THE UNIVERSITY OF HULL

Experiences of seeking support from health services in the context of homelessness and alcohol dependence

being a Thesis submitted in partial fulfilment
of the requirements for the degree of Doctor of Clinical Psychology
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by

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Thank you to my family for supporting me to get to this stage in my education and career. Particularly for believing in my abilities and celebrating my successes when I may otherwise stay modestly quiet.

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A. Overview

The portfolio thesis is comprised of three parts: a systematic literature review, an empirical paper, and supporting appendices.

Part one is a systematic literature review, exploring the themes that represent the experiences of people experiencing homelessness in the context of seeking help from UK health services. Twenty-two articles were critically quality assessed, and a thematic synthesis was performed to analyse and synthesise the findings. There were three super-ordinate themes generated which represented positive and negative experiences of help-seeking for people experiencing homelessness at the individual, service, and social-contextual levels. Implications for services, policy and future research are outlined to facilitate people experiencing homelessness seeking health support.

Part two is an empirical paper, exploring the role of alcohol and what helps and hinders access to alcohol treatment for people experiencing homelessness and alcohol dependence. A sample of seven participants, combining people experiencing homelessness and alcohol dependence and outreach and key workers, engaged with semi-structured interviews. Interviews were thematically analysed to identify five themes describing the role of alcohol and the capability, opportunity and motivation factors that help and hinder access to alcohol treatment for people experiencing homelessness and alcohol dependence. Clinical and research implications are discussed to aid engagement with people experiencing homelessness and alcohol dependence.

Part three accumulates the appendices that accompany the systematic literature review and the empirical paper, including a reflective statement and epistemological statement to inform the context of the thesis portfolio.

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PART ONE: SYSTEMATIC LITERATURE REVIEW

PART TWO: EMPIRICAL PAPER

PART ONE: SYSTEMATIC LITERATURE REVIEW

This paper is written in the format ready for the submission to:

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See Appendix C for submission guidelines.

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Experiences of people experiencing homelessness when seeking help from health services: a UK systematic literature review.

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Title

Experiences of people experiencing homelessness when seeking help from health services: a UK systematic literature review.

Abstract

The aim for this systematic literature review was to explore the themes that represent the experiences of people experiencing homelessness (PeH) in the context of accessing UK healthcare. A subsequent aim was to identify recommendations for improving access to health services for PeH. The review question was: What experiences do PeH describe when seeking help from health services in the UK?

A systematic search was performed in November 2020, which yielded 1559 articles, 22 of which met the inclusion exclusion criteria. The articles were analysed and synthesised using thematic synthesis (Thomas & Harden, 2008). There were 649 participants across the studies, representing PeH across urban, semi-urban, and rural locations. The main findings were organised into 3 super-ordinate themes, with 11 subthemes. Within the super-ordinate theme ‘Individual Factors’, the subthemes ‘Prior experience’, ‘Self-sufficient until crisis’, ‘Psychology, lifestyle, and coping’ and ‘Emotional experiences accessing healthcare’ were identified. Within the super-ordinate theme ‘Service factors’, the subthemes ‘Navigating services and service relationships’, ‘Staff attributes’, ‘Accessibility’ and ‘Flexibility’ were identified. Within the super-ordinate theme ‘Social contextual factors’, the subthemes ‘Stigma’, ‘Power, control and choice’ and ‘Context dismissed’ were identified. The themes represented positive and negatives experiences of help-seeking for PeH, inclusive of barriers and facilitators at the individual, service, and social-contextual levels. Implications outline the importance of increased sensitivity to PeH’s context, balancing power, building trust and creating flexible and accessible services. Recommendations for services, policy and future research are outlined to facilitate PeH seeking health support. Consequentially, this may

increase health outcomes for a population that is disproportionately impacted by social, physical and psychological difficulties.

Key words

Homeless Persons; Healthcare; Help-seeking Behaviour; Review; Qualitative.

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

What is known:

- One-third of PeH deaths are treatable conditions that could be prevented.
- PeH disproportionately use emergency services over other health services.
- There are multiple barriers for PeH seeking health support suggested in the literature such as navigating healthcare systems, discourse, practical barriers and motivational factors.

What the paper adds:

- The paper clarifies the individual, service and social-contextual barriers and facilitators faced by PeH seeking health support in the UK, as reported by PeH and those working with them.
- The paper provides further insight into the experiences and perspectives of PeH, such as the pain of a health difficulty sometimes being preferred over the pain of seeking support.
- The paper identifies recommendations for improving access to health services for PeH, such as multidisciplinary teams including health and homeless liaison, assertive outreach, policy development for referrals to specialist homeless services, peer promotion of services, and training for professionals.

Introduction

Homelessness is a growing issue, having increased by 165% in England from 2010 to 2018 (Fitzpatrick et al., 2019). In 2019 it was estimated that 4,266 people were rough sleeping (Homeless Link, 2020). A total of 280,000 people were reported as homeless in 2019 (Shelter, 2019). The true severity of homelessness is difficult to measure, with forms of hidden homeless invisible from estimations, such as sofa surfing, which would have substantial impact on the figures (Reeve & Batty, 2011). PeH encompass people who: are rough sleeping, squatting, staying in a night shelter or hostel, sofa surfing, have been placed in temporary accommodation by the local authority, or are staying with friends or family as a short-term guest (The National Health Service; NHS, 2021). Public Health England (2021) state in the ‘Inclusion Health’ guidance that it is necessary for health services to facilitate access and positive outcomes for PeH. This means having an awareness of the barriers and facilitators to care for PeH and taking action.

PeH have multiple health needs in comparison to the general population (Wright & Topkins, 2006). The homeless population are at greater risk of premature death than the general population. Life expectancy is almost halved as a person experiencing homelessness, with the mean age of death for PeH being 45.9 years for males and 43.4 years for females, compared with the general population means of 76.1 years for males and 80.9 years for females, in England and Wales (Office for National Statistics, 2020). The cause of death for PeH in one-third of cases are treatable conditions that could be prevented (Aldridge et al., 2019). Aldridge et al. (2019) outlined that timely and effective care for PeH is vital for reducing such unnecessary deaths. This leads to the enquiry about what issues may arise for PeH seeking healthcare.

In the UK, there are four typical models of healthcare delivery for PeH: mainstream practices providing services for PeH, outreach teams of specialist homelessness nurses, full primary care specialist homelessness teams, and fully coordinated primary and secondary care services (Brennan, 2017). However, PeH are often reported to attend emergency services above other services (Lacobucci, 2019). Additionally, emergency services are described to have poor discharge processes, which perpetuate a cycle of emergency service use above other services (Cornes et al., 2018).

A critical community psychology approach may inform understanding PeH's help-seeking through a social inequality lens (Kagan, Burton, Duckett, Lawthom & Siddiquee, 2011). Social inequality exists when a characteristic of a person's social identity impacts access to resources, which can be applied to accessing health support (McClelland, 2014). Social inequalities have been formulated at levels of socio-cultural context, interpersonal context, the lived experience context (inclusive of internalised inequalities and symptoms of inequality), solidarity and social justice (McClelland, 2014). PeH are often described as 'marginalised' or 'hard-to-reach' reach' (Caton et al., 2016; Pfeil & Howe, 2004; Luchenski et al., 2018; Taylor et al., 2019) which can be an internalised inequality with the potential consequence of struggling to seek health support. The socio-cultural context of experiencing homelessness, alongside interpersonal inequalities such as limited family, social support, and meaningful roles can impact the disempowerment of PeH (McClelland, 2014). Alongside experiencing homelessness, there is intersectionality of social inequalities that PeH often experience (Burnham, 2018). For example, there is a higher prevalence of intellectual disability and a disproportionate amount of people who are black in the homeless population, compared with the general population (Oakes & Davies, 2008; Ministry of Housing, Communities and Local Government, 2020). Critical community psychology would suggest such social inequalities to be impactful on seeking health support; this is supported through findings that experiencing social inequalities can impact the likelihood of seeking help from services, additional to increased reports of negative experiences with services (McClelland, 2014).

Poor access to healthcare has been attributed to a variety of individual and systemic factors for PeH. Riley, Harding, Underwood and Carter's (2003) discussion paper described intersectional influences, such as many immigrants and asylum seekers becoming homeless and facing multiple barriers in navigating the UK healthcare system. Luchenski et al.'s (2018) review of health interventions for marginalised populations found stigmatising barriers to PeH seeking health support, in the form of societal discourse about homelessness. There are practical barriers to healthcare, such as living further than walking distance from the general practice (GP) and the affordability of travel (Riley et al., 2003). In terms of individual motivation, Hewett's (1999) brief survey found PeH describe prioritising other needs such as shelter, warmth, food and money over healthcare. This may contribute to seeking health support only once the health issue is at its worst, requiring an emergency response. Such priorities of needs are understandable when considering Maslow's (1942) theory of human motivation, whereby physiological needs, such as those described by Hewett (1999), would be prioritised above safety needs, such as health. Additionally, many PeH have a multitude of basic needs that are not met (Wright & Topkins, 2006); thus, it is difficult to commit to meeting health needs alongside other needs. A deeper understanding into the experiences faced by PeH in seeking healthcare support could facilitate health services adapting and raising healthcare as a priority.

The literature suggests that health services need to be integrated with other sources of support for PeH, such as social services and advocacy projects (Riley et al., 2003). It suggests that embedding health services in homeless hostels and having services exclusive for PeH, including outreach work, can aid access (Riley et al., 2003). Focus from health services on relationship building and engagement is considered key to PeH accessing health services (Cornes et al., 2018).

The outlined initial issues and recommendations for PeH accessing health services are often narrowly focussed on one type of health service (for example, GP) and do not include the perspectives of PeH. Improving access to services for PeH is a current priority research area, with specific focus on the barriers and enablers experienced by PeH when seeking health support (Jagpal et al., 2020). Stakeholders in the healthcare of PeH discussed the identification of barriers to be important in improving services, and the necessity of identifying PeH experiences and preferences in this process (Jagpal et al., 2020).

The consistent reporting of barriers to healthcare across the decades suggests that the barriers have not been overcome. Instead, a gap in understanding remains for how to facilitate PeH seeking help and having their health needs met. Systematically collating and synthesising the literature for experiences described by PeH when seeking support across healthcare services can aid understanding for what could facilitate PeH to have their health needs met. This knowledge could contribute towards health service delivery for PeH and ultimately reduce the percentage of lives lost to preventable health conditions.

There are existing systematic reviews in homelessness and healthcare that highlight individual and structural issues with accessing health services. For example, trust, stigma, and fragmented services are themes in the literature (See for example Magwood et al., 2019; McGeough, Walsh, & Clyne, 2020; Omerov, Craftman, Mattsson, & Klarare, 2020). However, these reviews mostly draw from research in countries with a different context of healthcare and cultural context from the UK (for example, US, Canada, Iran, Bangladesh, amongst others) which will impact transferability of findings. Additionally, the review questions are either broadly focussed on health and social care, or narrowly focussed on specific health services. Furthermore, the research is rarely grounded in the perspectives of PeH, which limits the knowledge gained from the rich experiences of PeH.

The aim for this systematic review was to explore the themes that represent the experiences of PeH in the context of accessing UK healthcare systems. In line with The British Psychological Society's (2000) aims for research considering community psychology principles, the strengths and competencies of the systems of PeH and health services aim to be identified, alongside the difficulties. A subsequent aim was for the findings to identify recommendations for improving access to health services for PeH.

The research question for the review was:

What experiences do PeH describe when seeking help from health services in the UK?

Method

Search Protocol

A systematic search was performed via EBSCOhost, which facilitated access to Academic Search Premier, APA PsycArticles, APA PsycInfo, CINAHL Complete, and Medline. Such databases include articles from psychological, nursing, and medical professions, alongside a general database, to locate relevant articles for health support seeking. Search terms were guided by existing research, and discussion between the author with their research supervisor and academic liaison librarian. The following search captured published articles up to and including 6th November 2020.

homeless* or "rough sleep*" or "unstabl* hous*" or "precariously housed" or unsheltered or squatting or "sofa surfing" or "night shelter" or "no fixed abode"

AND

(“help seek*” OR “seek* help” OR support* OR access* OR engag*) N3 (service* or healthcare or “GP” or “general practit*” or doctor* or hospital* or "emergency service" or “A&E” or “A and E” or “accident and emergency” or “primary care” or “secondary care” or dentist* or pharmac* or optician*)

AND

UK OR “United Kingdom” OR britain OR england OR wales OR “northern Ireland” OR Scotland

[‘TX All Text’ field selected]

AND

qualitative* or survey* or opinion* or interview* or narrative* or experience* or perspective* or “focus group*” or “case stud*” or ethnograph* or view* or account* or attitude*

[‘TX All Text’ field selected]

‘English language’ and ‘Scholarly (Peer Reviewed) Journals’ limiters were applied due to the financial cost of translating articles, and to ensure the articles were peer reviewed.

Study Selection

The search identified 1559 articles, 1162 of which were screened by their title and abstract following the removal of duplicates. Of these, 1067 articles were excluded due to not meeting the inclusion criteria or meeting at least one of the exclusion criteria (table 1). The remaining articles were assessed for eligibility upon reading the full text. A final sample of 22 articles remained. Their reference lists were searched, which yielded 0 additional results. The study selection process was informed by Moher, Liberati, Tetzlaff, and Altman’s (2009)

Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) statement (figure 1).

