a consideration of reflexivity throughout the research process and how this may have influenced the different stages of design, data collection, analysis, and interpretation. The clinical implications of this research and suggestions for future areas of research will also be explored.

Summary of Research

The SLR explored the perspectives of adults who have experienced homelessness in accessing support for their mental health. The review employed a meta-ethnographic approach, following the process outlined by Noblit and Hare (1988). The review identified 15 relevant papers which were analysed and synthesised into four themes: the intersectionality of stigma, the importance of relationships, service pressures, and connectedness vs disconnectedness. The findings highlight the challenges faced by people experiencing homelessness (PEH) when navigating complex systems to access mental health support. Participants in the studies shared common experiences of stigma and marginalisation from services, professionals, and wider society, with a detrimental impact on their ability to access and engage with mental health support. The experiences of stigma were often related to multiple aspects of identity; race, gender, mental health, substance use, criminal history, and being a mother. The intersectionality of this stigma transcended all aspects of interactions with services, including the ability to form trusting relationships. These barriers were influenced by the context in which services operate, often in environments of increased demand and high pressure. To alleviate these barriers, including people with lived experience of homelessness in service design is recommended to promote inclusion, improve access through integration and enhance communication.

The empirical paper explored what makes a psychologically informed environment (PIE) work in a homelessness service from the perspectives of people working in or receiving support from the service. A grounded theory approach, informed by Charmaz (2014) was used to develop a model based on participants' accounts gained through semi-structured interviews. Despite variation between the services participants described, there were shared experiences about what contributes to a functioning PIE. The model and theory developed illustrate the different components that work together, the driving forces of systemic and engagement factors, and the service user and staff experiences. Throughout the interviews, it was clear that service user and staff experiences were improved when the different elements in the model worked together, and those working in or receiving support from a PIE homelessness service were at the centre. This study highlights the complexity of implementing a PIE in a homelessness service and factors to consider to improve how a PIE is experienced. Recommendations for services include considering the wider contextual and systemic influences surrounding homelessness.

Crossover Between the SLR and Empirical Paper

Similar themes are found across the two papers. Both highlight the importance of viewing interventions for PEH through a systemic lens, to understand homelessness in the context of social inequalities rather than just focusing on the individual. This includes thinking about the causes and maintenance factors of homelessness, in addition to broader influences related to funding and service design. Both papers highlight the importance of joint working, integration across services, and collaboration rather than exclusion and competition between different services.

Furthermore, both papers highlight the importance of considering the context for staff and developing an understanding of the challenges of their role. The findings from both papers emphasise the need to focus on staff support to create a working environment that is safe and supportive, to counteract the demands of their roles in the context of working with complexity, limited resources, and traditionally limited support.

Both papers have relationships and engagement as central themes when working with PEH and staff in homelessness services. In the SLR, relationships between service users and staff based on trust, empathy, and compassion could break down the barriers PEH faced when accessing services. Similarly, in the empirical study, relationships are a key engagement factor and a driving force in the model for a working PIE. These findings highlight that a focus on relationships can support access and engagement and alleviate challenges associated with service or system pressures.

Further similarities include the recommendations for improving co-production and involvement of people with lived experience of homelessness. The SLR highlights the value of including people with lived experience at a support level and in designing and creating services. Similarly, the empirical paper highlights the benefits associated with including service users in decision-making processes to ensure they are kept at the centre. The findings emphasise the importance that services operate with these principles in mind.

Reflexivity

This section will consider my reflections on different aspects of the research process and acknowledge limitations and suggestions for what could have been approached differently.

Inclusivity in homelessness research

A key consideration at the beginning was the choice of language when talking about people with experiences of homelessness. When conducting the SLR, I was shocked by terminology used in research papers to describe this population, labels such as “socially dead” (Knight, 2010) and “mentally disordered homeless people” (Salize et al., 2013). More recently, numerous terms have been developed to describe this population, such as people with “multiple complex needs” and people experiencing “multiple disadvantage” (McCarthy et al., 2020; Public Health England [PHE], 2019). Through reading, I discovered that these terms are not well understood by people with lived experience and can be generalising or stigmatising (Bowpitt et al., 2018). I chose to use people experiencing homelessness (PEH) as a term used within organisations that involve people with lived experience of homelessness (Groundswell, 2022) and recent clinical guidance (NICE, 2022).

Although not the focus of the current study, due to the co-occurrence of homelessness, mental health difficulties, and substance use, I noticed the terms “substance abuse” and “substance misuse” often being used. Where necessary, I decided to use the term “substance use” based on personal beliefs that disagree with criminalisation and demonisation of substance use in PEH and other marginalised groups (Southwell, 2021). I argue that these narratives are based on stigma, discrimination, and exclusion and disagree with the contrast to socially acceptable substance use when associated with non-marginalised groups. I aimed to conduct this research in a way that would not contribute to experiences of stigma and exclusion for PEH. In the SLR, substance use was a key factor in the intersectionality of stigma theme, being associated with experiences of stigma and exclusion from services and society. A recent report acknowledged that services need to do more to reduce the exclusion faced by people with co-occurring mental health difficulties and substance use, with recommendations for collaborative commissioning and service design (Black, 2021).

To ensure the research was inclusive and accessible to potential service user participants, I was keen to involve people with lived experience of homelessness, often termed “experts by experience” (EbE) in the design of the study materials. I contacted local third-sector organisations and groups who support the involvement of EbE’s in homelessness research and advertised my study to their members. Unfortunately, I did not receive any responses to this advert and due to the time-limited nature of the research project, I decided to progress without this involvement. As I have learnt more about co-production, I recognise the importance of authentic and meaningful involvement that is not tokenistic. True co-production takes time, and does not happen overnight (Homeless Link, 2018). In research this may be achieved by including EbE as contributors at every stage in the research process, to open all doors to allow for real power sharing (Homeless Link, 2018).

I acknowledge that this research is missing a key element of co-production with people with lived experience of homelessness. I recognise that I may have had more success if I had approached the EbE groups in person rather than virtually to build relationships and trust. Furthermore, the inability to offer payment may have been a barrier. I recognise the importance of paying people with lived experience for their contributions when providing an EbE perspective to ensure equity of their participation (Homeless Link, 2023). The importance of co-production was further highlighted when both SLR and empirical results identified the need to include people with lived experience, to ensure research and services meet the needs of PEH. I will take this learning forward into future clinical and research work.

I also recognise the aim to include the voice of PEH through interviews, however only two service users participated. Furthermore, both service user interviews were considerably shorter than others which may indicate less contribution to the overall results. On reflection, service user recruitment may have been improved by attending the PIE services to present the research, so that any potential participants could meet me before the interview. However, developing relationships and trust with PEH often takes time to overcome barriers related to experiences of trauma (Levy, 2021). Unfortunately, this was not possible within the constraints of a thesis project. Furthermore, during conversations with staff working in PIE services, it was advised that the research would be better received if communicated by someone a service user already had a relationship with. This may have supported the recruitment of the two service users who took part, however I recognise it may have also reduced potential contact with other people who may have been interested.

During recruitment, I wondered about the relevance of the research question to capture service user experiences and recorded my thoughts in my reflective diary. However, as the research progressed and during analysis, I developed confidence that the service user contributions added valuable insights to the results. Both service users contributed to key areas of understanding in the developed model related to what makes a PIE work. For example, recommendations for a psychologist in the service with an open-door policy to promote flexibility and build relationships.

Theoretical Standpoint and Reflexivity

Exploring epistemology and developing my understanding of how I view reality has been a process that I have grappled with during this research. Through reading, discussions with supervisors, and self-reflection I feel my views most align with a critical realist viewpoint (Bhaskar, 2016). This stance assumes that an objective reality exists that is external to us and interacts with us (Pilgrim, 2019). Knowledge and research are partially shaped by subjectivity and meaning is socially constructed through how we describe the world (Forrester & Sullivan, 2018; Willig, 1999). Critical realism encourages a critical and reflective approach to research and practice (Pilgrim, 2019), which aligns with how I aim to approach clinical and research work. This enabled consideration of participants' experiences whilst holding in mind wider contextual and social influences, in addition to my role in the research process (Banister et al., 2011).

When conducting the SLR, it was important to acknowledge the influence of my own context as a trainee clinical psychologist and working in a service that supports adults experiencing homelessness. This may have introduced the potential for bias when selecting or interpreting information from the included papers. By adhering to a robust strategy for conducting the review, discussing the process with other members of the research team, and using a reflective diary, this impact was reduced. However, it is acknowledged that the outcome of the synthesis may be different if conducted by another researcher, which highlights the experiences and biases that researchers can bring to the process.

The empirical paper used grounded theory methodology (Charmaz, 2014) which adopts a social constructivist epistemology. This stance states that the beliefs and views of the researcher will influence the model created. Therefore, as part of the research process, I considered the compatibility of critical realism and grounded theory. Critical realist-informed grounded theory has been explored and explained by others, with contemporary grounded theory being more in line with critical realist principles than early grounded theory (Hoddy, 2019; Oliver, 2012). Both grounded theory and critical realism are associated with processes of meaning-making to explore implicit meanings and actions that may not be registered in empirical data (Charmaz, 2006). Both critical realism and grounded theory allowed me to focus on the processes by which staff working in homelessness navigated this work, while at the same time being aware of the negative beliefs and perceptions that surround homelessness in wider society. Critical realism was appropriate for researching the topic of homelessness as it lends itself to recognising the interplay between individual and systemic factors (Fitzpatrick, 2005).

Empirical analysis

The approach employed in the empirical paper was a grounded theory methodology (Charmaz, 2014). Charmaz and Thornberg (2020) highlight that focusing on processes in grounded theory studies ensures the quality and usefulness of the model and theory developed. Previous qualitative research on the PIE model has primarily used thematic analysis approaches to explore experiences (Blackburn, 2012; Buckley et al., 2021; Phipps et al., 2017). Therefore, the current study adds a different perspective to the research base on PIEs by focusing on the process of implementing and developing PIEs in practice. The model and theory developed through this research highlights the different factors involved in making a PIE work and are hoped to have practical utility. The model may be helpful for services that have incorporated the PIE approach or services that may do so in the future. For example, to identify aspects within services that may support the implementation and functioning of a PIE, such as focusing on the engagement factors to drive the process.

Personal reflections

My reasons for choosing this thesis topic and opting for a specialist placement in homelessness relate to my interest in community psychology approaches that promote the voices of the most excluded in society and focus on social justice, inclusion, and empowerment (Jason et al., 2019). I hoped that this research would highlight some of the issues faced by PEH when accessing and engaging with services and give a voice to the perspectives and experiences of PEH. As the research progressed, it was interesting to hear similar views from participants working in homelessness. One participant shared how they previously understood their views aligned with their politics however, recently noticed that these views also aligned with those of psychology and PIEs.

> I believe when I first started from having socialist politics and growing up in a, on a personal level with erm… beliefs in equality. Definitely helped me do the job and I think the politics has swapped with psychology recently in the journey of my own working relationship, and sometimes when we talk about psychology and psychologically informed services, we used to call it having politics and believing in equal opportunities for everybody and not giving up on people. P9, staff

As I come toward the end of the research project, I have reflected on how my understanding of the role of psychology in PIEs and homelessness services has evolved. This has been supported through beginning a clinical placement in a team that supports PEH, and my role involving direct work with clients, and indirect approaches to support staff. This has supported my understanding of the clinical implications of this research and making theory-to-practice links. For example, as with findings in both the SLR and empirical paper, I have seen the benefits when a system around PEH works together, focusing on the engagement factors of relationship building, trust, and communication. I found it helpful to keep a reflective diary to capture my thought processes and ensure that during the analysis I was being guided by the data rather than personal experiences.

An example of this relates to the theme of values in the empirical paper. During the interviews and data analysis, I spent time reflecting on my values and relevance to my role as a trainee psychologist and desire to work in line with my values when I qualify. During an interview with one participant, the below quote resonated with me as I felt it highlighted the importance of work that could happen within a PIE approach. The following reflective diary entry captured my thought process at the time.

> So, I just personally was really passionate about making sure that just because you don't have a home, wanting to be a part of somewhere where actually having psychological support. You know, doesn't, like you would still require that and if not, maybe the most poignant time to kind of have that as well. P6, psychologist

> Reflective diary entry: "Really interesting interview, wonder if resonated with as recently qualified and talked about homelessness placement whilst a trainee. Haven't started placement yet but thinking about how I'll be working in a service with a big focus on engagement, relationships, and bringing support to people rather than expecting them to come to me will be very different. Also making me think about the big range of psychological support, not traditional therapy, sometimes very brief but doesn't mean it's any less valuable. Big focus in this interview on the psychologist's values as a reason why want to work in homelessness. Noticing that this is making me think about the kind of psychologist I want to be when I qualify."

As the theme of values had relevance for me, I ensured that during the analysis process, when this theme was emerging as a conceptual category, I revisited the data to confirm it was spoken about by several participants and not just something I had identified as relevant.

Implications for Practice

In addition to the implications discussed in the empirical paper, there was an interesting discussion from the psychologists about using specific psychological models in PIEs. Within initial guidance for PIEs, there was a focus on developing a psychological framework (Keats et al., 2012), which later shifted to developing psychological awareness through models and techniques (PIElink 2019). During the interviews, I asked psychologists about specific psychological therapies or techniques they drew on as part of the PIE work. It was interesting to hear about a variety of psychological models however, with a consensus that a flexible, integrative approach was most useful.

> God how, how can I capture the complexity of the clients that we get within one particular model? Why can't we just use all of the kind of different ideas in psychology and do what's appropriate for that particular person. P1, psychologist

Some psychologists who took part identified that they chose an overarching model to base their understanding, however this was applied loosely and varied in how explicitly they shared it with staff. One framework that came up consistently was compassion-focused therapy (CFT), in addition to relational approaches such as Cognitive Analytic Therapy and specific techniques such as Motivational Interviewing.

> An overarching model that I found was about compassion, and so it fit with the compassion-focused module. Erm particularly because the way that we do understand trauma as well, which is a, a really key part of PIE and a really key part of working within homelessness. I think that it allows conversations around that in a much softer way, I think a much more reflective way. P6, psychologist

I found these discussions very interesting and noticed myself reflecting on my preferences with psychological models and therapeutic work. However, I was mindful not to let my own views influence the data and again used my reflective diary to be aware of my thought processes.

> Reflective diary entry: Interesting that compassion keeps coming up, makes sense when thinking about working with people who have experienced trauma. Seems to be in contrast to other PIE approaches read about in the literature that use mentalisation

> based approaches. Making me think ahead to starting placement and using CFT but being integrative seems to be important.

Within these discussions was a broader conversation about the skill set of clinical psychologists and how working in a PIE can involve using skills and training differently than working in more traditional mental health settings. Through this research process and current clinical placement, I can see that as a psychologist or any staff member working in a psychologically informed way, focusing on skills related to engagement and relationship building is essential. Some participants shared that this can initially be outside their comfort zone and increase uncertainty. It was reassuring to hear some of my own feelings about this work were shared and reiterated the importance of keeping service users and staff at the centre of the work, in line with pre-treatment ideas (Levy, 2021).

> It's not just the psychologist in the hostel seeing a young person […] it's creating an environment that is more trauma-informed, more focused on relational aspects, thinking about how we treat people how we work with people. It's much bigger psychology than just that tiny narrow, description of being a clinical psychologist that you train to be. It's a fantastic job to be able to be a psychologist in the broadest sense, but it's been a bit of a baptism of fire. P10, psychologist

These discussions led me to consider the role of psychology in homelessness services. As discussed in the empirical paper, psychology in homelessness in the UK is still relatively new, with initial insights from the first five psychologists who worked in homelessness over 20 years ago (Rosebert, 2000). Throughout the research process, I have reflected that although lots has changed, there are still similar challenges linked to the availability of resources. More recently, clinical psychologists working in NHS mental health services link a lack of experience working with PEH with a lack of understanding about what this work looks like or appreciate its' value (Xenophontos, 2020). The model generated in the empirical paper may contribute to the ongoing development of the psychology role. It highlights the helpfulness of having a psychologist in a team, however also the need for collaboration with others to share knowledge and develop the skills of other staff for an intervention to have long-term benefits for those at the centre.

The current study and previous research (Xenophontos, 2020) argue for including teaching on homelessness in clinical psychology training, to enhance the confidence of qualified psychologists working in homelessness. However, the systemic nature of homelessness and the social inequalities this population face will not be addressed by solely increasing training for clinical psychologists (Tickle, 2022). This highlights the role of psychologists working in services to support PEH and staff, in addition to a role in preventative interventions. Through the interviews, it was clear that a psychologist's role in a PIE was a position of leadership, and the psychologists interviewed varied in the ratio of direct work, indirect work, and leadership duties. Training for clinical psychologists includes leadership competencies and when qualified are expected to be competent in working at different levels to support the system (Skinner et al., 2010). The model developed through this research highlights the different levels of intervention and leadership roles involved in a PIE homelessness service. This could include the involvement of psychologists in service design or commissioning processes to influence the allocation of funding.

> From the point where you are starting to think about designing or commissioning a PIE service, actually consulting with a psychologist could be helpful. And I think that's a huge thing that's often missed. P4, psychologist

Future research into PIEs may benefit from including the voices of people involved in the commissioning process. This may support an understanding of the process of allocating funding and designing service contracts in the context of current budget cuts and economic austerity. As with the current research, Making Every Adult Matter (MEAM) describes short-term funding as a barrier to systemic change and advocates for joint funding and commissioning across the homelessness sector (MEAM, 2022).