Table 1. *Inclusion and exclusion criteria.*

Inclusion	**Exclusion**
Study participants included people currently experiencing homelessness, using the definition of homeless from the NHS data dictionary (NHS, 2021): Rough sleeping; squatting; staying in a night shelter, emergency hostel, direct access hostel; sofa surfing; placed in temporary accommodation by the local authority; staying with friends or family as a short-term guest. ‘Other homeless’ is included in the definition, but for reliability in including studies, ‘other homeless’ was not an inclusion criterion. Participants who self-identified as being homeless were included.	Participants can provide only a third person perspective. For example, healthcare professionals. Participants who are people living in prison. This scenario may be considered as temporary accommodation by the local authority, but health service use would differ for this group.
Participants must have attempted to access support from health services or must have been engaged with or in receipt of health services.	The services are not health services. For example, support groups, fitness classes, activity groups.
UK studies due to the UK having a unique healthcare system, thus increasing the transferability of study findings.	Non-UK studies.
Peer-reviewed journal articles.	Review or discussion articles.
Studies that collected qualitative data from PeH, that addressed the research question.	Qualitative data, relevant to the systematic literature review (SLR) research question, are not identifiable as being from PeH. No evidence of qualitative data. For example, only quantitative methods are used.

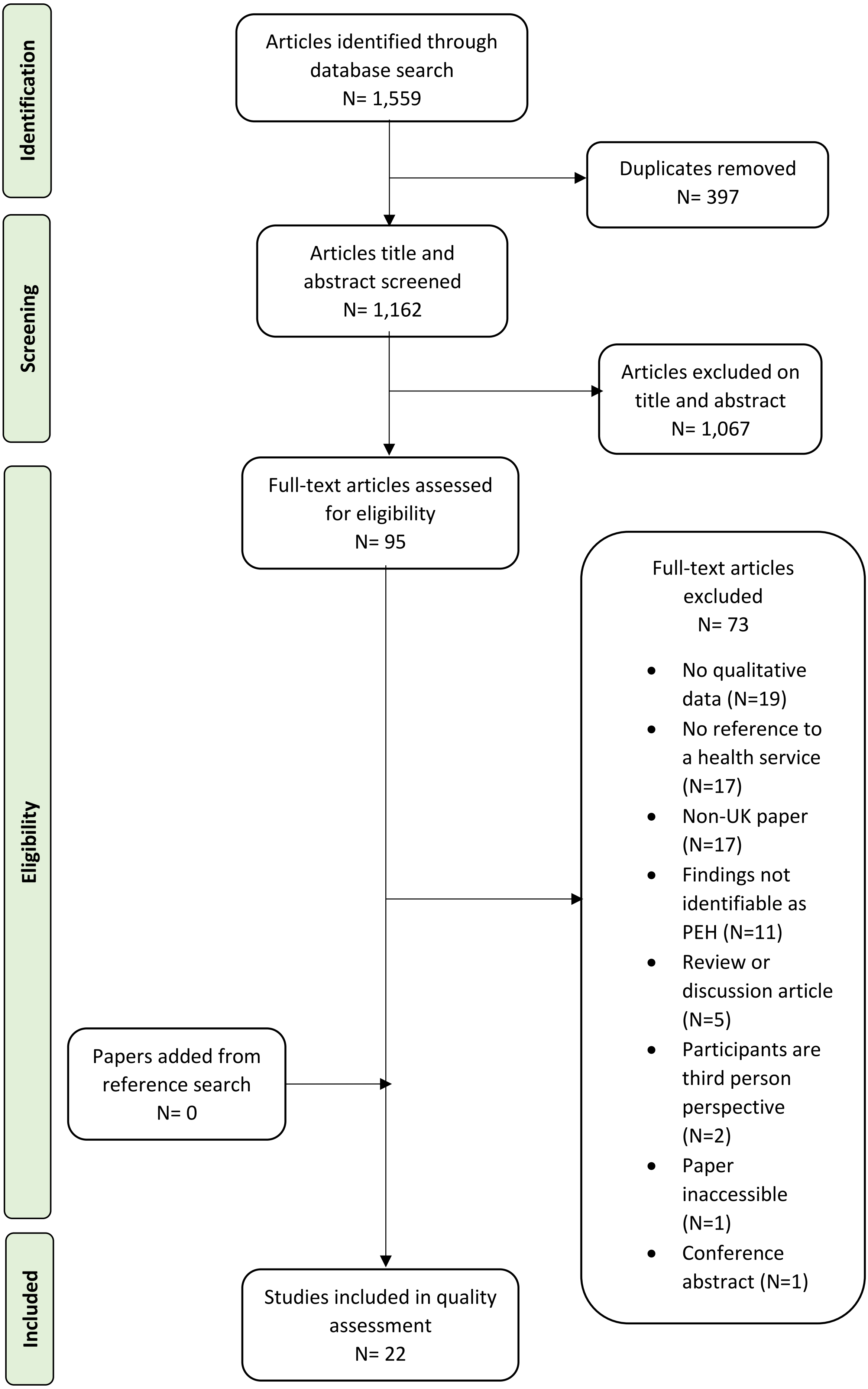
Identification
Screening
Eligibility
Included
Articles identified through database search N= 1,559
Duplicates removed N= 397
Articles title and abstract screened N= 1,162
Articles excluded on title and abstract N= 1,067
Full-text articles assessed for eligibility N= 95
Full-text articles excluded N= 73
No qualitative data (N=19)
No reference to a health service (N=17)
Non-UK paper (N=17)
Findings not identifiable as PEH (N=11)
Review or discussion article (N=5)
Participants are third person perspective (N=2)
Paper inaccessible (N=1)
Conference abstract (N=1)
Papers added from reference search N= 0
Studies included in quality assessment N= 22

Figure 1. Summary of the search and selection process.

Data Extraction

A data extraction form designed for the current review was utilised to extract data from the articles (Appendix D). Data extraction included general article information, methodology, and findings and conclusions.

Quality Assessment

The National Institute for Health and Clinical Excellence (NICE) Quality Appraisal Checklist for qualitative studies was used to rigorously appraise the articles (NICE, 2012; Appendix E). The checklist consists of 14 items rated either 0, 1, or 2 (with 0 being ‘inadequate’ or ‘unreliable’ or similar, and 2 being ‘adequate’ or ‘reliable’ or similar, and 1 for ‘not sure’ or similar). The scores (maximum score 28) were converted into a percentage and awarded an identifier of -, +, or ++. For the mixed design studies (n=2), the checklist was adapted minimally. For example, ‘Is a qualitative approach appropriate?’ was adapted to ‘Is the approach appropriate?’. Quality was selectively assessed for the qualitative aspects of the studies, as they possessed the relevant findings to answer the review question which is grounded in the perspectives of PeH.

To ensure reliable quality assessment, an independent researcher performed a quality check with the highest, median, and lowest ranking articles. The assessors’ scores were generally consistent (79% of items) and any discrepancies identified were thoroughly discussed and addressed.

Data Synthesis

Thematic synthesis (Thomas & Harden, 2008) was used to analyse and synthesise the data within the literature. An inductive approach facilitated the generation of analytical themes from the findings, to enable further concepts and understandings to be derived from the articles and applied to the experiences described by PeH when seeking help from health services. Similarities and differences can be explored and represented within the derived themes.

The three stages of thematic synthesis were followed (Thomas & Harden, 2008):

1. The line-by-line coding of findings, according to their meaning and content as described in the articles' results sections.
2. The development of themes into a hierarchy of codes, whereby new codes were developed to encapsulate the meaning of the initial codes.
3. The generation of analytical themes, developed from the descriptive themes, to address the review question and consider how themes in the findings attend to experiences described by PeH when seeking help from health services.

Reflexive stance of the researcher

Thomas and Harden (2008) describe translating methods from thematic analysis, such as Braun and Clarke's (2006) thematic analysis, to enable thematic synthesis in systematic reviews. Thus, it is important when representing the voices of PeH, a group to which the author does not belong, that the author states their personal and social positioning (Braun & Clarke, 2021). As a healthcare worker, as a consumer of health services, as somebody housed and with their basic needs met, as somebody with wealth and access to a phone or the internet, the author reflected on how such positions shaped their perspective. Peer reflection and a reflective diary were helpful in this process.

The primary researcher was in their Clinical Psychology Doctoral training. The researcher remained reflective on their position within the profession of psychology, to minimise the influence of bias on data extraction and analysis and synthesis of themes. For example, recognising particular interest in psychological issues and psychological services, and ensuring data was similarly acknowledged and explored for social, physical, practical, and medical issues. With support from research supervision, the themes were developed, revisited, discussed, and developed again over time to facilitate the reflective process and ensure the findings encapsulated the meanings from the original articles and addressed the review question. The representation of both positive and negative experiences followed the critical community psychology approach (BPS, 2000). This span of experience is considered important in gaining a fuller understanding of experience that can be applied to recommendations and improvements; thus, having more impact on minimising the statistic for treatable causes of death for PeH than if solely barriers were represented.

Results

Characteristics of Included Studies

Twenty-two studies met the inclusion criteria for the thematic synthesis (table 2). Eleven of the papers had direct aims or study designs associated with a health service, for example Caton, Greenhalgh and Goodacre’s (2016) association with a community dental service for PeH. Whereas eleven papers referred to multiple health services in their findings without a direct aim to analyse PeH’s perspectives of using the services, for example Massie, Machin, McCormack and Kurth (2018).

Most studies were qualitative (n=20), whilst two were mixed (Reid & Klee, 1999; Tischler, Vostanis, Bellerby & Cumella, 2002). The majority utilised semi-structured interviews (n=16), two facilitated surveys, one used focus groups, one used a combination of semi-structured interviews and focus groups, and one study utilised a narrative interview.

Most studies had a majority male sample (n=13) or an all-male sample (n =3). Where there were majority female samples (n=4), these represented samples that were homeless families (n=2), rather than single homeless, or were samples that had accessed mental health support (n=2). There was inconsistency across the papers for collecting other participant demographic information. The smallest sample of PeH was 4 (Archard & Murphey, 2015), and the largest sample of PeH was 200 (Reid & Klee, 1999). The total participants covered across the studies was 649.

A thematic approach to analysis was most used (n=18). Of the eighteen studies, eight studies utilised Braun and Clarke's (2006) thematic analysis, using various approaches or epistemological stances. Three studies utilised a framework method; one utilised The Andersen Model (Andersen, 1995), one utilised the Theoretical Domain Framework (Cane, O'Connor, & Mitchie, 2012), one utilised the Colaizzi method (Colaizzi, 1978), one utilised Joffe and Yardley's (2004) approach to coding, one used TagCrowd (n.d.) for the study's minimal qualitative data, one described following grounded theory principles, and one had no reference for the type of thematic analysis. The remaining studies were analysed utilising a schema-based method (n=1; Agar, 1986), the constant comparative method (n=1; Silverman, 2000), by categorising data and analysing it quantitatively (n=1), and one study did not state the analysis method.

Table 2. *Characteristics of the included studies.*

Author(s), year, and geographical location	**Aims of the study (as stated in the paper)**	**Methodology**	**Participants and identifiable demographic data**	**Analysis of qualitative data**	**Health service(s) described in findings**	**Key findings (themes relevant to thematic synthesis underlined – not inclusive of subthemes)**	**Quality assessment score (maximum = 28)**
Archard and Murphey (2015), unknown geographical location, however correspondence suggests Nottingham.	To explore a programme of social support work delivered in a specialized psychological trauma service as it was received by service users domiciled in supported housing for homeless persons, encompassing experiencing the programme, worker-service user engagement and contextual influences bearing upon positive outcomes.	A qualitative 'practice research' project utilising a narrative interview data collection method.	Four PeH Participants: - Aged 45-58 years - All male - Sleeping in a male-only supported accommodation for PeH - All White British - Health status: Trauma survivors Two support workers also participated but their perspectives were not included in the SLR thematic synthesis.	Thematic analysis informed by 'the framework method' (Ritchie & Spencer, 1994; Gale, Heath, Cameron, et al., 2013).	Support work programme in a traumatic stress service.	Themes: 1. Rapport, commitment, flexibility and worker autonomy and practical assistance, 2. Truncated involvement and incongruities in professional status, 3. Residential arrangements, peer relationships and everyday adversities.	17 (60.71%) -
Bhui, Shanahan, and Harding (2006), The East London	The article is concerned exclusively with the under-researched area of	A qualitative study utilising semi-structured interviews.	Ten PeH Participants: - Aged 19 – 54 years (mean = 36.8 years)	Framework approach (Pope et al., 2000).	General Practitioner (GP), private counselling,	Themes: 1. Mental health problems and biographies,	19 (67.86%) +