Conclusion

This critical appraisal has aimed to draw attention to my role within the research process, to enhance transparency and reduce bias. This research aimed to contribute to the understanding of homelessness and mental health, with a particular focus on PIEs. The role of clinical psychologists has been a focus of this exploration; however, the overarching theme is the need to focus on intervention at different levels in the system. It is hoped that this research can support services working with PEH and most importantly the individuals who provide support and those who are at the centre of support systems.

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Section 4 Ethics Form

Rosa Pitts

Lancaster University

Doctorate in Clinical Psychology

Ethics Governance Checklist

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the Research a Support Office website.

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

Name: Rosa Pitts **Department**: Division of Health Research

Title of Project: What makes a Psychologically Informed Environment (PIE) in a homeless service work? Views from staff and service users. **Supervisor** (if applicable): Suzanne Hodge

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)

b. Animals - the term animals shall be taken to include any non-human vertebrates, cephalopods or decapod crustaceans.

c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress

d. Human cells or tissues other than those established in laboratory cultures

e. Risk to the environment

f. Conflict of interest

g. Research or a funding source that could be considered controversial

h. Any other ethical considerations

Section 1A response: ☑ Yes - complete Section 1B

☐ No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

If your research is not being reviewed by an NHS Research Ethics Committee, any other external ethics committee or one of the Lancaster University local ethics committees (e.g Psychology Department Ethics Committee, Faculty of Health and Medicine Research Ethics Committee) then it will be considered by the University Research Ethics Committee (UREC).

UREC offers an expedited short form review for more straightforward projects and more in depth review by the full committee for projects that raise more complex issues. Further information is available from the Research Support Office website; if you are unsure of the approval route to use for your project please contact the Research Ethics Officer for advice.

Ethical approval is not required at the time the proposal is submitted, but please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the Research Ethics Officer will advise on the most suitable method according to the specific circumstances.

1.2 Please indicate which item(s) listed in section 1A apply to this project (use the appropriate letter(s), eg a,c,f)

Items: a. Human participants

1.3 Please indicate which committee(s) you anticipate submitting the application to:

☐ NHS ethics committee

☐ Other external committee

☐ LU FST REC

☑ LU FHM REC

☐ LU FASS & LUMS REC

☐ AWERB (animals)

Section 2: Project Information

This information in this section is required by the Research Support Office (RSO) to expedite your proposal and/or award

2.1 If a statement of institutional commitment is required by the funder (such as a letter of support from the VC or PVC Research), please indicate below and liaise with RSO as soon as possible.

☐ Statement of institutional commitment required

Please note: If match funding is required please inform RSO (if you have not already done so). It is the PI's responsibility to notify their HoD that match funding is required before the costing is submitted for approval.

2.2 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

☐ Establishment of a research ethics committee required

2.3 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

Section 2 notes: Click here to enter text.

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see Data Protection website
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see FOI website
- The University's Research Data Policy can be downloaded here
- The health and safety requirements of each research project must be considered, further information is available from the Safety Office website
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the Research Ethics Officer for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the Head of Research Services (ext. 94905)
- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the Intellectual Property Development Manager (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the Intellectual Property Development Manager (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the University Secretary for further details

- Online Research Integrity training is available for staff and students here along with a Research Integrity self-assessment exercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

☑ Confirmed

Section 4a: Statement Part 1

4.1 I confirm that while preparing this application I asked for and received advice from the following people (minimum 2 colleagues who are not closely involved with the proposal i.e. excluding staff named on the proposal)

Names: Craig Murray

Section 4b: Statement Part 2

4.2 I understand that as Principal Investigator I have overall responsibility for the financial and ethical management of the project and confirm the following:

- I have read the Code of Practice, Research Ethics at Lancaster: a code of practice and I am willing to abide by it in relation to the current proposal
- I have completed the ISS Information Security training and passed the assessment
- I will manage the project in an ethically appropriate manner according to: (a) the subject matter involved; (b) the code of practice of the relevant funding body; and (c) the Code of Practice and Procedures of the university.
- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for the exploitation of intellectual property.
- I will give all staff and students involved in the project guidance on the good practice and ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students here.)
- I will take steps to ensure that no students or staff involved in the project will be exposed to inappropriate situations.

☑ Confirmed

Please note: If you are not able to confirm the statement above please contact Faculty Research Ethics Officer and provide an explanation

Applicant

Name: Rosa Pitts Date: 7/10/21 Signature:

***Supervisor (if applicable):**

Name: Suzanne Hodge Date: 7/10/21 Signature:

**I declare that I have reviewed this application, and discussed it with the applicant as appropriate. I am happy for this application to proceed to ethical review.*

Head of Department
(or delegated representative)

Name: Bill Sellwood Date: 11/10/21 Signature:

Please return this form to your Faculty Research Ethics Officer

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Title of Project: What makes a Psychologically Informed Environment (PIE) in a homeless service work? Views from staff and service users.

Name of applicant/researcher: Rosa Pitts

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

X Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

2. Contact information for applicant:

E-mail: r.pitts1@lancaster.ac.uk **Telephone**: 07710245293 (please give a number on which you can be contacted at short notice)

Address:

3. **Names and appointments of all members of the research team (including degree where applicable)**

Chief Investigator/ Academic Supervisor: Dr Suzanne Hodge

Field Supervisor: Dr Anna Duxbury

Field Supervisor: Dr Colm Gallagher

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐]
DClinPsy Thesis X

4. Project supervisor(s), if different from applicant:

Chief Investigator/ Academic Supervisor: Dr Suzanne Hodge

Field Supervisor: Dr Anna Duxbury

Field Supervisor: Dr Colm Gallagher

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr Suzanne Hodge, Lecturer, Lancaster University

Dr Anna Duxbury, Clinical Tutor & Clinical Psychologist, Lancaster University

Dr Colm Gallagher, Clinical Psychologist & Clinical Lead Homelessness, Manchester Mental Health and Homeless Team

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line ‘chat-rooms’ no

4c. If yes, where relevant has permission / agreement been secured from the website moderator? no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

People who are homeless often go through difficult early life experiences which may mean that they end up without a safe place to live. Whilst being homeless it is also common for people to struggle with their mental health. Recently, homeless services try to be trauma-informed to support the complex needs of their service users. A psychologically informed environment (PIE) is one approach that looks at the wellbeing of both service users and staff through developing psychological ideas and building relationships. Research shows that how services are using PIEs can be different and there is not much research directly with staff and service users. This study will use qualitative interviews to find out what makes a PIE work well and anything that might be a barrier from the point of view of staff and service users. What participants say will help develop a model to explain what is involved when using PIEs in homeless services.

2. **Anticipated project dates (month and year only**)

Start date: 01/2022 End date: 04/2023

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The participants will be either psychologists, staff or service users recruited from homelessness services in the XXXXXX. The recruitment target aims to recruit at least one participant from each group from approximately 3 services, aiming for a minimum of 9 and maximum of 15 participants. To meet inclusion criteria, participants will be over the age of 18, have capacity to provide informed consent and consent to relevant safeguarding requirements. Due to the time limited nature of the study, participants will be English speaking.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

The researcher will contact an appropriate or named person in the organisation to discuss the study and recruitment. Prior to attending the service, agreement from the service manager will be obtained in addition to compliance with any required approval processes. The researcher will attend service/staff/resident meetings to share information about the research and speak to potential participants. All services will be given participant information sheets (PIS) Appendix C,D), interested people will have the option to contact the researcher directly or leave their details on a response slip (Appendix E). If necessary to aid recruitment, participants may also be recruited via the social media platform Twitter or through the Homeless Psychologists Network.

Purposive sampling will be used initially to select who takes part in the study. The researcher(s) will make decisions about who to include in the sample based on a variety of criteria, including job role of staff (psychologist, other) or whether they are a service user, in addition to time in PIE service, amount of training or psychological input for staff. Sampling in this way will allow consideration of who would be most likely to contribute appropriate data, both in terms of relevance and depth. Theoretical sampling will be used in later stages of data collection as key categories and concepts emerge, to identify participants likely to have specific relevant experience, e.g.- job role. Participants will be informed through the PIS that there may be a chance they are not selected for the study, if this is the case the researcher will explain reasons for this.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

The interviews will primarily be conducted within the homeless service the participant has been recruited from or remotely via telephone or video software (e.g., Microsoft Teams). The researcher will ensure there is a private space available for the interviews to ensure confidentiality. The researcher will take responsibility for understanding and following policies and procedures within the service including those related to risk or COVID-19.

The analysis employed in this study will follow the approach to grounded theory described by Charmaz (2006). The process will involve a cycle of coding the data and memo writing leading to the creation of themes. Once this stage of the analysis is complete, the next stage will be developing the theory. This will involve theoretical sorting, creating new memos, using diagrammatic representations and integrating memos and categories.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Interviews will be recorded on an encrypted, portable device, once completed the audio file will be uploaded to the researcher's University OneDrive folder, password protected and removed from the recorder.

Transcription will take place at the researcher's home address or within Lancaster University, completed on a university allocated laptop which is password protected. Any paper documents with identifiable information such as consent forms will be stored separately from any data collected. In paper form this will be in a locked cabinet in the researcher's home. The paper documents will be scanned and saved electronically in a different location of the OneDrive folder to the data. Once an electronic copy has been created the paper copies will be destroyed using a shredder. Access to the OneDrive folder will be granted to the academic and field supervisors who are Lancaster University staff.

7. Will audio or video recording take place? ☐ no X audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Interviews will be recorded on an encrypted portable device.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The interview will be digitally recorded and once the file has been uploaded to the researcher's University OneDrive folder it will be password protected and removed from the recorder. Once a transcript has been completed with any identifiable data anonymised and accuracy checks completed the digital recording will be erased from the computer. Data in the form of the interview transcripts will be kept for 10 years as recommended in University guidance.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will be saved and stored by the research coordinator at Lancaster University for 10 years following completion. As this study will generate small qualitative data, to preserve the anonymity of participants the data will not be publicly available.

8b. Are there any restrictions on sharing your data ?

All steps will be taken to preserve the anonymity of participants, however due to small scale nature of study it may be possible for participants to identify themselves in the data, therefore data will not be publicly available.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?
Yes

b. Detail the procedure you will use for obtaining consent?
Before beginning the interview, the researcher will go through the PIS and offer time for any questions. If the participant agrees to continue, the researcher will obtain written consent for participation using the consent form (Appendix G). If the interview is conducted via telephone or via Teams a copy of the consent form will be sent via post or email prior to the interview and participants will be asked to return a signed copy to the researcher.

It is expected that during recruitment, queries around capacity for informed consent of potential participants may arise. In line with the Mental Capacity act (MCA) a person must be assumed to have capacity until it is established otherwise (MCA, 2005). Within guidelines from the MCA and British Psychological Society (2008) the researcher will judge a decision to participate in the research on the basis of: freedom of choice and absence of coercion; an understanding of the research and aims; and an understanding of potential risks and benefits. If the participant is believed to have capacity an interview will be arranged. If the potential participant is not considered to have capacity the researcher will discuss this with the participant and the implications on eligibility for the study. If appropriate and consent is given, the service user's key worker can be informed of the outcome and support the individual following the decision.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

The study will be conducted in a way to minimise distress. Consideration will be given to the potentially stressful impact of research activities and the discussion of potentially distressing information on the individual. Within the PIS and prior to the interview, participants will be reminded they can take breaks during the process and ask to stop the interview at any point. The researcher will use their clinical skills to monitor the participant's emotional state and if necessary, use clinical skills to contain distress. Following the interview and within the PIS, information on who participants can contact for support within their service and external agencies will be provided.

Participants will be informed via the PIS and verbally that they are welcome to withdraw from the study at any time before or during the interview and up to 1 week following their interview. After this point it may not be possible to remove their data due to the nature of grounded theory with data informing the ongoing interview process. However, if possible, every attempt will be made to extract the data.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

All face-to-face interviews will take place within the homeless service, during which the researcher will be in a private room with the staff/service user. There will be other people present in the building whilst the interviews take place. The researcher will adopt LSCFT lone worker guidance and follow this procedure during recruitment and data collection:

- Prior to conducting an interview, the researcher will be familiar with the service layout, policies and have a named contact who is aware that the interview is taking place.
- The researcher will inform academic/field supervisor when an interview is booked with details of where, times of interview and expected finish time.
- Before and after an interview the researcher will text the supervisor, if the researcher does not make contact when expected the supervisor will contact the named contact within the service.
- The researcher will have access to a Peoplesafe 'MySOS device' should there be an incident during the interview process where the researcher requires emergency support.

The researcher will be able to access support from supervisors who are Clinical Psychologists following interviews if necessary to debrief following discussion of sensitive and distressing topics.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There are no direct benefits to participation in this study. However, taking part will allow staff and service users to share their experiences of a PIE homeless service, which will aid our understanding of this topic and the model generated may contribute to the evidence base for future PIE services to consider.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

It is not anticipated that participants will need to claim travel expenses as interviews will take place at the service the participant works/lives. Participants will not be reimbursed monetarily for their time, refreshments will be provided during the interviews.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

Yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

During recruitment, to aid with theoretical sampling, the researcher will collect name, length of time in service and contact details through the participant response slip following an expression of interest in the study from a potential participant. This information will be kept separate from the research data and anonymised with a participant ID. Furthermore, consent forms will be stored separately from any data collected, in paper form this will be in a locked cabinet. The paper documents will be scanned and saved in a different location of the OneDrive folder to the data. Once an electronic copy has been created the paper copies will be destroyed using a shredder. Access to the OneDrive folder will be granted to the academic and field supervisor who are Lancaster University staff.

During analysis, all identifiable information will be removed from the interview transcripts. For the write up of the research, direct quotes from participants will be used however with a pseudonym to protect anonymity. Participants will be offered the opportunity to choose their pseudonym.

All participants will be informed via PIS and verbally before taking part in the research that if safeguarding concerns arise during the interview, then confidentiality will be breached. For service users if there are disclosures of risk, the consent form will require permission for the researcher to contact their key worker. For the staff interviews if there are disclosures which highlight concerns related to staff practice, the consent form will require permission for the researcher to contact their line manager. Any safeguarding concerns will be discussed with either academic or field supervisor(s) and acted on accordingly following local policies and procedures.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The research materials such as PIS and advert will be reviewed by Expert(s) by Experience, who have lived experience of homelessness. This may result in minor changes to wording, layout or font to make the materials more accessible for the participants. Minor changes may include changing a word(s) to make the materials easier to understand, or changes to make the font bigger or to include a picture. The recommendations from the EbE(s) will not alter the content of the research materials, or change any details which relate to ethical considerations e.g.- confidentiality.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Participants involved in the research will be offered an accessible summary report of the findings and the services involved in recruitment will be offered a presentation of the results. The research findings will also be written up for submission to a suitable academic journal for dissemination within the research field. Finally, results of the study will also be shared via the researcher’s professional twitter account.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

N/A

SECTION FOUR: signature

Applicant electronic signature: R.Pitts Date 08/10/21

✓ Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review

Project Supervisor name (if applicable): Suzanne Hodge Date application discussed 8/10/21

Submission Guidance

1. **Submit your FHMREC application <u>by email</u> to Becky Case (**fhmresearchsupport@lancaster.ac.uk) as two separate documents:

i. **FHMREC application form.**
Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

ii. **Supporting materials.**
Collate the **following materials for your study, if relevant, into a single word document:**

  a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
  b. Advertising materials (posters, e-mails)
  c. Letters/emails of invitation to participate
  d. Participant information sheets
  e. Consent forms
  f. Questionnaires, surveys, demographic sheets
  g. Interview schedules, interview question guides, focus group scripts
  h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

   i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

   ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

      a. existing documents/data only;
      b. the evaluation of an existing project with no direct contact with human participants;
      c. service evaluations.

3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

Appendices

Appendix A- Research Protocol

Title: What makes a Psychologically Informed Environment (PIE) in a homeless service work? Views from staff and service users.

Chief Investigator/ Academic Supervisor: Dr Suzanne Hodge

Researcher: Rosa Pitts

Field Supervisor: Dr Anna Duxbury

Field Supervisor: Dr Colm Gallagher

Introduction

In the United Kingdom (UK) the number of people recorded as homeless has increased in recent years (Reynolds, 2018), with a figure of 280,000 people reported in England in 2019 (Fitzpatrick et al., 2019). Homelessness is defined as "not having a home" and includes a range of circumstances from living in temporary accommodation to those who sleep and live on the streets (Shelter, 2018). A multitude of factors contribute to the number of people without appropriate housing, including wider societal influences such as poverty (Johnsen & Watts, 2014), and an imbalance between housing demand and supply with limited affordable social housing (Fitzpatrick et al., 2019). People who experience long-term poverty, particularly during childhood, with a lack of social support networks are at higher risk of becoming homeless (Bramley and Fitzpatrick, 2018).

Homelessness and mental health

Increasing understanding and support for people experiencing homelessness is important to clinical psychology due to the complexity of support needs within this population. People who are homeless are reported to experience mental health difficulties, physical health problems and engage in previous or current substance use (Mackie et al., 2017). Longer periods of homelessness are associated with increased risks of long-term mental health difficulties, due to the increased likelihood of stressful and traumatic experiences (Lippert & Lee, 2015). Additionally, homeless people are likely to have experienced childhood trauma and complicated family relationships before becoming homeless (Homeless Link, 2017; Mackelprang et al., 2014). Experiences of adverse childhood experiences (ACEs) and trauma are associated with impaired attachment patterns, which in adulthood can influence forming relationships, the ability to trust others and emotional regulation (Danquah & Berry, 2013).

This complex relationship between experiences of trauma, mental health and homelessness indicates the importance of psychological and trauma-informed support.