Boroughs of Tower Hamlets and the City of London.	service users' perceptions about the adequacy of services rather than the broader literature on rates of mental disorder across homeless populations, or models of service provision.		- 5 males, 5 females - Sleeping arrangements not stated - Nationalities stated as 6 UK, 1 USA, 2 Somali, 1 Sudanese. - Health status: Mental health: 2 schizophrenia, 1 unspecified chronic psychosis, 3 depression, 2 PTSD, 1 substance use, 1 no mental health problem but experienced distress seeking support for homelessness. Physical health: 2 joint pains, 2 gastrointestinal upset, 1 gunshot wound causing pain, 1 skin conditions, 1 multiple somatic complaints including sleep disturbance.		community psychiatric nurses, psychiatrist, key worker, occupational therapist.	2. Stigma, 3. Experience of services, 4. Coping strategies, 5. Finances, 6. Hostels and homelessness, 7. Recommendations for services.	
Caton, Greenhalgh, and Goodacre (2016), Greater Manchester.	1. Explore the dental care experienced by people accessing the service, 2. Examine barriers	A service evaluation implementing a qualitative phenomenological	Twenty patients from homeless or disadvantaged backgrounds accessing a dental	Thematic analysis (Braun & Clarke, 2006).	A community dental service for homeless and hard-to-reach people.	Themes: 1. Dental experiences, 2. Reaching out, 3. Accommodating	21 (75.00%) +

	and facilitators to using a dental service, 3. Examine the impact of the service, 4. Identify good practice in providing dental services for homeless people.	design, utilising semi-structured interviews.	service for homeless and hard-to-reach people. - 17 males, 3 females Nine staff members from the service, and 4 staff members from the community centres also participated but their perspectives were not included in the SLR thematic synthesis.			chaotic lives, 4. Behaviour change: ‘I’m going to reform’, 5. Looking forward	
Chaturvedi (2016), London.	To understand young, homeless people who had accessed counselling’s thoughts on the main barriers to counselling and how they could be overcome.	A qualitative study utilising semi-structured interviews.	Six PeH Participants: - Aged between 16-25 years-old (range or mean not stated) - 2 male, 4 female - Sleeping in hostels	Thematic analysis using an inductive approach (Braun & Clarke, 2006).	Counselling service in the context of supported housing.	Themes: 1. Barriers - Resistance to opening up; Stigma; Past experiences of help seeking; Denial about needing help; Lack of familiarity with therapy. 2. Facilitators - Patience and consistency of offer; Simple explanations; Demystifying and normalising	24 (85.71%) ++

						counselling.	
Coles and Freeman (2016), 4 cities/towns in Scotland covering different NHS board areas.	1. To examine, using a grounded theory approach, homeless people’s awareness of their oral health needs ‘bring to consciousness’ and how they access dental services ‘social interaction’ using a deconstruction–reconstruction formulation. 2. To provide recommendations for service designers and dental professionals who work with people experiencing homelessness.	A qualitative study utilising semi-structured interviews.	Thirty four PeH Participants: - Aged 16 – 70 years - 21 males, 13 females - Sleeping arrangements not stated for all, however 5 were young people in temporary accommodation and 2 were people in temporary hostel accommodation.	Grounded theory principles (Glaser & Strauss, 1967; Glaser, 1978).	Dentist	1.Oral health and homelessness: a deconstruction-reconstruction formulation [Stage 1: Oral health deconstruction; Stage 2: Oral health construction: the neglected dentition], 2. Oscillation: from oral health construction to oral health reconstruction [Stage 3: Oral Health Reconstruction].	13 (46.43%) -
Craig, Joly, and Zumla (2014), London.	To analyse patients’ knowledge of tuberculosis (TB), their experiences of symptoms and their health care seeking behaviours. Additionally, the study formed part of a wider service development project conducted in London,	A qualitative study utilising semi-structured interviews.	Sixteen PeH participants (17 participants in total, but 1 not included in SLR due to being at risk of homelessness rather than experiencing homelessness): - Aged 18 – 67 years (mean 44 years). - 12 male, 5 female	Theoretical thematic analysis, including deductive and inductive coding (Braun & Clarke, 2006).	Major TB centre, GP, Accident & Emergency (A&E).	Headings: 1. Participant characteristics, 2. Income, housing and employment, 3. Drug and alcohol use, 4. Experiences of violence and social exclusion, 5. Personal accounts of health,	21 (75.00%) +

	UK, which aimed to develop a social outreach model of care for marginalised groups with TB and generate an evidence base for the need of a TB caseworker in supporting clients with complex needs and is reported elsewhere.		(unknown sex of excluded participant) - Sleeping arrangements: 4 hostel, 1 between B&B and staying with relatives, 2 B&B, 1 temporary bedsit, 1 between bedsit and hostel, 5 NFA, 1 NFA sometimes stays at a friend's house, 1 shared house (temporary) - Places of birth : 9 UK, 2 Ethiopia, 1 Nigeria, 3 Somalia, 1 Ireland - Health status : All living with TB.			6. Knowledge of TB and personal susceptibility, 7. Recognising symptoms, 8. Accessing health care, 9. Barriers to seeking care, 10. Managing risk to access care.	
Csikar, Vinall-Collier, Richemond, Talbot, Serban, and Douglas (2019), Leeds.	To understand the barriers and facilitators to achieving and maintaining good oral health by homeless people in Leeds.	A qualitative study utilising focus groups.	Sixteen PeH participants: - Adults (age not stated) - 14 males, 2 females	Themes developed inductively from the focus group transcripts, driven by the research questions. A theoretical	Oral health services.	Codes: 1. Patient-related factors, 2. Oral healthcare professional-related factors, 3. Governmental, political and societal factors.	24 (85.71%) ++

				or deductive approach used to undertake the analysis of the themes. Use of The Andersen Model (The behavioral model and access to health care; Andersen, 1995).			
Garner and Ratschen (2013), Nottingham.	To explore homeless smokers' views, attitudes, experiences and knowledge with regard to smoking and quitting in an urban UK setting.	A qualitative study utilising semi-structured interviews.	Fifteen PeH participants: - Aged 18 – 53 years (mean 33 years) - 11 male, 4 female - Sleeping arrangements: 6 hostel or winter shelter, 5 rough sleepers, 4 sofa surfing - Health status: Concurrent substance use (8 Alcohol, 4 Heroin, 4 Crack, 6 Cannabis, 3	Thematic analysis using framework analysis (Pope, Ziebland, Mays, 2000).	NHS stop smoking services, GP, a drug harm reduction and sexual health service.	Themes: 1. Perception of the physical and mental health impacts of smoking, 2. Sourcing of tobacco and risk behaviour, 3. Smoking, quitting and harm reduction: environmental influence, past experience and future needs.	23 (82.14%) ++

			Amphetamine, 6 Methadone, 9 Currently receiving treatment for drug or alcohol misuse).				
Gunner, Chandan, Marwick, Saunders, Burwood, Yahyouche, and Paudyal (2019), West Midlands.	To explore the perspectives of the population that is homeless around their access to and use of primary healthcare services, including mainstream general practices and a specialist primary healthcare centre for people who are homeless (SPHCPH).	A qualitative study utilising semi-structured interviews.	Twenty PeH participants: - Aged 24 – 70 years - 15 male, 5 female - Length of time homeless: <6 months = 8, 6 months – 1 year = 5, 1-2 years = 4, 3-4 years = 1, 5+ years = 2 - Ethnicity: 14 white, 2 Asian, 2 Black, 1 Mixed, 1 Prefer not to say - Health status: 5 Very good, 5 Good, 5 Fair, 5 Bad, 0 Very bad.	Inductive coding to form themes that mapped onto the Theoretical Domain Framework (Cane, O'Connor & Michie, 2012).	GP, A&E, SPHCPH.	Themes: 1. Organisation and delivery of services, 2. Patient-related factors, 3. Social exclusion and stigma, 4. GP awareness of the complex healthcare needs of people who are homeless.	23 (82.14%) ++
Jagpal, Barnes, Lowrie, Banerjee, and Paudyal (2019), Birmingham.	To conduct public involvement sessions using qualitative methodology to inform a proposal to develop a novel, patient-centred clinical pharmacy service for homeless persons in an English	A qualitative study utilising public involvement sessions (focus groups and semi-structured interviews).	Nine PeH Paticipants (7 for focus groups, and 2 for semi-structured interviews): - 6 males, 1 female - Sleeping arrangements: 2 sleeping rough, 7 not stated	Thematic coding (no reference).	Pharmacy, specialist homeless health centre.	Themes: 1. Acquaintance with pharmacy services, 2. Perceived feasibility and benefits of a clinical pharmacy service 3. Prospect of	18 (64.29%) +

	specialist homelessness health service and outreach setting, including temporary shelters and streets.					outreach visits by pharmacists, 4. Peer support and social influences in engaging with services, 5. Addressing challenges in following up homeless persons.	
Jenkins and Parylo (2011), Leicester.	To seek the views of clients (homeless families) who are homeless or in temporary accommodation regarding health services and how they would like them developed.	A quality involvement project, with a service evaluation design utilising surveys facilitated by volunteers and nursery nurses.	Forty nine PeH participants: - 42 (85%) aged under 30 years-old, 21 (43%) aged under 20 years-old - 5 male, 44 female - Sleeping arrangements: temporary accommodation - Length of time homeless: 32 (65%) had been homeless or in temporary accommodation for less than a year	Descriptive and thematic analysis, using Microsoft Excel and an online application to generate 'tag clouds' (TagCrowd, accessed 2010).	Health visiting service, GP.	Headings: 1.General aspects and attitudes, 2. Contacting the health visiting service, 3. Impressions of the health visiting service, 4. Children's centre and Sure Start, 5. Access and barriers, 6. Ease of accessing health care, 7. Threshold to seeking health care 8. Desired services, 9. Likes and dislikes, 10. Service	21 (75.00%) +

						improvement, 11. Attendance at accident and emergency, 12. Attendance at urgent care or walk-in centre, 13. GP out of hours services.	
Massie, Machin, McCormack, and Kurth (2018), West Midlands.	To understand the lived experience of people who have experienced homelessness and street activity and professional stakeholders' views about the challenges faced by this client group.	The methodology was influenced by community based participatory appraisal, which creates a cycle of data collection, reflection and learning; seeking to build community knowledge and encourage collective action (Glasgow centre for population health, 2011). It utilised semi-structured interviews.	Eight PeH participants: - Aged 30 – 60 years - All males - Sleeping arrangements: 6 described as homeless, 2 in longer-term accommodation but were engaged in street activity Ten stakeholders also participated but their perspectives were not included in the SLR thematic synthesis.	Thematic analysis (Braun & Clarke, 2006).	GP, pharmacy, A&E, walk-in centre.	Themes: 1. Pathways to support, 2. Developing opportunities	21 (75.00%) +
McConalogue, Maunder, Areington, Martin, Clarke,	To explore homeless people's experiences and perceptions of health and health	An interpretivist qualitative approach, utilising semi-structured	Twenty-eight PeH participants (24 individuals, 2 couples):	Thematic analysis (Braun & Clarke,	GP, mental health service, homeless	Themes: 1. Becoming homeless, 2. Perceptions and	20 (71.43%) +

and Scott (2019), Gloucestershire.	services to inform policy, commissioning and service provision to deliver better health outcomes for this group.	interviews.	- 29% female, 71% not stated (likely male). - Ethnicity: 71% White British, 29% Not stated. - Sleeping arrangements: 54% supported housing, 39% rough sleeping, 7% sofa survers or living in B&Bs.	2006), guided by an interpretivist approach.	healthcare team, substance misuse services.	understanding of health, 3. Health issues for homeless people, 4. Managing health, 5. Social networks and health, 6. The relationship between health and living environment, 7. Primary and secondary healthcare services, 8. Experiences of mental health (and substance misuse) services.	
Paisi, Witton, Withers, Plessas, Burrows, Morrison, McDonald, and Kay (2020), Plymouth.	To identify strategies to improve oral health behaviours as well as access to and provision of dental care for people experiencing homelessness from the twin perspectives of people experiencing homelessness and those working with or supporting them.	A qualitative study utilising focus groups for PeH.	Eleven PeH participants: - Aged 21.1 – 55.3 years (mean 34.1 years). - All male. - British but ethnicity not stated. - Sleeping arrangements: residential homeless centre. Twelve stakeholders	Thematic analysis (Braun & Clarke, 2006) using an inductive approach.	Oral health service.	1. Awareness and empowerment, 2. Supportive environment and dental health system, 3. Flexible and holistic care, 4. Outreach and community engagement, 5. Collaboration with other health services,	26 (92.86%) ++

			also participated but their perspectives were not included in the SLR thematic synthesis.			6. Effective communication.	
Rae and Rees (2015), London.	To understand the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influence their health-seeking behaviour.	A qualitative study with an interpretive phenomenology approach, utilising semi-structured interviews.	Fourteen PeH participants: - Aged 29 – 53 years - 12 males, 2 females - Ethnicity: 1 Irish, 2 Mixed British, 5 White British, 2 Asian, 4 Afro-Caribbean. - Sleeping arrangements: 2 street homeless, 9 hostels, 3 temporary accommodation	Colaizzi (1978) 8-step method of analysis.	GP, A&E, CBT (service unknown), hospital, drug and alcohol team.	1. Expressed health need, 2. Healthcare experiences, 3. Attitudes	24 (85.71%) ++
Reid and Klee (1999), Greater Manchester (25% Central Manchester, 75% surrounding towns).	Overall aim: To examine risk behaviour and coping strategies amongst young homeless drug users. Particular aim: To examine the extent to which consequences of homelessness, such as physical and psychological health problems, may be alleviated through the	A mixed design study utilising semi-structured interviews.	Two hundred PeH participants: - Aged 14 – 25 years - 143 males, 57 females - Sleeping arrangements: 86 (43%) hostels, 35 (17.5%) temporarily living with family or friends, 19 (9.5%) B&B, 12 (6%) living in squats or sleeping rough, 168 (84%)	The majority of text variables associated with open questions were assigned to categories by three independent judges, included in quantitative	GP, hospital (A&E), psychiatrist, drug treatment services, counselling.	1. Housing services, 2. Health Services 3. Drug services, 4. Basic sustenance, 5. Information sources 6. Voluntary agencies, 7. Informal support networks	15 (53.57%) -

	use of drugs.		had slept rough at some time. - Length of time homeless: Ranged from 6 months to over 5 years, with 115 (57.5%) having ben homeless for between 2 and 5 years	analyses of all data and subjected to Chi-squared analyses.			
Shiner (1995), London.	To reflect upon existing literature by taking an in-depth analysis of the views of a small sample of homeless people; to consider why homeless people in the least secure forms of accommodation make little use of the primary health care services provided by the National Health Service.	A qualitative study utilising semi-structured interviews.	Sixteen PeH participants: - Ages: 4 <25 years, 4 26 – 35 years, 4 36 – 45 years, 4 >45 years - All male - Ethnicity: 15 White, 1 African Caribbean - Sleeping arrangements: 7 sleeping rough, 3 long stay hostel, 2 project accommodation, 1 short stay hostel, 1 coucil flat, 1 B&B, 1 alcohol rehabilitation centre.	Analysed using the methodology outlined by Agar (1986), applying schema to strips of text.	GP, A&E, specialist provider.	1. Service use, attempts to gain care and accommodation, 2. Attitudes to health and illness, 3. Satisfaction, dissatisfaction, stigmatisation and service use.	20 (71.43%) +
Shiner and Leddington (1991), Central	To develop insight into the attitudes of the street homeless.	A qualitative study utilising an outreach work	One hundred PeH participants: - 78 males, 22	Not stated.	Mainstream GP, day centre	Headings: 1. GP registration, 2. Other sources of	11 (39.29%)