Staff of homeless services

Staff working in homeless services report working with people with complex mental health and relational difficulties, in addition to managing complex behaviours such as aggression and self-harm (Benson & Brennan, 2018). Despite supporting people with complex needs, referrals to mental health services are often rejected, subject to delays or ignored (Arslan, 2013) and staff often have minimal clinical training and rarely receive support for their wellbeing (Keats et al., 2012). Working in such challenging circumstances can influence the emotional health of staff, increase stress levels, feelings of frustration and burnout (Arslan, 2013; Rogers et al., 2020). Burnout in staff can be in response to organisational pressures such as unmanageable workloads and include emotional exhaustion and feeling unsupported at work (Lemieux-Cumberlege & Taylor, 2019). Staff also report tension between providing person-centred care and the reality of support being rationed and out of their control, resulting in feelings of helplessness (Johnson et al., 2012). These feelings may influence how a staff team functions, with activities that should be helpful such as meetings, training or supervision becoming a source of tension and contributing to stress levels (Johnson et al., 2012).

Accommodation services for homeless people

In addition to the barriers facing homeless people with accessing mental health services, access to long-term housing support is also a challenge. Services including temporary shelters, hostels and day centres often implement rules around behaviour and substance use which result in high rates of eviction and a return to rough sleeping (Keats et al., 2012). This cycle of accessing support followed by eviction is unhelpful for the individuals and influences staff morale (Homeless Link, 2015). With regards to policies, NICE guidelines for health and social care for people who are homeless are in the process of development (NICE, 2020).

A shift to Psychologically Informed Environments

To meet the psychological and emotional needs of both users and staff of homeless services, psychologically informed environments (PIEs) were developed to enhance psychological thinking within services (Johnson & Haigh, 2010). Central to PIEs is a focus on relationships between staff and service users, psychological support to promote wellbeing, and elastic tolerance to reduce evictions and reliance on strict rules (Keats et al., 2012). Additionally, enhancing psychological awareness through training for staff in psychological models and the development of a trauma informed approach are key (PIElink, 2019). There is guidance available for implementing PIEs (Appendix A) however recent updates describe PIEs as a lens to view a service through rather than a required checklist to allow flexibility in implementation (PIElink, 2019).

Following implementation of PIE principles into homeless services there is evidence of their effectiveness at policy level, with reduced costs to health, social care and criminal justice systems (Cockersell, 2011; Ritchie, 2015; Quinney & Richardson, 2014). In addition to service level changes, with improved warning and eviction policies reducing the short-term nature of homeless accommodation placements (Ava, 2017; Benson & Brennan, 2018; Cockersell, 2016; Herbert, 2019; Williamson, 2018). Benefits have also been linked to changes with staff, such as enhanced staff confidence, understanding of trauma-informed practices and well-being (Cumming et al., 2017; Fulfilling Lives, 2019; Maguire et al., 2017).

Some qualitative investigations have been conducted with staff which found improved psychological awareness, enhanced empathy towards clients and greater awareness of functions of behaviour in line with trauma-informed support (Buckley et al., 2020; Fulfilling Lives, 2016). These changes were associated with improved interactions with clients, managing relationships and the importance of communication, all key elements of PIEs (Ava, 2017; Focus Ireland, 2014; Fulfilling Lives, 2016). Some staff in PIE homeless services identified improvements to their wellbeing with reduced feelings of stress and improved team dynamics following attendance at reflective practice discussions (Fulfilling lives, 2019) and team formulation meetings (Buckley et al., 2020).

There has been some research directly with service users of PIE homeless services, however this evidence base is in its infancy. Themes from service users include the importance of the relationships with staff, increased support related to making meaningful changes and breaking negative cycles, in addition to improved understanding of links between behaviours and emotions (Blackburn, 2012; Phipps et al., 2017; Quinney & Richardson, 2014; Revolving Doors Agency, 2019).

The above literature indicates that implementation of PIEs in homeless services produces beneficial outcomes at numerous levels. A barrier to implementation of PIE reported by staff is balancing normal job demands alongside additional PIE responsibilities (Fulfilling Lives, 2019; Phipps et al., 2017). Further research into barriers with the implementation process is needed. A literature review of PIEs in homeless services highlighted the considerable variation in service design and outcomes reported, which limits direct comparisons and highlighted the need for additional research into PIEs (Breedvelt, 2016). A key consideration when conducting future research will be the impact of the COVID-19 pandemic on homeless individuals, services and the ability to deliver PIEs. Understanding of the impact of COVID-19 on the homeless sector is still developing, however a rise in poverty and unemployment is expected to affect those already experiencing disadvantages (Whitehead et al., 2021). In the context of PIE, the effect of social distancing on team dynamics and restrictions on the ability to form PIEs would need to be considered.

Relevance to Clinical Psychology

As outlined above, the complexity of support needs within the homeless population indicates the importance of psychological and trauma-informed support. Within services where PIEs have been implemented, psychologists have often been involved with the set up and running of key elements such as staff reflective practice groups (Keats et al., 2012). The benefits of having a clinical psychologist embedded within the service have been shown for both staff and service users. For example, staff are reported to view reflective practice groups more positively when the psychologist has visited the service (Revolving Doors Agency, 2019). For service users, direct engagement with the psychologists was associated with reduced self-harm, aggression and depression, in addition to improved interpersonal relationships and engagement with activities of daily living (Williamson, 2018).

Research Aims

The outlined research and policy highlights that the process of implementing PIEs is unclear and whilst there are guiding principles, PIEs are developed in a unique way to meet a specific service need. This study will aim to build on the existing knowledge base to explore what processes contribute to a successful PIE and which may be a barrier to implementation. Due to the limited qualitative research with staff and service users, this study will aim to include the voices of different stakeholders. It is anticipated that some staff and service users will be new to psychological ways of thinking and so exploring how PIE principles are embedded in the service will contribute to the evidence base.

The research question will be: What makes a Psychologically Informed Environment (PIE) in a homeless service work?

To address this question the aims will be to explore:

1. What is currently happening in homeless services that have implemented/are currently implementing PIE principles;
2. Who and what is involved in decisions around setup and design of a PIE;
3. What people involved think works well and what needs to change.

The questions will be explored using qualitative methods to include the views of people involved in the implementation and experience of a PIE in a homeless service.

Rationale

Grounded Theory will be employed to develop understanding and lead to the generation of an explanatory model of the processes in the research aims. The model will be developed from information and examples of the process of PIE implementation sought from different perspectives including clinical psychologists involved with the setup, staff who work in the service and the service users who experience the service. The approach will contribute to the developing research area of PIEs in homeless services and inform future research in the field, in addition to clinical practice.

Method

Research design

This study will use a qualitative methodology and semi-structured interviews to explore the experiences of service users, staff and psychologists in the process of PIE implementation in homeless services. The research will adopt a social constructionist epistemological stance to acknowledge the presence of multiple social realities, with none being objectively true (Charmaz, 2006). In line with grounded theory's inductive, iterative approach to data collection and analysis, the topic guide (Appendix B) will be reviewed and updated as necessary at each stage of data collection (e.g., before the next interview).

Participants

The participants will be people who have experience of a PIE homeless service, this may be through involvement in the process of implementing PIE or experience of providing or receiving support from the service. The participants will be either psychologists, staff or service users. Participants will be recruited from homeless services that have incorporated a PIE approach. Services will be identified through contacts from the field supervisors who also work in a PIE homeless service. If necessary to aid recruitment, participants may also be recruited via the social media platform Twitter or through the Homeless Psychologists Network. This will be done via posting an advert (Appendix H). Participants will be given the choice of a face to face or remote interview, due to the time limited nature of the research project face to face interviews will be limited to the XXXXX.

Staff:

Inclusion criteria:

- Staff involved in the implementation of a PIE in a homeless service.
- Capacity to provide informed consent to participate in the research.
- Consent to line manager being contacted regarding any practice issues.

Exclusion criteria:

- Under the age of 18

Service users:

Inclusion criteria:

- Service user receiving support from a PIE homeless service.
- Consent to key worker being contacted regarding any risk issues.

- Capacity to provide informed consent to participate in the research.

Exclusion criteria:

- Under the age of 18

Sampling

Purposive sampling will be used initially to select who takes part in the study. The researcher(s) will make decisions about who to include in the sample based on a variety of criteria, including job role of staff (psychologist, other) or whether they are a service user, in addition to time in PIE service, amount of training or psychological input (for staff). Sampling in this way will allow consideration of who would be most likely to contribute appropriate data, both in terms of relevance and depth. This may mean that not everyone who expresses an interest in the study will necessarily take part. The total number of participants will be dependent on theoretical sampling and data sufficiency (Charmaz, 2006). Theoretical sampling will be used in later stages of data collection as key categories and concepts emerge, to identify participants likely to have specific relevant experience. Data sufficiency will be used at the stage where categories within the data do not need to be revised, therefore no new participants will be recruited.

Demographic information

Demographic information will be included in the research paper to provide context for the sample. The following demographic information will be collected at the interview stage, following completion of a consent form:

- Role: psychologist, staff, service user
- Age
- Gender
- Ethnicity
- Time in service
- Length of time working within PIE approach
- Amount of training/ psychological input
- Type of psychological interventions used within the service

Setting

The interviews will primarily be conducted within the homeless service the participant has been recruited from or remotely via telephone or video software (e.g., Microsoft Teams). The researcher will ensure there is a private space available for the interviews to ensure confidentiality. The researcher will take responsibility for understanding and following policies and procedures within the service including those related to risk or COVID-19.

Procedure

The researcher will contact an appropriate or named person in the organisation to discuss the study and recruitment. Prior to attending the service, agreement from the service manager will be obtained in addition to compliance with any required approval processes. With the service's consent the researcher would attend service/staff/resident meetings to share information about the research and speak to potential participants. All services will be given participant information sheets (PIS) (Appendix C and D), interested people will have the option to contact the researcher directly or leave their details on a response slip (Appendix E & F).

The researcher will discuss the PIS with the potential participant, if necessary, a copy will be sent via post or electronically. The participant response slip (Appendix E & F) will collect information on role and length of time in PIE service to aid with theoretical sampling. If the individual agrees to participate and fits with the sampling decision a date for the interview will be arranged. An interview will take place at least 48 hours after the person receives the PIS to allow time to understand the study and consider whether to take part.

Before beginning the interview, the researcher will go through the PIS and offer time for any questions. If the participant agrees to continue the researcher will obtain written consent for participation using the consent form (Appendix G). If the interview is conducted via telephone or via Teams a copy of the consent form will be sent via post or email prior to the interview and participants will be asked to return a signed copy to the researcher.

It is anticipated that during recruitment queries around capacity for informed consent of potential participants may arise. In line with the Mental Capacity act (MCA) a person must be assumed to have capacity until it is established otherwise (MCA, 2005). Within guidelines from the MCA and British Psychological Society (2008) the researcher will judge a decision to participate in the research on the basis of: freedom of choice and absence of coercion; an understanding of the research and aims; and an understanding of potential risks and benefits. If the participant is believed to have capacity then an interview will be arranged. If the potential participant is not deemed to have capacity the researcher will discuss this with the participant and the implications on eligibility for the study. If appropriate and consent is given, the service user's key worker can be informed of the outcome and support the individual following the decision.

Qualitative Methodology; informed by Grounded Theory

The participants will initially meet with the researcher once to conduct the interview however, in line with Grounded Theory, if there is a need to clarify or gather further information they may be asked if the researcher can contact them again. The interview topic guide (Appendix B) will include semi structured, open-ended questions to encourage participants to give their personal experiences and views. In line with grounded theory, the topic guide may be adapted as recruitment progresses to become more focused and reflect themes occurring in collected data. It is anticipated that interviews will last approximately 45-60 minutes.

Participants will be informed (PIS and verbally) that if they wish to withdraw from the study, they have one week following the interview, after which it may not be possible to remove their data. This is due to the nature of grounded theory with data informing the ongoing interview process.

Proposed Analysis

The analysis employed in this study will follow the approach to grounded theory described by Charmaz (2006). A constructivist approach will be adopted which assumes that theories are constructed through the research process as a result of interpretation of both researchers and participants. The analysis process will begin with line-by-line coding of a transcript followed by focused coding where important information linked to the research question is identified. The process will involve a cycle of coding the data and memo writing, constant comparisons will be made within and between transcripts. Subsequent transcripts will be coded with previous transcripts in mind, to compare data with data. Memo writing will be used to define and elaborate categories once developed and inform ongoing hypotheses and ideas arising from the data. Data collection will continue until saturation of analytical themes occurs. Once this stage of the analysis is complete, the next stage will be developing the theory. This will involve theoretical sorting, creating new memos, using diagrammatic representations and integrating memos and categories.

Dissemination

There will be multiple levels of dissemination to ensure the research findings are shared widely. Participants involved in the research will be offered an accessible summary report of the findings and the services involved in recruitment will be offered a presentation of the results. The research findings will also be written up for submission to a suitable academic journal for dissemination within the research field. Finally, results of the study will also be shared via the researcher's professional twitter account.

Practical issues (e.g., costs/logistics)

Confidential Information and Research Data

The researcher will have access to personal information through the demographic information sheet once a potential participant has expressed an interest in taking part in the study (as outlined in the method section). This information will be kept separate from the research data and anonymised with the participant ID. The interviews will be digitally recorded and once uploaded to the researcher's OneDrive folder will be password protected and removed from the recorder. Interviews will be transcribed by the researcher as soon as possible following completion. Any identifiable information within the transcript will be removed and files will be password protected. Once a transcript has been completed and checked the digital recording will be erased from the computer. Transcription will take place at the researcher's home address or within Lancaster University, completed on a university allocated laptop which is password protected. Any paper documents such as consent forms will be stored separately from any data collected, in paper form this will be in a locked cabinet at the researcher's home. The paper documents will be scanned and saved in a different location of the OneDrive folder to the data. Once an electronic copy has been created the paper copies will be destroyed using a shredder. Access to the OneDrive folder will be granted to the academic and field supervisors who are Lancaster University staff.

For the write up of the research, direct quotes from participants will be used however with a pseudonym to protect anonymity. Participants will be offered the opportunity to choose their pseudonym.

Expenses

Any research costs of photocopying, printing and posting will be covered by the researcher's personal budget allocated from Lancaster University. It is not anticipated that participants will need to claim travel expenses as interviews will take place at the service the participant works/lives. Participants will not be reimbursed monetarily for their time, refreshments will be provided during the interviews.

Practical issues:

If COVID-19 restrictions limit opportunities for face-to-face interviews, remote interviews via Teams or phone could be conducted. The researcher will follow policies within the service related to COVID-19 such as social distancing and PPE if required.

Ethical concerns

The study will be conducted in a way to minimise distress and with consideration of the potentially stressful impact of research activities and discussion of potentially distressing information on the individual. Within the PIS and prior to the interview, participants will be reminded they can take breaks and ask to stop the interview at any point. The researcher will use their clinical skills to monitor the participant's emotional state and if necessary, use clinical skills to contain distress. Following the interview and within the PIS, information on who participants can contact for support within their service and external agencies will be provided.

Furthermore, both staff and service users will be advised that if there are safeguarding concerns then confidentiality will be breached. For service users if there are disclosures of risk, the consent form will require permission for the researcher to contact their key worker. For the staff interviews if there are disclosures which highlight concerns related to staff practice, the consent form will require permission for the researcher to contact their line manager. Any safeguarding concerns will be discussed with either academic or field supervisor and acted on accordingly following local policies and procedures. At the end of the interview, the participants will be de-briefed verbally to recap the purpose of the study, the withdrawal procedure and the researcher's contact details.

All face-to-face interviews will take place within the homeless service, during which the researcher will be in a private room with the staff/service user. There will be other people present in the building whilst the interviews take place. The researcher will adopt LSCFT lone worker guidance and follow this procedure during recruitment and data collection:

- Prior to conducting an interview, the researcher will be familiar with the service layout, policies and have a named contact who is aware that the interview is taking place.
- The researcher will inform academic/field supervisor when an interview is booked with details of where, times of interview and expected finish time.
- Before and after an interview the researcher will text the supervisor, if the researcher does not make contact when expected the supervisor will contact the named contact within the service.
- The researcher will have access to a Peoplesafe 'MySOS device' should there be an incident during the interview process where the researcher requires emergency support.

Timescale

- Apply to ethics committee: September-October 2021
- Data collection: January-August (inclusive) 2022
- Data analysis: April- October (inclusive) 2022
- 1st draft of introduction and method: May-June (inclusive) 2022
- Complete 1st draft: December 2022
- Complete 2nd draft: February 2023
- Submit thesis: March 2023
- Dissemination: June 2023

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Table of PIE Guidance

Key elements of a PIE	Details
Keats et al (2012): Good Practice Guide	
Developing a psychological framework	A commitment to the introduction of a psychological informed approach (e.g.- psychodynamic, CBT, DBT, ACT, MBT etc). Must be made explicit to staff.
The physical environment and social spaces	Thoughtful design to consider the effect of the environment on mood and behaviour, a welcoming, safe space to meet different levels of engagement required. Consideration of formal vs informal spaces, kitchen/dining facilities, well decorated, noise/acoustics, light, open/green spaces.
Staff training and support	Increased psychological understanding to facilitate interactions and enhance skills for managing conflict. Introduction of reflective practice and supervision sessions.
Managing relationships	Relationships principal tool for change, interactions between staff and service users an opportunity for development and learning. Promote ownership of behaviour and shift power balance in context of previous (abusive) relationships. E.g.- review eviction protocols, 'elastic tolerance', consistency and opportunities for service users to modify behaviour.
Evaluation of outcomes	Evidence generating practice 1. Policy level measures e.g.- reduction in antisocial behaviours or emergency service use. 2. Service level measures e.g.- quality of relationships, reduction in evictions 3. Individual measures e.g.- meaningful and realistic, focus on relationships and emotions.
PIElink (2019)	

Psychological awareness	Developing more 'psychological awareness' of the needs of service users: emotional awareness, psychological techniques, psychological models
Training and support for staff	Valuing training and support for staff (and volunteers) as well as service users to understand psychological and emotional trauma
Learning and enquiry	Creating a service culture of constant learning and enquiry: an attitude and atmosphere of learning, reflective practice, evidence generating practice
Spaces of opportunity	Creating and/or working with 'spaces of opportunity': the built environment and its ‘social spaces’, local surroundings and networks, referral pathways and systems
The Three Rs: rules, roles and responsiveness	Fine-tuning the 3 Rs 4. the rules of the service, that govern the day-to-day operations 5. the roles that are available - for both staff and users 6. the ways in which the service works - the responses or responsiveness to events.