London.		based survey.	females		doctors, A&E, specialist health teams, homeless mobile surgery.	primary healthcare.	-
Taylor, Stuttaford, Broad, and Vostanis (2007), 5 areas across the UK including urban, semi-urban, and rural.	To investigate young homeless people's experiences of 'Strong Minded', a new mental health service set up within selected homeless shelters and run by a voluntary sector organization.	A qualitative service evaluation utilising semi-structured interviews.	Nineteen PeH participants: - Aged 16 – 23 years (mean 19 years). - 6 males, 13 females - Sleeping arrangements: homeless shelter 'Foyers'. - Health status: mental health difficulties.	Thematic analysis (Joffe and Yardley, 2004).	Strong Minded mental health service, doctors.	Themes: 1. Experience of new Strong Minded mental health service, 2. Aspects of Strong Minded service that contributed to perceived effectiveness	20 (71.43%) +
Tischler, Vostanis, Bellerby, and Cumella (2002), Birmingham.	To describe the characteristics of homeless children and families seen by the mental health outreach service (MHOS), to evaluate the impact of this service on the short term psychosocial functioning of children and parents, and to establish perceptions of, and	A service evaluation with a mixed methods design, utilising structured questionnaires (quantitative) and semi-structured interviews (qualitative).	Twenty-three families and 27 children (homeless families): - Family composition: single mother (16), couple (7), single father (0) - Main reason for homelessness: domestic violence (10), neighbour harassment (4), relationship	The constant comparative method (Silverman, 2000).	The community psychiatric nurse from the MHOS.	Themes: 1.Satisfaction with mental health outreach service, 2.Impact on parental mental health, 3.Impact on child mental health, 4. Service needs, 5. Staff satisfaction.	20 (71.43%) +

	satisfaction with, the service, by using quantitative and qualitative measures.		breakdown (3), eviction (2), rent arrears (2), overcrowding (1), refugees (1) - Ethnicity: UK White (16), Afro-Caribbean (3), Asian (3), Other European (1) Ten staff also participated but their perspectives were not included in the SLR thematic synthesis.				
Ungpakorn and Rae (2020), London.	To understand how health-related street outreach is perceived by homeless people with experience of sleeping rough.	A qualitative description study utilising semi-structured interviews.	Ten PeH participants: - Aged 26 – 56 years. - 9 males, 1 female - Ethnicity: 5 White British, 1 White Latvian, 1 White Polish, 1 Black Ghanaian, 1 White Bulgarian, 1 Mixed Caribbean Cuban - Sleeping arrangements: 3 emergency shelter, 7 street homeless - Length of time	Thematic analysis (Braun & Clarke, 2006) using an inductive approach.	GP, health-related street outreach.	Themes: 1. A human connection, 2. Street outreach as a bridge, 3. The right approach.	25 (89.29%) ++

			homeless: Range from 9 days (with previous episode) to 7 years				
Webb, Mitchell, Snelling, and Nyatanga (2020), spread over 4 (unidentified) counties in the UK.	To explore the end of life concerns, fears, preferences and priorities of a sample of people experiencing homelessness in the UK.	Interpretative phenomenological qualitative research, utilising semi-structured interviews.	Twenty-one PeH participants: - Aged: 3 40 – 45 years, 5 45 – 50 years, 2 50 – 55 years, 8 55 – 60 years, 3 65+ years - 17 males, 4 females - Sleeping arrangements: Not stated, however 9 were interviewed at hostels.	Data-driven, inductive approach to Thematic Analysis (Braun & Clarke, 2006).	Medication, nursing, emergency support.	1. Spiritual concerns, 2. Practical concerns, 3. Fear of needing care, 4. Fear of being forgotten, 5. Preference for dying suddenly, 6. Preference for being somewhere comfortable, 7. Prioritising autonomy and self-determination, 8. Prioritising authenticity.	25 (89.29%) ++

Table 3. *Quality assessment checklist ratings.*

Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	Total (and percent)
Archard & Murphey (2015)	1	1	1	0	2	2	1	1	2	1	1	1	1	2	17 (60.71%)
Bhui et al. (2006)	2	1	1	1	0	2	2	2	2	2	1	1	1	1	19 (67.86%)
Caton et al. (2016)	2	2	2	1	1	1	2	1	1	1	2	2	1	2	21 (75.00%)
Chaturvedi (2016)	2	1	2	2	2	1	1	2	2	2	2	2	2	1	24 (85.71%)
Coles & Freeman (2015)	1	2	0	0	0	2	0	1	1	1	0	1	1	1	11 (39.29%)
Craig (2014)	2	2	2	0	1	1	1	2	2	1	1	2	2	2	21 (75.00%)
Csikar et al. (2019)	2	2	2	2	2	1	2	1	1	2	1	2	2	2	24 (85.71%)
Garner & Ratschen (2013)	2	1	2	1	2	2	2	1	2	1	1	2	2	2	23 (82.14%)
Gunner et al. (2019)	2	1	2	2	1	2	1	0	2	2	2	2	2	2	23 (82.14%)
Jagpal et al. (2019)	2	2	1	1	1	1	1	0	1	1	1	2	2	1	18 (64.29%)
Jenkins & Parylo (2011)	2	2	2	2	2	1	2	1	1	1	1	1	2	1	21 (75.00%)
Massie et al. (2018)	2	1	2	1	1	1	1	2	1	1	2	2	2	2	21 (75.00%)
McConalogue et al. (2019)	2	2	1	1	1	1	1	2	1	1	1	2	2	2	20 (71.43%)

Paisi et al. (2020)	2	2	2	2	2	1	2	2	2	1	2	2	2	2	26 (92.86%)
Rae & Rees (2015)	2	2	1	2	2	2	1	2	2	1	1	2	2	2	24 (85.71%)
Reid & Klee (1999)	1	1	1	1	1	1	1	1	2	1	2	1	1	0	15 (53.57%)
Shiner (1995)	2	2	2	1	0	2	1	2	2	1	1	2	1	1	20 (71.43%)
Shiner & Leddington (1991)	2	1	1	1	0	1	1	0	1	0	1	2	0	0	11 (39.29%)
Taylor et al. (2007)	2	2	2	1	1	1	1	1	1	1	1	2	2	2	20 (71.43%)
Tischler et al. (2002)	2	1	2	1	0	2	2	1	2	1	2	2	2	0	20 (71.43%)
Ungpakorn & Rae (2020)	2	2	2	2	2	2	1	2	2	1	2	2	1	2	25 (89.29%)
Webb et al. (2020)	2	2	2	2	1	2	1	2	2	1	2	2	2	2	25 (89.29%)
Totals	41	35	36	27	25	31	29	29	35	25	30	39	35	33	

Methodological Quality

The appropriate implementation of a qualitative approach was a strength across the papers. Where it was unclear, this was due to an implied hypothesis (Archard & Murphey, 2015; Coles & Freeman, 2015). Most studies stated clear aims (n=13). However, there were occasions where the aims/objectives/research questions were unclear (Bhui et al., 2006; Chaturvedi, 2016; Massie et al., 2018; Reid & Klee, 1999; Shiner & Leddington, 1991; Tischler et al., 2002), or there was not appropriate reference to the literature (Archard & Murphey, 2015; Garner & Ratschen, 2013; Gunner et al., 2019).

The research design and methodology were defensible for most studies (n=14). For some it was unclear as it may not have been appropriately justified (Archard & Murphey, 2015; Bhui et al., 2006; Coles & Freeman, 2015; Jagpal et al., 2019; McConalogue et al., 2019; Rae & Rees, 2015; Reid & Klee, 1999; Shiner & Leddington, 1991).

Where data collection was carried out appropriately, it was clearly described and systematic (n=8). Where it was carried out inappropriately, data collection methods and procedures were described to vary between participants (Archard & Murphey, 2015; Coles & Freeman, 2015; Craig et al., 2014). This is an understandable difficulty in most cases, due to the difficulty of interviewing within an appropriate research environment with PeH. The remaining studies inadequately reported the data collection procedure (n=11); therefore, it was unclear if carried out appropriately.

A clear description of the role of the researcher was a relative weakness across the studies, with 5 studies not describing the role, and 9 providing an unclear description. Where it was clearly described, sometimes within a reflexive statement, authors stated their demographics and professional background, and it was clear how the research was explained and presented to participants (n=8). All studies gave some context to the sample and settings.

However, this was only clearly defined for 9 of the papers. Data was mostly collected by one method (most commonly interviews). Though this was outlined to be reliable if the method investigated what it claimed to, and it was justified.

Where data analysis was sufficiently rigorous, the procedure was explicit with a systematic process, making it clear to identify how the findings were derived from the data (n=10). For 9 studies, it was difficult to identify this process, or it was not reported. For 3 studies (see for example Shiner and Leddington, 1991) the process was not rigorous, possibly due to some studies being published prior to the publication of quality standards for qualitative studies. Most studies displayed rich data with depth and detail demonstrated (n=13). Where it was unclear, this was due to supporting quotes dominated by a small pool of participants, or there were multiple perspectives explored but the contexts were not clearly defined, or not all themes had supporting data. Evidence of reliable data analysis was a relative weakness across the studies. The findings were convincing for 9 papers. Where findings were unclear, this was due to either being unclearly presented, or extracts of data were inconsistent or not appropriately referenced, or coherency was poor. There was one study where the findings were not convincing, due to utilising deductive analysis despite using grounded theory. Additionally, discussion embedded within the findings was detrimental to coherency (Coles & Freeman, 2015).

Overall, the findings were relevant to the aims of the studies, except for 5 papers where they were partially relevant (Archard & Murphey, 2015; Bhui et al., 2006; Coles & Freeman, 2015; Jenkins & Parylo, 2011; Reid & Klee, 1999). Conclusions were mostly adequate (n=14). Where it was unclear, this was due to unclear links between data, interpretation and conclusions, or limited discussion of alternative explanations, implications, and limitations. One conclusion was inadequate due to the lack of detail (Shiner & Leddington, 1991).

The study quality ranged from 39.93% to 92.9%. See table 3 for a more detailed overview of quality scores. Studies were not excluded based on their quality score, due to there being no evidence for the exclusion of qualitative studies for qualitative syntheses (Thomas & Harden, 2008). However, in line with Thomas and Harden (2008), studies with a lower quality score did not contribute to the more unique themes. Despite this, the range in the quality of the studies should be taken into consideration whilst interpreting the results of the synthesis.

Synthesis of Findings

The super-ordinate themes were organised into individual factors, service factors, and social contextual factors as it was evident there were ecological layers to the issues experienced by PeH (as displayed in table 4). It should be noted that relationships exist between and within each super-ordinate theme. See table 5 – 7 for example quotes to illustrate each theme.