Lancaster University

Participant information sheet (staff)

What makes a Psychologically Informed Environment (PIE) in a homeless service work?
Views from staff and service users.

My name is Rosa Pitts and I am a student in the Doctorate of Clinical Psychology programme at Lancaster University, England. As part of this, I am conducting a research study which I would like to invite you to take part in. Before you decide whether you would like to participate, it is important to understand why the research is being done and what you will be asked to do, so you can make an informed decision. Please read the following information and feel free to ask any questions before deciding.

What is the study about?

This study aims to explore the process of implementing a psychologically informed environment (PIE) in a homeless service. The research aims to understand what is happening in these services, what works well and what needs to change from the perspectives of staff and service users.

Why have I been approached?

I have approached you because you are currently working in a homeless service which uses PIE principles. I would be very grateful if you would agree to take part in this study.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. Not taking part will not affect your work with the service. Your participation is voluntary.

What will I be asked to do if I take part?

If you decide to take part, the researcher will ask you to complete a contact sheet with your name, contact details, job role and length of time in PIE service. This will help with decisions on who is most appropriate to take part, as it may not be possible to interview everyone who expresses an interest. If you are asked to take part, this will involve being interviewed by the researcher about your experiences of PIE being implemented in the service, what works well and what could be improved. Before the interview you will be asked to read and sign a consent form and you will have the opportunity to ask any questions. The interview will include questions about your views of how the service is run and your experiences. The interview should take no longer than 45-60 minutes. There can be breaks during the interview and you can request to stop at any point. The interview will either take place at the service you work in or remotely, this is your choice and can be discussed with the researcher.

What are the possible benefits from taking part?

There are no direct benefits to you taking part, however participating in this study will allow you to share your experiences of working in a PIE homeless service which will help us understand what works well and what could be improved.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

What if I change my mind?

If you change your mind, you are free to withdraw at any time during your participation in this study. If following the interview, you decide that you want to withdraw your data from the study, this will be possible up to 1 week after the interview. After this point it may not be possible to remove your data as it has been anonymised and added to other data. However if possible, every attempt will be made to extract your data.

You can withdraw from the study by contacting me on **[research mobile] or [university email].**

Will my data be identifiable?

After the interview only the researcher conducting this study and their supervisors will have access to the ideas you share.

All personal information about you (e.g. your name and other information about you that can identify you) will be kept confidential, that is I will not share it with others. I will remove any information that could identify you personally or the service in which you work from the written record of your contribution. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.

How will we use the information you have shared with us and what will happen to the results of the research study?

I will use the information you have shared with me for research purposes only. This will include my DClin thesis and other publications, for example journal articles. I may also present the results of my study at the university or at conferences.

When writing up the findings from this study, I would like to reproduce some of the views and ideas you shared with me. I will only use anonymised quotes (e.g., from my interview with you), so that although I will use your exact words, all reasonable steps will be taken to protect your anonymity in our publications.

If during the interview there are concerns around safeguarding of you or someone else, I will be obliged to share this information with your line manager and my supervisor. If possible, I will inform you of this breach of confidentiality.

How my data will be stored

Any paper copies with identifiable information or contact details will be stored in a locked cabinet in the researcher’s home. This will be scanned and saved electronically in a secure folder away from your interview data. Once an electronic copy has been created the paper copies will be destroyed using a shredder.

Your interview data will be stored in encrypted files (no-one other than the research team will be able to access them) and on password-protected computers. Any paper copies of interview data will be stored securely in a locked cabinet in the researcher’s home. I will keep data that can identify you separately from non-personal information (e.g. your views on a specific topic). In accordance with University guidelines, I will keep the data securely for a minimum of ten years.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

What if I have a question or concern?
If you have any queries or if you are unhappy with anything that happens concerning your participation in the study, please contact myself or my supervisors.

Rosa Pitts
Student researcher
Lancaster University
[email]

Dr Suzanna Hodge
Research supervisor
Lancaster University
[email]

Dr Colm Gallagher
Field supervisor
Clinical Psychologist & Clinical Lead Homelessness, Manchester Mental Health and Homeless Team
[email]

If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact:
Ian Smith
Research Director
[email]

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Sources of support:
Samaritans: call 116 123, https://www.samaritans.org/
Crisis: call 08000384838 ,
https://www.crisis.org.uk/

Participant information sheet (service user)

What makes a Psychologically Informed Environment (PIE) in a homeless service work?
Views from staff and service users.

My name is Rosa Pitts and I am a student in the Doctorate of Clinical Psychology programme at Lancaster University, England. As part of this, I am conducting a research study which I would like to invite you to take part in. Before you decide whether you would like to participate, it is important to understand why the research is being done and what you will be asked to do, so you can make an informed decision. Please read the following information and feel free to ask any questions before deciding.

What is the study about?

This study aims to explore how homeless services use psychological ideas, sometimes called a psychologically informed environment (PIE). The research wants to understand what is happening in these services, what works well and what needs to change from the perspectives of staff and service users.

Why have I been approached?

I have approached you because you are an adult receiving support from a homeless service which uses PIE principles. I would be very grateful if you would agree to take part in this study.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. Not taking part will not affect your care with the service. There are no negative consequences to not taking part in the research.

What will I be asked to do if I take part?

If you decide to take part, the researcher will ask you to complete a contact sheet with your name, contact details and how long you have been supported by the PIE service. This will help with decisions on who is most appropriate to take part, as it may not be possible to interview everyone who expresses an interest. If you are asked to take part, this will involve being interviewed by the researcher about your experiences of receiving support from the service you're in. The interview will include questions about your views of how the service is run and experiences. Before the interview you will be asked to read and sign a consent form and you will have chance to ask any questions. The interview will take about 1 hour, but it doesn't have to last this long. The interview will stop when you want it to stop. We can have breaks throughout the interview too if you want. The interview can take place at the service where you're supported or it can be arranged for a phone call, this is your choice and can be discussed with the researcher.

What are the possible benefits from taking part?
Taking part in this study will allow you to share your experiences of being a service user in a PIE homeless service which will help us understand what works well and what could be improved.

Are there any disadvantages or risks?
There are no disadvantages expected with taking part in this research. However, it is possible that talking about your experiences may be distressing. If you do feel distressed during or after the interview you are encouraged to let me know and we can discuss options to help support you. This may include me talking to your key worker about how you are feeling. I would always aim to do this after talking to you about it first. There are also services listed at the end of this information sheet that you can contact should you feel distressed.

What if I change my mind?
If you change your mind, you are free to withdraw at any time during your participation in this study. If following the interview, you decide that you want to withdraw your data from the study, this will be possible up to 1 week after the interview. After this point it may not be possible to remove your data as it has been anonymised and added to other data. However if possible, every attempt will be made to extract your data.
You can withdraw from the study by contacting me on [email].

Will my data be identifiable?
After the interview only the researcher conducting this study and their supervisors will have access to the ideas you share.
All personal information about you (e.g. your name and other information about you that can identify you) will be kept confidential, that is I will not share it with others. I will remove any personal information from the written record of your contribution. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.

How will we use the information you have shared with us and what will happen to the results of the research study?
I will use the information you have shared with me for research purposes only. This will include my DClin thesis and other publications, for example journal articles. I may also present the results of my study at the university or at conferences.

When writing up the findings from this study, I would like to reproduce some of the views and ideas you shared with me. I will only use anonymised quotes from my interview with you, so that although I will use your exact words, all reasonable steps will be taken to protect your anonymity in any publications.

If anything you tell me in the interview suggests that you or somebody else might be at risk of harm, I will be obliged to share this information with your keyworker and my supervisor. If possible, I will inform you of this breach of confidentiality.

How my data will be stored
Any paper copies with identifiable information or contact details will be stored in a locked cabinet in the researcher’s home. This will be scanned and saved electronically in a secure folder away from your interview data. Once an electronic copy has been created the paper copies will be destroyed using a shredder.