Table 4. *Super-ordinate themes and subthemes identified from data synthesis.*

Super-ordinate themes	Subthemes	Contributory papers
Individual factors		
	Prior experience	Chaturvedi (2016); Csikar et al. (2019); Rae & Rees (2015); Ungapakorn & Rae (2020).
	Self-sufficient until crisis	Caton et al. (2016); Chaturvedi (2016); Coles & Freeman (2016); Csikar et al. (2019); Gunner et al. (2019); Jagpal et al. (2019); Paisi et al. (2020); Rae & Rees (2015); Reid & Klee (1999); Shiner (1995); Shiner & Leddington (1991).
	Psychology, lifestyle, and coping	Bhui et al. (2006); Chaturvedi (2016); Coles & Freeman (2016); Craig et al. (2014); Gunner et al. (2019); McConalogue et al. (2019); Paisi et al. (2020); Rae & Rees (2015); Shiner (1995); Ungpakorn & Rae (2020).
	Emotional experiences accessing healthcare	Chaturvedi (2016); Csikar et al. (2019); Gunner et al. (2019); McConalogue et al. (2019); Paisi et al. (2020); Taylor et al. (2007); Ungpakorn & Rae (2020).
Service factors		
	Navigating services and service relationships	Bhui et al. (2006); Caton et al. (2016); Coles & Freeman (2016); Csikar et al. (2019); Gunner et al. (2019); Jagpal et al. (2019); Jenkins & Parylo (2011); Massie et al. (2018); McConalogue et al. (2019); Rae & Rees (2015); Shiner (1995); Shiner & Leddington (1991); Tischler et al. (2002); Ungpakorn & Rae (2020); Webb et al. (2020)
	Staff attributes	Archard & Murphey (2015); Chaturvedi (2016); Csikar et al. (2019); Garner & Ratschen (2013); Gunner et al. (2019); Jagpal et al. (2019); Jenkins & Parylo (2011); Paisi et al. (2020); Rae & Rees (2015); Shiner (1995); Taylor et al. (2007); Tischler et al. (2002); Ungpakorn & Rae (2020).
	Accessibility	Bhui et al. (2006); Caton et al. (2016); Coles & Freeman (2016); Csikar et al. (2019); Garner & Ratschen (2013); Gunner et al. (2019);

		Jagpal et al. (2019); Jenkins & Parylo (2011); McConalogue et al. (2019); Rae & Rees (2015); Reid & Klee (1999); Shiner (1995); Ungpakorn & Rae (2020).
	Flexibility	Bhui et al. (2006); Chaturvedi (2016); Coles & Freeman (2016); Csikar et al. (2019); Gunner et al. (2019); Jagpal et al. (2019); Jenkins & Parylo (2011); Massie et al. (2018); McConalogue et al. (2019); Paisi et al. (2020); Rae & Rees (2015); Shiner (1995); Shiner & Leddington (1991); Ungpakorn & Rae (2020).
Social contextual factors		
	Stigma	Bhui et al. (2006); Chaturvedi (2016); Coles & Freeman (2016); Csikar et al. (2019); Gunner et al. (2019); Jagpal et al. (2019); McConalogue et al. (2019); Rae & Rees (2015); Shiner (1995); Shiner & Leddington (1991); Webb et al. (2020).
	Power, control and choice	Bhui et al. (2006); Caton et al. (2016); Chaturvedi (2016); Csikar et al. (2019); Gunner et al. (2006); Rae & Rees (2015); Paisi et al (2020); Ungpakorn & Rae (2020); Webb et al. (2020).
	Context dismissed	Bhui et al. (2006); Csikar et al. (2019); Gunner et al. (2019); Massie et al. (2018); Jenkins & Parylo (2011); Rae & Rees (2015); Shiner (1995); Shiner & Leddington (1991).

Super-ordinate theme: Individual factors

Individual issues accounted for: the impact of prior experience of seeking and/or receiving support, the self-sufficiency of PeH until crisis point, psychological and lifestyle experiences with their associated coping, and emotional experiences whilst seeking support from health services.

Subtheme: Prior experience

This subtheme outlines how prior experience of seeking and/or receiving support influences PeH's following experiences of seeking support. Prior experiences of being invalidated for difficulties led to feelings such as embarrassment in following experiences of help-seeking. Experiences of coercion or harassment to engage PeH with services is likely to influence PeH to distrust services and avoid seeking support. Where fear has been experienced and not overcome, this will remain a barrier to seeking support. A common experience was fearing opening up to professionals about their difficulties, since trust is often a difficult concept to build for PeH. Conversely, positive experiences of receiving support conditions the context for confident health support seeking in the future.

Subtheme: Self-sufficient until crisis

Initially PeH describe managing their health problems self-sufficiently. Within this, they may minimise their health problems, or have competing needs that take priority over their health. Some participants described dismissing their health needs until crisis point, due to their attention focussing on shelter, food and other issues. Only once they reach crisis point is seeking help from health services a necessity. This process was observed across physical, mental and oral health. For example, PeH may self-medicate, operate, or avoid the issue, before seeking health support. Only once an intolerable level of distress is reached, and there is an absence of alternatives, might PeH seek health support.

There seemed to be an attitude of, ‘if I can cope alone then I should’. Many articles outlined PeH to deem their health difficulties not sufficiently severe for health support. One article acknowledged a level of pride in living independently as a rough sleeper without support.

Subtheme: Psychology, lifestyle and coping

This subtheme describes cognitive abilities, mental health, and beliefs about the self that impact on seeking support from health services. A ‘chaotic’ lifestyle was referenced with associated issues with attending appointments, treatment from services, or prioritising health. Coping strategies were issues that were often barriers to support-seeking from health services.

Issues with memory and orientation to time were described to impact on keeping appointments. The requirement of completing forms and interpreting letters can be barriers for PeH with limited literacy skills. This barrier may impact on confidence and be sufficient for PeH to disengage with services. Those able to complete the forms and understand the processes felt more confident in engaging with mainstream health services.

Significant negative life events impacted the level of motivation experienced by PeH to seek healthcare. Similarly, mental state, such as experiencing psychosis, may influence PeH’s perspective on whether they are experiencing a health problem, and thus seeking help.

Lifestyle factors as PeH, including tiredness as an outcome of sleeping arrangements, may be the decider between keeping a health appointment or not attending. This contributed towards assertive outreach being preferred. Motivation for seeking health support for some seemed dependent on their psychological capability, which was influenced by their lifestyle.

Specifically when seeking mental health support, a self-view as ‘crazy’ was highlighted as a barrier. The discourse of mental health difficulties being associated with ‘craziness’ was suggested as being particularly pertinent across PeH.

Coping strategies, such as alcohol and substance use or self-harm, were highlighted as issues whilst seeking support from health services. Whether it was planning substance and alcohol use to fit with accessing healthcare in case of withdrawal symptoms, or referral criteria as a barrier to receiving healthcare whilst using alcohol or substances, alcohol and substances were cited as impactful on help-seeking experiences. Particularly with mental health services, some participants experienced rejection from services until they addressed their coping strategies, further perpetuating the use of their coping strategies due to them being interrelated. Thus, creating a vicious cycle. This cycle, created by poorly integrated services, leaves PeH with little resources to manage their difficulties.

Subtheme: Emotional experiences accessing healthcare

There was an array of emotional experiences described when seeking help from health services.

Some PeH experienced self-blame for withholding information they may feel ashamed of. For example, their homeless status, or the pain they were experiencing. Without services having this knowledge, gaps in formulations and treatment plans follow. Shame was a barrier to attending health services, for example due to the difficulties faced by PeH in maintaining hygiene.

Anxiety was described in many contexts. For example, anxiety due to finding services intimidating, perpetuated by staff or other patients demonstrating prejudice towards PeH. Some PeH described anxiety as increasing paranoia about practitioners’ views of them. Ultimately, accessing health services sometimes came at a cost to self-esteem. Sometimes anxiety was dependent on the type of service, such as the dentist. Some PeH were concerned about the level of qualification of people working in health settings. In the case of visiting the hospital, some PeH feared having little control over their substance withdrawal in the event of hospitalisation. Mental health support produced anxiety due to the uncertainty for what the appointments may be like, fear about sitting one-to-one with a practitioner, or fear about opening up. All these situations influenced anxiety levels and associated avoidance. Health services that provided staff support in attending appointments were reported as beneficial for reducing anxiety and increasing confidence in attending health services. Sometimes anger may mask feelings of anxiety or overwhelm.

Table 5. *Example quotes to support the theme 'Individual factors'.*

Subthemes	Example quotations
Prior experience	*"[if] they felt that they were being harassed or interfered or coerced into doing something that they're not really interested in [...] when you leave this person their thoughts are going to be all over the place whereas they were settled before [...] there's a chance that they'll never speak to another nurse person again."* (Ungpakorn & Rae, 2020, p. 259). *"...when I was ... younger ... my family would take me to the dentist. As soon as I'd hear the drill, I'd be off! They'd have to physically restrain me! To... get owt done!"* (Csikar et al., 2019, p. 2). *"Like they might not think they can talk to anyone.. because of the experiences they have had.... Especially young people at Centrepoint."* (Chaturvedi, 2016, p. 57). *"I was only able to do the second counselling due to the fact that the first counselling was really good."* (Chaturvedi, 2016, p. 58).
Self-sufficient until crisis	*"I'd have took [sic] heroin and I'd have took [sic] painkillers and if I'd come to the point of – I'd wait till it was an emergency. That's what I did with everything, I waited till it was an emergency and then I dealt with it if that happened."* (Caton et al., 2016, p.68). *"Because.. I know it myself. I was so stressed. Like... so stressed. And I said "let's try"."* (Chaturvedi, 2016, p. 58). *"When people are homeless they don't really want to see doctors. It's only if they're really bad. Then they go to hospital."* (Rae & Rees, 2015, p. 2100). *"...I'd have to hit my head on the street and be unconscious, and somebody else would have to call the ambulance, then I'd go to hospital." "Why wouldn't you go otherwise?" "Well what's the point? I felt all-right afterwards. If I can pick myself up why should I let anyone else do it?"*

	(Shiner, 1995, p. 539).
Psychology, lifestyle and coping	*“People have dyslexia … learning difficulties, people that maybe are on drugs or addictions will not be able to maybe erm get through so easy in signing up to a GP because of their mental state, personality disorder, erm also not understanding the waiting times and procedures, they get frustrated.”* (Gunner et al., 2019, p. e532). *“I just needed to clear my head, with my wife and everything, I just wanted to go to sleep. I didn’t really care. I had nothing to give up. I had nothing.”* (Rae & Rees, 2015, p. 2101). *“Some people may not be in touch with reality and not seek help because in their minds, in the first place there is nothing wrong…”* (Chaturvedi, 2016, p. 58). *“If they’ve had a bad night sleeping and they’re tired, they’re not going to go. Carrying their baggage all over with them […] But I think if they’re coming to find you on the street, they’re coming and knowing and understanding what you’re going to be like.”* Ungpakorn & Rae, 2020, p. 258). *“Being in a better place in my head, knowing that if I had an appointment, I would keep to it. Before I wouldn’t, because I had a certain lifestyle. But now I would because I want to help myself. Basically I want my body to be [as] healthy as it possibly can now”* (Paisi et al., 2020, p. 3). *“You’re just gonna start thinking like “Do I have any problem that I need to go and talk to someone”. For me that’s what I think when I hear that word. “What do you think I am crazy or what?””* (Chaturvedi, 2016, p. 57). *“Anyway this w’ when was it Tuesday night and I just. I had the money to score my heroin to be able to keep me, in, the A & E Department until I was to be admitted and to get my methadone. You see that was my main concern. I didn’t want to be in a situation where, I’d maybe be in there mayb’, I dunno, maybe ten or twelve hours and start withdrawing…”* (Craig et al., 2014, p. 8). *“… if you’ve self-harmed within the last 6 months they won’t touch you as well as if you’re on the alcohol or drugs as well they won’t touch you because they think you’re too high of a risk … you shouldn’t be using [recreational drugs] to self-medicate but when you don’t have access to the services what else are you meant to do?”* (Gunner et al., 2019, p. e530).
Emotional experiences accessing healthcare	*“I’ve not said anything I don’t — I don’t know if they [GP] could [help] … so I do blame myself … for not mentioning it [homelessness] but I think it’s just better that way.”* (Gunner et al., 2019, p. e532). *“If you are homeless you are like not well taken care of, so people may be ashamed to go to a clinic.”* (Ungpakorn & Rae, 2020, p. 258). *“Some people find it intimidating enough going in there [to the dental practice]...So if they’ve got someone who’s, say, like not being very I don’t know nice then it can put them even more on edge”* (Paisi et al., 2020, p. 4). *“I wouldn’t go to the doctor’s on my own, I couldn’t . . . and so she would come with me just to make sure, keep me at ease, allow me to know that it wasn’t that bad, that I was all right and so she would just like keep reassuring me . . . That increased my confidence and made me able, like, to go to the doctors whenever now.”* (Taylor et al., 2007, p. 226). *“You push it away at first because you’re... you don’t want any support...*

	everything feels too much. But then you start opening up to it and you realise that you were annoyed before because you just felt overwhelmed maybe." (Chaturvedi, 2016, p. 57).

Super-ordinate theme: Service factors

At the service level, there were issues related to: navigating services and the relationships between services, experiences of staff, a preference for an assertive and encouraging approach, the accessibility of services, and the importance of a flexible service.

Subtheme: Navigating services and service relationships

This subtheme described the difficulties faced by PeH whilst navigating services, as well as preferences for certain services over others. The process of seeking support can be so difficult, that the physical pain of the health difficulty is preferred over the pain of seeking support; it can be easier to self-medicate than to navigate health systems.

Poor service coordination was an issue in seeking support, for example GPs being unaware about operations that had occurred to be able to prescribe appropriate treatment. Poor continuity of care was outlined, as PeH perceived hospitals to rush discharge, often placing them back into the context which caused their health difficulty.

PeH described waiting for untimely prescriptions, and the consequences this can have on their recovery if expectations are not met, for example, relapsing with substance use.

There can be anxieties present about service relationships, and how interactions with one service may impact the knowledge held by other services. For example, concerns about involvement of the police and the Home Office.

There were accounts of conflictual information between services on health issues (for example between doctors and pharmacists). There were expressed preferences for emergency support over GP, unless it was a homeless specialist practitioner. There was distrust that PeH would be listened to by the GP, or that the GP could provide the necessary care. Additionally, signposting and awareness of health services for PeH from GP was often poor. This contributed towards a slow process from GP involvement to specialist service involvement.

It can be difficult to understand which services are NHS or not, to know which services are available to PeH. This was more commonly described with dental services. Conversely, there were successful narratives of health services liaising with other services, and homeless services or places of safety bridging the gap between mainstream services. For example, health services working with food distribution sites.

Subtheme: Staff attributes

There were staff-related attributes described as beneficial when seeking support from health services. Most cited was having time and listening (equally not being listened to was associated with frustration).

The selflessness of staff was commended. An assertive, motivating approach was appreciated, and it was noticed when this approach was missing. Persistence with PeH seemed necessary, as trust and unstructured lives can cause issues with engagement. Feelings of containment as an outcome of comfort, or encouraging structure, or being held in mind were described. Contrastingly, there were occasions where PeH remembered being discouraged. This process appeared to impact self-efficacy and motivation.

An informal approach was often preferred. This was communicated across articles, but also in theme titles such as '*A human connection*' (Ungpakorn & Rae, 2020). An emphasis on the shared humanity through mutual sharing of personal information was thought to minimise the power imbalance between PeH and professionals.

A consistent relationship was viewed as beneficial, as the re-telling of one's story can become repetitive or feel painful. One practitioner allocated for healthcare was viewed as convenient and improved continuity of care. A lack of continuity of care was apparent with students working in health care settings. Additionally, some PeH experienced worry about the age or qualification status of students.

Staff-related factors perceived as detrimental were taking authoritative positions or evidencing prejudice attitudes. Both of which are outlined under the subthemes 'power, control, and choice' and 'stigma' respectively.

Subtheme: Accessibility

PeH face inequitable accessibility barriers whilst seeking health support. A key issue was GP registration, whilst having no proof of address. Common issues were travel, financial and practical difficulties. Recommendations to increase service visibility were cited.

Across the 29 year span of the articles, PeH expressed that there were too few GPs who work with PeH. A repeated issue is GP registration without proof of address, even though GPs can offer the surgery address as a 'care of' address. Health difficulties then accumulate and increase in severity due to the inaccessibility of primary care.

Often health services are dispersed across large geographical areas, making it difficult for PeH to travel to appointments. Transport is mostly unaffordable for PeH, and individuals will need to walk, often with physical health limitations. The journey is enough to discourage PeH from seeking health support, even in times of crisis. Conversely, at specialist healthcare centres, multiple healthcare needs can be met in one setting and they are often located nearby the hostels, increasing convenience and accessibility for PeH.

PeH described being unable to afford long-term therapy, and the financial implications of essential dental work. Some acknowledged that they may have free access via the NHS, however, were uncertain on the processes.

The routes into health services were described as challenging. This was sometimes due to lack of internet or phone access, learning difficulties as a barrier to completing forms, a need for interpreters, or a lack of knowledge for how to access the services. Once a service had been accessed, there was a need for appointment reminders to remain engaged.

A lack of knowledge and awareness of services was outlined, and PeH seemed disconnected from what was available to them. Some shared that they would access the services if they were better publicised. Visibility of options, such as through posters, was described as insufficient. Active encouragement instead seemed to be required. To help resolve PeH disconnect from services and build trust between PeH and health services to facilitate engagement, peer promotion of services was suggested.

Subtheme: Flexibility

This subtheme considers flexibility as services being patient, having easy access, and practitioners that persevere or take on multiple roles. Some people can access telephone support, whilst some may require face-to-face drop ins. A flexible service can accommodate the differing needs. The flexibility can extend to enabling appropriate appointment duration, and to minimising waiting times for a service.

PeH require a service that will allow them to have the time to work through contemplating support. Time and perseverance can enable the PeH-service relationship to be established. Participants suggested that service user involvement may facilitate person-centred care.

Often homeless specialist services were complimented across the articles. PeH appreciated having a multidisciplinary team and emphasised the ease of access. Outreach support is flexible around PeH's lifestyles; outreach can help PeH feel as though they are not alone, and they are worth caring for. Outreach was viewed as a bridge into services. Some PeH voiced they would trust other members of the outreach team they had not met, because of what they represented.

Little waiting time for appointments was perceived as a key benefit. Long waiting times placed seeking healthcare lower down PeH's priorities. There were reports of appointment length being insufficient. For example, PeH experienced having limited opportunity to query their prescriptions or explain their situation, additional to professionals not having time to provide sufficient information or advice.

Table 6. *Example quotes to support the theme 'Service factors'.*

Navigating services and service relationships	*"Drank more, it takes away the pain. Eat paracetamol, it takes away the pain. Generally ignore it. I've had abscesses over the years and I just pop them myself and carry on, it doesn't bother me. […] it's easier than trying to go through the system."* (Caton et al., 2016, p. 68). *"As for the hospitals, all they want to do is discharge you. I went straight back to where I'd been attacked which was the only place under shelter. They didn't care."* (Rae & Rees, 2015, p. 2103). *"He's gone down the chemist this morning but they haven't got a script in. Oh, I must have had an appointment yesterday like. So, he's come up here to get his prescription. The doctors took 15 minutes to tell him he can't have a prescription, but he'll give him the prescription tomorrow. He's gone to score now, he's been clean for 7 and half months."* (Massie et al., 2018, p. 6). *"[they] would literally like wake people up with the police and the Home Office and with healthcare [...] I was quite concerned that they were in tandem with the Home Office and the police."* (Ungpakorn & Rae, 2020, p. 259). *"Even when I'm registered, I see others… in day centres and shelters. If no one's around, I'll go to casualty too."* (Shiner & Leddington, 1991, p. 22). *"[At] my local GP, the one near the hostel, the staff don't give accurate information"* (Jenkins & Parylo, 2011, p. 23). *"She [CPN] has contacted the education department on my behalf and both*

	kids have seen her to talk about their problems in private, it is counselling for them, it's made a lot of difference to them." (Tischler et al., 2002, p. 161).
Staff attributes	*"I found it very useful to talk to them (. . .) because they sat and listened and the [shelter] staff don't always have the time, haven't always got the time to sit and listen to us"* (Archard & Murphey, 2015, p. 363). *"Midwives should be more helpful towards patients and have more time for people."* (Jenkins & Parylo, 2011, p. 23). *"She took it upon herself to say you're OK in not being on the streets now, but what is the effect that you've had as a healthy person? What has changed about you? And she sat down with me and said, I'm going to put some appointments together and every now and then I'll examine you."* (Rae & Rees, 2015, p. 2103). *"They might be worried about like their.. they'll get to like... they'll try and be like I don't know... too formal. Too enclosed with them..."* (Chaturvedi, 2016, p. 58). *"Well, she says to me 'you're addressing other things at this time, I don't think you're ready to sort this out yet (...). She made me not interested"* (Garner & Ratschen, 2013, p. 6). *"it wasn't very clinical, it was just like relaxed, it was like: oh I know this girl, she just so happens to be a nurse."* (Ungpakorn & Rae, 2020, p. 257). *"... you make a relationship with the doctor then the next week you come and it's a totally different doctor and you have to re-tell them your whole life's story ..."* (Gunner et al., 2019, p. e531). *"The students make me anxious because I'm... not totally sure if they know exactly what they're supposed to be doing!"* (Csikar et al., 2019, p. 2). *"Someone comes to see you so it looks like someone cares about you [...] You know on the side of the society, like out, so if someone comes it like care."* (Ungpakorn & Rae, 2020, p.257).
Accessibility	*"...Course every doctors surgery is requesting proof of address and how can you do that if you're on the street."* (McConalogue et al., 2019, p. 5). *"If I haven't got an address like, them receptionists, I know it's not their fault, but I've said, 'Can't I just see a doctor? – 'No!'. Now and again they have let me see a doctor, but they don't really want to know you."* (Reid & Klee, 1999, p. 21). *"Yeah, I've missed medication cause I, I couldn't get, cause I suffer with arthritis so, certain days I, it's a no go even walking, I can't walk."* (Jagpal et al., 2019, p. 4). *"The financial implications of going to the dentist, I wasn't sure what they were, I didn't take the time to find out...I didn't know which dentists were NHS."* (Coles & Freeman, 2016, p. 58). *"... if it was more well known to people that it was available because I've been homeless for years on and off and I didn't know anything like this existed. So if there was more publicity, if it was pushed out there a bit more a lot more people would actually come to it."* (Caton et al., 2016, p. 70). *"Suggesting recruiting people like us, who are already on the street, some of us, going to know certain people, and I'm just getting nowhere, here*

	mate, I'll signpost you to them…" (Jagpal et al., 2019, p. 6). *"I've seen leaflets stuck on walls but no one has ever said anything and I think they could do a lot more, GPs and in general, the NHS [National Health Service] as a whole, because I think beyond sticking leaflets on walls, they don't do anywhere near enough"* (Garner & Ratschen, 2013, p. 6).
Flexibility	*"I don't know... like... Give them time you know? Like even me.. at the start I was not ready for the support because I just wasn't... uh... I wasn't in a good place and didn't want to meet anyone or talk to anyone... but with time I became more open to it."* (Chaturvedi, 2016, p. 58). *"Different strokes for different folks isn't it, that's why it's hard to do because everybody wants something different so, yes, questionnaires to find out what each individual wants and then they can cater for the client or patient around that."* (Paisi et al., 2020, p. 3). *"...when I found out about the homeless dentist, it was just really easy."* (Coles & Freeman, 2016, p. 61). *"Most days at 1 o'clock it's a drop-in, ask for a nurse or a doctor [inaudible] other surgeries you've got to wait 2 to 3 weeks to get an appointment, that doesn't happen [at the SPHCPH]."* (Gunner et al., 2019, p. e531). *"… it seems like they just like have you in for 5 minutes … they have a quick chat with you, ask how you feel then like kick you out … like they spend less time with you."* (Gunner et al., 2019, p. e531). *"I've not had a chance to speak to anybody about the medication or potential side effects…"* (Jagpal et al., 2019, p. 4).

Super-ordinate theme: Social contextual factors

Experiences of stigma, issues of power, control and choice, and social-contextual factors leading to PeH being dismissed from services, all contribute to the super-ordinate theme of social contextual factors.

Subtheme: Stigma

There were dedicated themes for stigma across the studies, and many instances of prejudice and discrimination described. These experiences were expressed as a key factor for not seeking regular healthcare. Prejudice was even described on one occasion as a detrimental decider between life and death, as stigma may mean crucial healthcare support is not received. PeH described being perceived as less than human, whilst treated differently to other patients. A powerful statement to demonstrate this, was one person's belief that they should be seen by the vet.

Professionals were cited to make incorrect assumptions about PeH. For example, assuming all PeH use alcohol or substances; or assuming PeH are lying such as about stolen medication or lost forms; or assuming their motivation for seeking support is to seek shelter in the building rather than for medical attention. Such assumptions appeared to impact PeH's self-esteem and reduce the likelihood of them seeking health support.

Conversely, PeH shared positive experiences where they were treated equally. This seemed to occur within specialist homeless services, or with doctors that worked in partnership with day services or hostels. Receiving healthcare in a setting where there were other PeH felt normalising for participants.

There was also a theme of stigma in association with mental health difficulties, which seemed to come from within the population of PeH. There were experiences of being treated negatively following sharing the presence of a mental health difficulty; thus, there was an avoidance of admitting to struggling with mental health for self-protection. Contrastingly, if it was evident others had a mental health difficulty, then the difficulty and associated help seeking was normalised.

Subtheme: Power, control and choice

An individual's perceived power and control over their health was a motivator for seeking help from health services and engaging with treatment. Having choice and being informed at each step of seeking help was seen as empowering PeH, by centring them in their care. Power, in terms of the power dynamic between PeH and professionals, and hierarchy and authority were prominent issues.

Some PeH were motivated to seek health support, influenced by a suggested internal locus of control, and followed advice from health professionals. However, this was dependent on accessible advice. Contrastingly, the multitude of barriers existent due to governmental, political, and societal factors led to abandoned attempts at seeking healthcare support, as it was believed to be impossible despite best efforts, leaving PeH feeling powerless.

PeH may experience motivation to seek support and have the knowledge for what would benefit them. However, services present barriers and are prescriptive with what interventions they will provide for individuals. Sometimes treatment is avoided, to remain in control. For example, declining medication.

Where the process of support is made explicit, this aids the cost benefit analysis that PeH make when deciding on healthcare choices, enabling them to enter treatment fully informed.

Some literature showed the determination some PeH had to seek health support and have their health needs met, despite the barriers into healthcare. For some, this meant deceiving to receive care, or committing crime to receive healthcare in prison.

The theme '*The right approach'* (Ungpakorn & Rae, 2020) described experiences that felt '*totalitarian*', included threatening visits to the police station. Recommendations for balancing the power dynamic between professionals and PeH included: professionals showing respect, balancing power through body language, avoidance of being '*pushy*', avoidance of uniform as it is associated with authority, avoidance of blame for not completing health behaviours, not demanding the PeH's name, accepting a PeH declining their support and giving them choice to call if they change their mind. An emphasis on balancing the power between staff and PeH and promoting respectful non-condescending communication was apparent across other articles.