Your interview data will be stored in encrypted files (no-one other than the research team will be able to access them) and on password-protected computers. Any paper copies of interview data will be stored securely in a locked cabinet in the researcher's home. I will keep data that can identify you separately from non-personal information (e.g. your views on a specific topic). In accordance with University guidelines, I will keep the data securely for a minimum of ten years.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

What if I have a question or concern?
If you have any queries or if you are unhappy with anything that happens concerning your participation in the study, please contact myself or my supervisors.
Rosa Pitts
Student researcher
Lancaster University
[email]

Dr Suzanne Hodge
Research supervisor
Lancaster University
[email]

Dr Colm Gallagher
Field supervisor
Clinical Psychologist & Clinical Lead Homelessness, Manchester Mental Health and Homeless Team
[email]

If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact:
Ian Smith
Research Director
[email]

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.
Sources of support:
Samaritans: call 116 123, https://www.samaritans.org/
Crisis: call 08000 384838 , https://www.crisis.org.uk/

Participant Response Slip (Staff)

Name	
Job role	
Length of time in PIE service	
Contact number/email	
Preferred time for contact	
Consent to being contacted by the researcher (Please circle)	Yes No

Participant Response Slip (Serive user)

Name	
How long have you been supported by the PIE service?	
Contact number/email	
Preferred time for contact	
Consent to being contacted by the researcher (Please circle)	Yes No

CONSENT FORM

Project Title: What makes a Psychologically Informed Environment (PIE) in a homeless service work? Views from staff and service users.
Name of Researchers: Rosa Pitts, Dr Suzanne Hodge, Dr Anna Duxbury
Email: [email]
Please tick each box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study without giving any reason. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data.	☐
3. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher/s, but my personal information will not be included. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.	☐
4. I understand that my name/my organisation's name will not appear in any reports, articles or presentation without my consent.	☐
5. I understand that any interviews will be audio-recorded and transcribed and that data will be protected on encrypted devices and kept secure.	☐
6. I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study.	☐
7. *Service user only:* I consent to my key worker being informed of my involvement in the research.	
8. I agree to take part in the above study.	☐

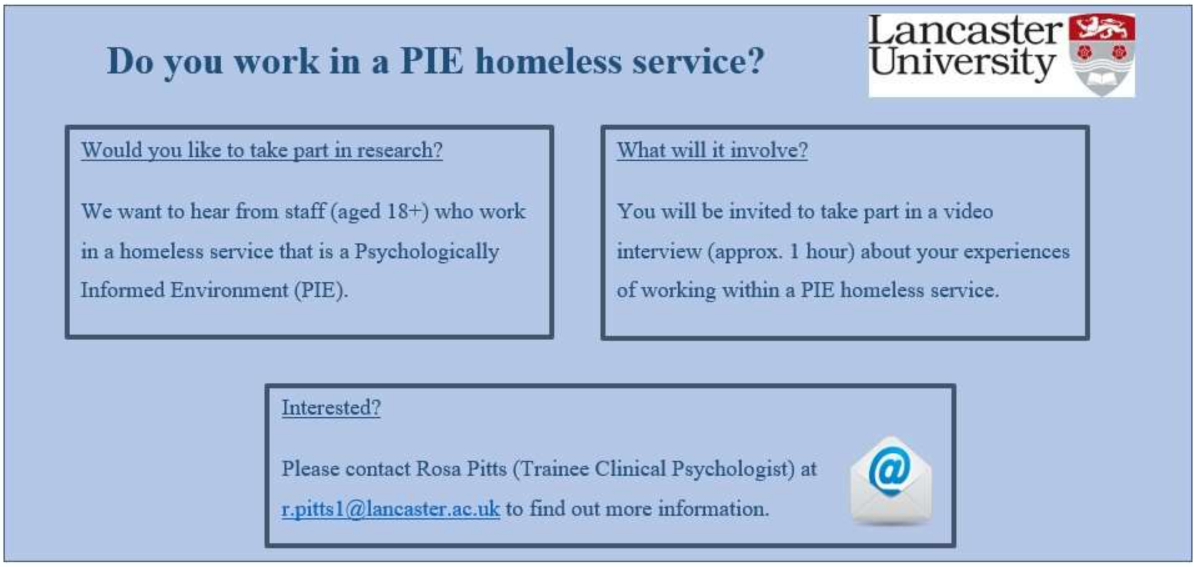
_________________________ ________________ _________________
Name of Participant Date Signature

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher ___________________________ Date ___________

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University

Social media recruitment advert



Do you work in a PIE homeless service?

Lancaster University

Would you like to take part in research?

We want to hear from staff (aged 18+) who work in a homeless service that is a Psychologically Informed Environment (PIE).

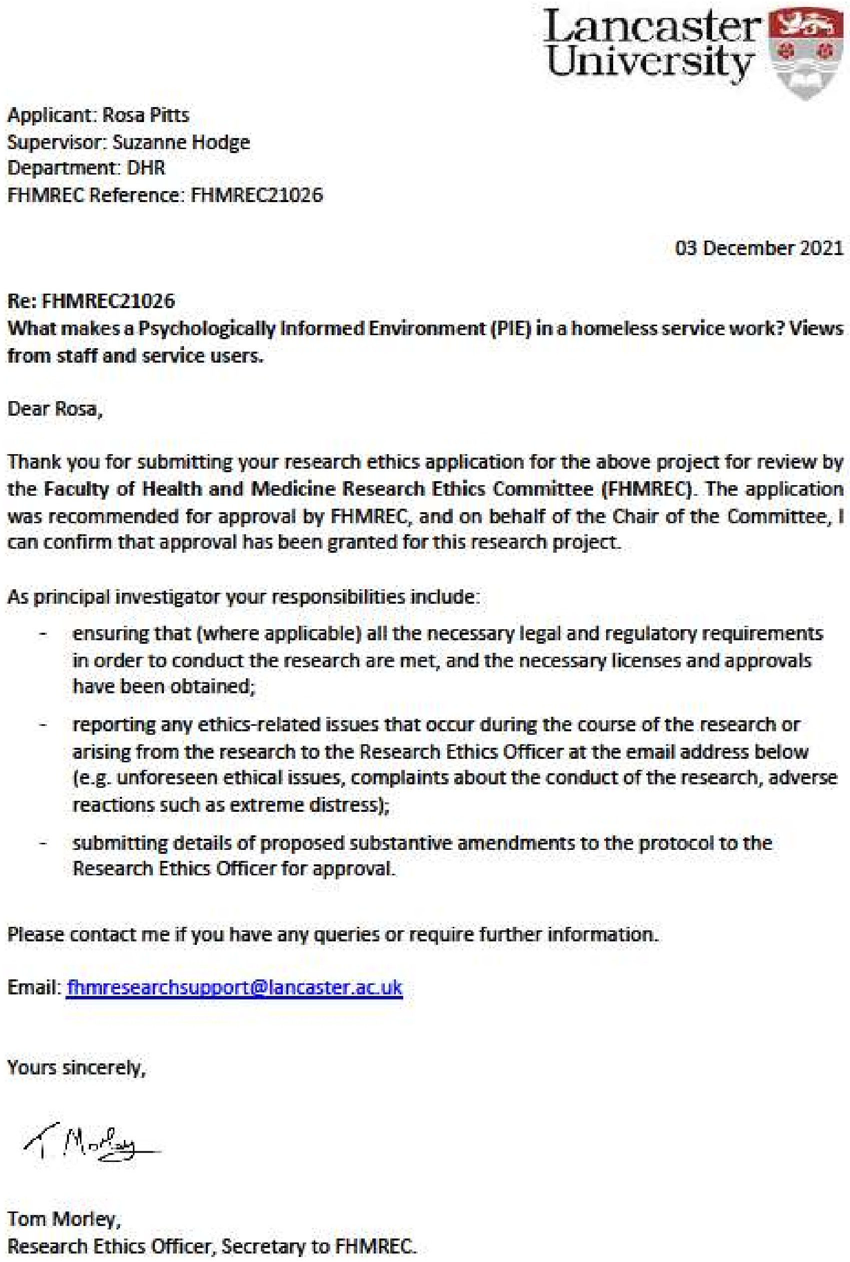
What will it involve?

You will be invited to take part in a video interview (approx. 1 hour) about your experiences of working within a PIE homeless service.

Interested?

Please contact Rosa Pitts (Trainee Clinical Psychologist) at r.pitts1@lancaster.ac.uk to find out more information.

Appendix B- Ethics Approval Letter



Lancaster
University

Applicant: Rosa Pitts
Supervisor: Suzanne Hodge
Department: DHR
FHMREC Reference: FHMREC21026

03 December 2021

Re: FHMREC21026
What makes a Psychologically Informed Environment (PIE) in a homeless service work? Views from staff and service users.

Dear Rosa,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

T Morley

Tom Morley,
Research Ethics Officer, Secretary to FHMREC.