Subtheme: Context dismissed

This subtheme represents the experiences of PeH as being dismissed whilst seeking support from health services, due to social-contextual factors. This may be in the form of practitioners seeking a quick fix, or a lack of sensitivity to circumstance, or being passed around gaps in services.

There were accounts of health services recommending interventions that would not improve an individual's health in the context of experiencing homelessness, whilst contributory factors to ill health continue (such as basic needs not being met). For example, recommending rest and relaxation in a context of rough sleeping. It was suggested that healthcare staff are not aware of PeH increased vulnerabilities to health issues.

PeH described experiences of being told they could not be helped or being '*fobbed off*' with medication having not been listened to, and therefore the need not identified. PeH at times felt '*ridiculed*' for their presenting problem, with multiple accounts of not being taken seriously.

It was suggested that the perception of need from services may leave gaps in who is receiving a service. For example, ethnicity, crime, and substance use issues may be considered priority factors for receiving care. Often services may reject PeH, and direct them to another service where the process repeats, and PeH are left unsupported.

There were also reports of being invalidated by professionals whilst seeking support, seemingly influenced by a lack of compassion for the context of homelessness.

Table 7. *Example quotes to support the theme 'Social contextual factors'.*

Stigma	*"Because I'm homeless I'm not seen as a priority. I have problems just like everybody else but I'm not treated equally. I know that. 'Cause she goes, 'I've got patients waiting.' Am I not a patient?"* (Rae & Rees, 2015, p. 2103).

	“it’s like we’ve got two heads, are all drunks and junkies” (Bhui et al, 2006, p. 157). *“When you go back in and you say [to a GP] something like ya know [the medication has] been stolen, for example, half the time the GP’s not going to believe you … they’re just gonna think you want another script early because you’re using it recreationally ….”* (Gunner et al., 2019, p. e532). *“I prefer to use the day centre because I get treated like a human being, not like a homeless person.”* (Shiner, 1995, p. 543). *“I felt good that I’m not the only one getting counselling, everyone else is getting counselling .. not just me.”* (Chaturvedi, 2016, p. 60). “*It makes you feel rotten really. I wouldn't take a bed off a dying person.”* (Shiner, 1995, p. 542).
Power, control and choice	*“She tells me things and then I try and do ‘em. So then she knows I’m trying to help myself as well. In this life if you don’t help yourself [other] people can’t do it for you.”* (Rae & Rees, 2015, p. 2103). *“...and you just think well what is the point? Do you know what I mean? What is the point of trying your best when you just can’t get anywhere? You just feel like just giving up. Do you know what I mean?”* (Csikar et al., 2019, p. 3). *“I don’t like being told what to do–you’ve got to do this, you’ve got to do that. If I wanna do it, I’ll do it, I’ll go along with it. My choices, not theirs. I wanted CBT. I wanted to come off drink. I knew what damage it was doing to me.”* (Rae & Rees, 2015, p.2103). *‘Well you need to promote the reality of the situation. And what counselling can do to help. And then the outcome that if they do seek counselling, what could happen. I think more would be interested.’* (Chaturvedi, 2016, p. 59). *“I wanted to come off alcohol that bad they said it was killing me — but they couldn’t have no funding until April … I got self-sent to prison for 3 weeks so they could help detox me.”* (Gunner et al., 2019, p. e530). *“It seems like maybe it’s just me but it feels like every time you go to the dentist you are going up to this like snobby land. You know like where it is full of like middle class erm fifty-year-old women who are all like ‘well this is how you are supposed to have done it and why you haven’t done it like this before’. Sorry. And it just feels like you are getting a lecture all the way down the line.” (*Csikar et al., 2019, p. 3).
Context Dismissed	*“I’ve always been susceptible to chest infections. So I had to go and see a doctor about that. And they’d say, ‘Oh, there’s nothing wrong with your lungs, you’ve just got a heavy cold, you’ve just got to relax and rest. [Raises his eyebrows.] That’s kinda difficult when you’re homeless.”* (Rae & Rees, 2015, p. 2103). *“I don’t know, they just saying it’s not us, go to here and they kept sending me to different places, go to A&E, go to the Police Station, go to the walk-in centre, go to your GP, go here, there – and that’s why I went mad, proper wound up, nobody’s helping me.”* (Massie et al., 2018, p. 6). “*I went to casualty, but they wouldn’t listen to me. They kept asking me if I’d got lice.”* (Shiner & Leddington, 1991, p. 23).

Discussion

Overview of Findings

This review aimed to synthesise the experiences of PeH when seeking help from UK health services, as well as identifying recommendations for improving access to health services for PeH. The main themes identified were organised into individual factors, service factors and social contextual factors. Such themes draw parallels with the three stages of the social inequalities model (McClelland, 2014). The subthemes identified specific areas of importance that are impactful on the help-seeking experience for PeH. Such themes span across positive and negative experiences of PeH, which inform individual, service-level and social contextual barriers and facilitators to help-seeking.

The findings outline that there are interactions between the ecological layers of the themes. For example, social contextual factors such as stigma can be impactful on service factors such as how staff interact with PeH (staff attributes) and impact individual factors such as the shame or anxiety experienced when PeH seek support (emotional experiences accessing healthcare).

Within individual factors, the subtheme ‘self-sufficient until crisis’ is congruent with the literature highlighting that PeH often attend emergency services above other services (Lacobucci, 2019), and provides further insight into the reasons why. One of which, is prioritising other health and social needs, as supported by Hewett’s (1999) survey and Maslow’s (1943) hierarchy of needs. Within the psychology of PeH, intersectional social inequalities of cognitive and mental health difficulties were highlighted. This is congruent with research suggesting the significantly higher prevalence of intellectual disability, mental health difficulty, and brain injury in the homeless population, compared with the general population (Depp, Vella, Orff & Twamley, 2015; Homeless Link, 2014; Oakes & Davies, 2008; Topolovec-Vranic et al., 2012). The identification of psychology, lifestyle and coping strategies of PeH can facilitate services adapting to accommodate the unique barriers that impact PeH, as well as ‘prior experience’ increasing sensitivity for what ways of working are helpful to reduce the risk of marginalising PeH.

Similarly to Cornes and colleagues’ (2018) findings, the review identified that services have poor discharge processes, often placing people back into the context that caused their health issue. Thus, sustaining the impact of structured and interpersonal inequalities (McClelland, 2014). The review identified services that may adopt helpful approaches to minimise the barriers experienced by PeH. Specialist homeless services, particularly outreach, were described as beneficial due to their flexibility, accessibility, and their respectful, encouraging, and assertive approach. Additionally, specialist homeless services often minimise the difficulties of navigating services and service relationships. The review helped identify the factors that make specialist homeless services successful, thus, providing insight into Riley et al.’s (2003) statement about specialist homeless services facilitating access for PeH. Through a critical community psychology lens, such tailored services can encourage normalisation and community (McClelland, 2014).

A lack of understanding for PeH’s context was described to lead to PeH feeling dismissed, ridiculed, and left them with unmet health needs. The issue of stigma was apparent across time, spanning from the earliest papers to the most recent in 2020. This finding is supported by Luchenski et al.’s (2018) finding of stigmatising barriers in the review of health interventions for marginalised populations. This shows that there is much work to be done on altering the attitudes of professionals and the public to emphasise compassion and reduce stigma and prejudice.

Specific experiences and preferences were outlined by PeH, such as means of balancing power between PeH and services, which can provide knowledge to stakeholders in the healthcare of PeH (Jagpal et al., 2020). Overall, the findings can aid health services in facilitating access and positive outcomes for PeH, as highlighted by the Public Health England's (2021) 'Inclusion Health' guidance.

Strengths and Limitations

Due to the qualitative nature of the review and synthesis, it is important to consider the influence of both the original researcher and the current researcher during the analysis of the results. A clear description of the role of the researcher was inconsistent across the studies. In accordance with thematic synthesis, the current researcher was always checking that the transfer of findings from the original studies to answering the review question was valid, and remained reflective on their own position through revisiting findings and discussion (Thomas & Harden, 2008). Therefore, whilst reflexivity was considered in the current review, it was not consistently present in the original studies. Consequentially this could impact the reliability of the review findings.

It was a strength of the review that 22 papers were included. However, there was an unequal distribution of attention to the types of health services in the findings. For example, GPs were frequently referred to, whereas some health services were only referred to on minimal occasions, such as sexual health or occupational therapy. Therefore, conclusions and recommendations should be interpreted with caution for such health services that did not contribute widely to the findings.

The review included studies conducted in the UK, and represented a range of urban, semi-urban and rural locations. This should aid transferability of the experiences of PeH seeking support across UK health services. However, it is unlikely that this review will extend to the experiences of PeH across international cultures.

The range in methodological quality is noteworthy. However, in line with thematic synthesis, none of the studies were excluded due to quality, as the relevance of the studies to answering the review question was prioritised (Thomas & Harden, 2008). Although all themes were contributed to by higher quality studies, it is still possible that the range of methodological quality may impact the validity and reliability of findings.

Implications for Research and Practice

This synthesis highlights the complexities of the experiences of PeH within their social, physical and psychological context, and the associated complexities of researching and working clinically with PeH. For example, the impact of living conditions or mistrust due to prior experience can impact the ability to research PeH in a controlled research setting and hinder the feasibility of systematic data collection procedures. Similarly, services must adapt to the complexities of PeH, for example, by building trust via balancing power, or creating flexible and accessible services. There is an inter-play between the individual factors and service factors that are influenced by social-contextual factors. In line with community psychology research, issues beyond the individual were highlighted to formulate the experience of seeking health support for PeH (BPS, 2000). Person-centred holistic assessment, formulation and intervention is necessary to recognise what is applicable and beneficial for PeH (Johnstone, Whomsley, Cole & Oliver, 2011).

The synthesis uncovered many barriers for PeH seeking support from health services; many barriers are inflicted by the services. It is noteworthy that this population is described as ‘hard-to-reach’ (Caton et al., 2016; Pfiel & Howe, 2004; Taylor et al., 2019), when perhaps a re-frame for services being ‘hard-to-reach’ is more appropriate; this is a concept considered in the literature with regards to populations marginalised from services (Bradley, n.d.; Bucci et al., 2019; Riggs et al., 2014). A shift from individually focussed intervention to organisational intervention is vital for such a re-frame (BPS, 2000). It should not be PeH's responsibility to inform professionals that resting is not a possible intervention in their context, or that medication for a chest infection will not fix the damp conditions they are sleeping in each night. It is imperative for services to understand the unique factors impacting PeH to support PeH meaningfully. Training, multidisciplinary teams including health and homeless liaison across services, increased intervention options and referrals for housing support may all support achieving this. Without improvement, it is understandable that PeH continue to self-medicate or tolerate their difficulties until the point of crisis.

Services which were generally highlighted within positive help-seeking experiences were those where the key practitioner provided multiple avenues of support and liaised with other services, as well as specialist homeless services. An informal approach and being treated as human are simple yet vital necessities for a population that describe experiences of prejudice. Such approaches facilitate a shift from PeH experiencing marginalisation, to experiencing normalisation; thus, promoting wellness over illness (McClelland, 2014). The findings highlighted that assertive outreach with an encouraging approach where power is balanced is a key resolution for engaging PeH with health support. This overcomes practical barriers such as time and travel and creates a discourse that PeH are worth caring for, which contrasts popular discourse shared by society, and internalised within PeH. Homeless Link (n.d.) outline guidelines for delivering effective assertive outreach which can be used to guide practice.

An aim of this synthesis was to identify recommendations for improving access to health services for PeH. It is deemed appropriate to apply qualitative research with such an aim to inform guidance and practice (Newman, Thompson & Roberts, 2006). Already it is written in policy that health professionals have a duty to refer PeH, or people who are threatened with homelessness, for housing support (The Homelessness Reduction Act, 2017). However, policy and guidance need to reach beyond this. A development could be that a person identified as homeless by the public authority must be offered support by a specialist homeless service that can support with housing, health and social needs. Additionally, guidance for discharge of PeH from hospital could be introduced to ensure PeH are not discharged back into the context that caused their health difficulty. The findings suggest recommendations for bridging the gap between PeH and health services. Perhaps guidance should state the necessity of peer promotion of services, such as health services employing PeH to facilitate PeH engagement with health services. To facilitate professionals' awareness across services and holistic support, there is a need for increased provision of homeless liaison professionals in health settings and health liaison professionals in homeless support settings.

Further research should prioritise quality improvement studies. For example, improving pathways into care for PeH. Service-user input, alongside the findings represented in this review, are important for facilitating the development of services that PeH feel safe to seek support from. Audits identifying the pathways into care and the discharge summaries of PeH can help to highlight how localities can implement prevention interventions and ensure maintenance of positive health outcomes.

Conclusion

This review synthesised the experiences of PeH seeking help from health services in the UK. It highlighted the multiple layers of barriers and facilitators to seeking support, that interact at an individual, service and social-contextual level. The identification of such themes has implications for practice and policy that can facilitate PeH accessing health support. Consequentially, this may increase health outcomes for a population that is disproportionately impacted by social, physical and psychological difficulties.

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PART TWO: EMPIRICAL PAPER

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See Appendix O for submission guidelines.

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An exploration of what helps and hinders access to alcohol treatment for people experiencing homelessness

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Abstract

Purpose

People experiencing homelessness disproportionately experience alcohol dependence and the majority are not accessing alcohol treatment. There is a paucity in research exploring what helps and hinders access to alcohol treatment for people experiencing homelessness and alcohol dependence (PHAD). The current study sought to answer the questions: what role does alcohol play for PHAD? What physical and psychological capabilities, and physical and social opportunities help or hinder access to alcohol treatment? What influences PHAD's motivation to access alcohol treatment?

Methods

A sample of 7 PHAD and outreach and key workers engaged with semi-structured interviews. Interviews were analysed using a constructivist approach to reflexive thematic analysis using inductive and deductive processes.

Results

Five themes and eleven subthemes were identified. 'Alcohol's role' highlighted alcohol's use as a coping mechanism and described the impact with other health and social issues. 'Motivation' described the process of weighing up and contributory factors to fluctuating motivation. 'Capability' described the cognitive, emotional, and physical capabilities of PHAD engaging with alcohol treatment. 'Social opportunity' considered the impact of others and the wider context. 'Physical opportunity' highlighted service and treatment factors and placed physical opportunity in context.

Conclusions

Implications are discussed to aid reducing barriers in research and clinical practice with PHAD.

Keywords

Alcohol Dependence; Alcohol Treatment; Empirical Research; Homeless persons; Qualitative.

Introduction

There are estimated to be over 250,000 people living in temporary accommodation in England (Shelter, 2020). The numbers for people experiencing homelessness (PeH) will be greater when including people who are: rough sleeping, squatting, sofa surfing and staying with friends and family short-term (The National Health Service; NHS, 2021). Within this population, more people experience alcohol dependence (AD), with between 21.3 and 50% of PeH experiencing AD (Gill et al., 1996; Harrison & Luck, 1997; Smith, 2005; Bowen et al., 2019) in comparison to between 1.2 and 4% of the general UK population (Drummond et al., 2004; McManus, Bebbington, Jenkins & Brugha, 2016; Bowen et al., 2019). At minimum, it could be estimated there are 60,000 people experiencing homelessness and alcohol dependence (PHAD) living in England. Conversely, it was reported that in 2019/2020, only 1,246 of people accessing alcohol treatment had an urgent housing problem (Public Health England, 2020). This highlights the gap in understanding how to engage PHAD with alcohol treatment. It is a priority of the Department of Health and Social Care (2018) to address the needs of individuals using alcohol, with adjustments made to improve access to treatment for those with differing levels of need, which is applicable to PHAD. Additionally, Public Health England (2021) state in the ‘Inclusion Health’ guidance that it is necessary for health services to facilitate access and positive outcomes for PeH, which can be applied to services providing alcohol treatment.

The impact of alcohol is known to be harmful across domains (Nutt, King & Phillips, 2010). For PHAD, the costs of using alcohol at the individual level include associated physical and chronic health problems, legal problems, goal interference, or can lead to the individual being vulnerable to harm from themselves and others (Collins et al., 2018). Moreover, coexisting mental, physical, and social difficulties are highly prevalent for PHAD (Fazel, Khosla, Doll & Geddes, 2008) and PHAD have attributed relationship breakdowns and their homelessness to their alcohol use (Neale & Stevenson, 2015). AD is costly for society, for example alcohol-related admissions account for a disproportionate amount of attendance to emergency departments, hospital admissions and hospital costs (Phillips, Coulton & Drummond, 2019). Economically, Public Health England (2016) estimates harmful drinking costs society £21 billion annually. Therefore, PHAD engaging with alcohol services is important at the individual and systemic level.

Engagement with alcohol treatment: the capability, opportunity, and motivation behaviour system (COM-B system)

The COM-B system theory (Michie, Stralen & West, 2011; figure 1) can be applied to understand the capabilities, opportunities, and motivation that PHAD may have to engage with alcohol treatment. Michie and colleagues (2011) describe behaviour as being an outcome of an interaction between:

1. The physical or psychological capabilities a person possesses to engage in the behaviour. Physical capabilities refer to skills, abilities or proficiencies acquired through practice. Psychological capabilities refer to knowledge, memory, attention, behavioural regulation, comprehension, and reasoning.
2. The social or physical opportunities available to a person to engage in the behaviour. Social opportunity includes social and cultural influences such as discourses, social

norms, social comparisons, and stigma. Physical opportunity refers to the environmental context and resources available.

3. The reflective or automatic motivations to engage in the behaviour. Reflective motivations involve evaluations, plans and identity. Automatic motivations refer to emotions and impulses.

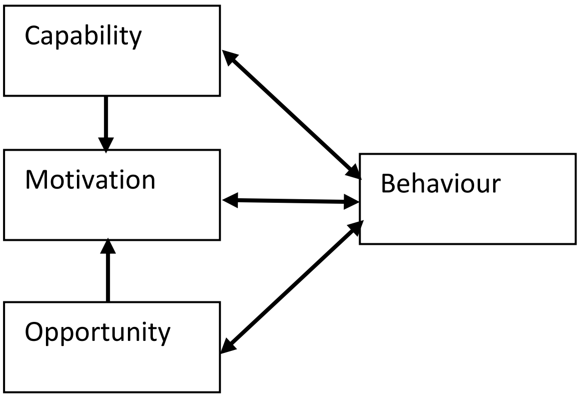

Figure 1. The COM-B system with arrows showing the flow of interaction in the system.

A strength of the COM-B system is that it encompasses multiple levels of experience that are internal and external to the individual, including considering context at the opportunity level. A limitation of the COM-B systems is that it categorises experience, which could be a reductionist representation of experience. Therefore, the current research may use the model less rigidly, to include wider experience loosely attached to each part of the system. On balance, although the model takes a behaviourist approach, it acknowledges multiple contextual layers of factors from the individual (such as within capabilities) to their social context (such as within opportunities). The model was constructed as an outcome of a systematic analysis of behaviour intervention frameworks, thus, overcoming the limitations of the prior existing frameworks (Michie et al., 2011). The model suggests interventions, mostly applicable to policy. However, in the current study, the model will be used solely to facilitate the formulation of the experiences explored in the study. Such experiences will lead to recommendations, rather than the recommendations being based on predefined interventions from the COM-B model.

This framework has informed the organisation of a review of the background literature. However, it is evident within the literature that the three components interact thus there is overlap.

Capabilities

People experiencing AD often have an avoidant attachment style (Howe, 2011). Individuals may feel safer using alcohol rather than engaging in relationships with others, such as with an alcohol worker or group support (Reading, 2002). In the context of an avoidant attachment style and the absence of a comforting and regulating relationship, although alcohol can be experienced as a secure base and satisfy the attachment cycle of security in a basic sense (Bowlby, 1988; Höfler and Kooyman, 1996), alcohol cannot provide the attunement and containment that a secure human relationship could provide due to its inanimate nature (Stern, 1985; Bion, 1962). Flores (2006, p. 5) describes this attachment between a vulnerable individual and alcohol to serve ‘both as an obstacle and as a substitute for interpersonal relationships’. Having few attachments appears particularly pertinent for PeH (Czarnecki et al., 2017; Kaplan et al., 2019). Therefore, PHAD’s attachment style and lack of social relationships may limit their psychological capability to engage with alcohol treatment.

Alcohol consumption has been perceived as a psychologically driven behaviour. Collins and colleagues (2018) conducted semi-structured interviews with 44 homeless individuals with alcohol use disorders in the USA. Alcohol was referred to as something PeH could control, suggesting that PHAD feel more capable using alcohol than reducing their alcohol use by accessing alcohol treatment. With 72.7% of the participants interviewed experiencing psychological reasons as an advantage of alcohol, this may reduce their motivation to engage in alcohol treatment. Such psychological reasons included using alcohol as a coping mechanism, specifically for mental health difficulties or confidence or to achieve a preferred emotional state (such as happiness).

PeH have additional limitations to their capabilities than the general population. For example, a significantly higher prevalence of intellectual disability, mental health difficulty, and brain injury (Depp, Vella, Orff & Twamley, 2015; Homeless Link, 2014; Oakes & Davies, 2008; Topolovec-Vranic et al., 2012). These may all impact PeH's capability of accessing alcohol treatment.

Opportunities

In the general population of people experiencing AD, social opportunity barriers and facilitators to accessing alcohol treatment in the literature include stigma, ethnicity, and gender (National Institute for Health and Clinical Excellence; NICE, 2011). An Australian review found that stigma is a pertinent barrier for PeH and problematic alcohol consumption; embarrassment and societal attitudes were outlined as barriers to seeking support (Scholes, 2019).

The discourses and social norms present within PHAD relationships may be facilitatory or limit engagement with alcohol services. Neale and Stevenson (2015) conducted semi-structured interviews with hostel residents in England. Participants referred to relatives and friends who had difficulties with alcohol which tempted their own alcohol use. Consequentially this could be a limiting social factor for PHAD accessing alcohol services. Relationships with hostel staff were generally facilitatory; however, there appeared to be discourses about staff thinking they are doing the homeless population a favour which was a barrier to engaging with them. The Power Threat Meaning Framework would suggest that this may be perceived as an operation of power where staff position themselves as more privileged than PHAD (Johnstone & Boyle, 2018). This can come at a cost to PHAD's self-esteem leading to a response of PHAD disengaging with staff, to protect their self-esteem. Similar discourses may be a barrier to accessing alcohol treatment.

The services available for PHAD include addiction services, homeless charities, counselling, and psychological therapy (National Health Service, 2019). Although, within the Institute of Alcohol Studies' (2015) report, people experiencing AD have been portrayed as a cost to society and a risk to health practitioners, suggesting there are social barriers to accessing alcohol treatment. Furthermore, it may be difficult to access some of these services whilst being homeless. For example, Grazioli, Collins, Daeppen and Larimer, (2015) surveyed 62 homeless attendees of a twelve-step peer support group. Some attendees experienced difficulties identifying with other homed attendees and past trauma was a psychological barrier to participation. Additionally, quantitative findings have suggested PeH to be less likely to enter therapy than people not experiencing homelessness; instead, injectable treatment was suggested to be preferred by PeH (Watkins et al., 2018). There was no qualitative data collected in this study to understand why this association was apparent. Both Grazioli et al.'s (2015) and Watkins et al.'s (2018) studies were conducted in the US, therefore the findings may not transfer to a UK population of PHAD.

Often services are designed according to Maslow's hierarchy of needs (Maslow, 1943), so that physiological and safety needs are addressed primarily. This may play a facilitatory or a hindering role for PHAD accessing alcohol treatment, as the individual may have a different perception for what their hierarchy of needs are, for example, the individual may wish to address their psychological needs primarily rather than their basic needs. However, services can be designed to prioritise supporting basic needs primarily before offering psychological support. Therefore, this may highlight a physical opportunity component that is pertinent for PHAD.

Motivation

External factors such as relationships, employment and education have been cited in the literature as influential on a person's motivation to discontinue alcohol use, in people who drink heavily (NICE, 2011). These influential factors may differ for PeH, due to often having limited relationships (Czarnecki et al., 2017; Kaplan et al., 2019) and being less likely to be employed or in education than the general population (ERSA, 2015).

Motivation has been found to be a predictor of alcohol behaviour change in homeless populations (Collins, Malone & Larimer, 2012). Collins et al.'s (2012) study used a closed scale to assess PeH's motivation to change their drinking behaviour, which did not provide insight into the factors and processes contributing towards the person's motivation to change. Similarly, Lapham Hall and Skipper's (1996) randomised controlled trial research in the USA found personal motivation and a supportive intervention programme to impact on recovery from AD, for PHAD. This may indicate the importance of both motivation and opportunity factors for AD outcomes in this participant group. However, the randomised controlled trial design does not provide insight for what motivated the participants.

There are some tentative suggestions in the literature that may provide insight into the factors influencing motivation processes for PHAD. Parkman, Neale and Day (2017) conducted semi-structured interviews with 30 people experiencing AD who frequently attended emergency departments in London. Of the 30 participants, 11 met the criteria for homelessness. The common barrier to accessing alcohol related treatment was that the participants did not feel they needed to prioritise addressing their AD. The paper suggests that this population's motivation to engage in alcohol treatment is low due to competing health and social problems being evaluated as more important, additional to having a low impulse to engage which may be influenced by other opportunity or capability factors. Though Parkman et al. (2017) did not analyse the homeless participants separate to the other participants, this may be particularly pertinent for PeH as health and social problems are more common in this population (Hewett & Halligan, 2010).

Upshur et al. (2018) found that 35% of the 241 women experiencing homelessness and AD surveyed were ‘feeling depressed/not up to going to treatment’, indicating low motivation to engage in alcohol treatment. Conversely, factors associated with accessing services were feeling ready to change. The above findings were collected via closed questions. Qualitative comments indicated a need for: mental health/emotional support, counselling for substance use, support with housing, groups for women’s issues (independent of addiction), taking on a voluntary role for others in a similar position, shorter waits, medication for substance use and attending to client’s general needs during visits. These qualitative findings provide some insight into both opportunity and capability factors that may impact a PHAD’s motivation to change their alcohol use. However, the study uses US PeH including both alcohol and drug dependent participants in a sample limited to women.

Identity is considered to be a powerful source of motivation (West & Brown, 2013). For example, van den Putte, Yzer, Willemsen and Bruijn (2009) have shown amongst people who smoke that a strong smoking identity is a barrier to quitting smoking. Within the homeless population, there is a higher proportion of people experiencing AD than in the general UK population (Gill et al., 1996; Harrison & Luck, 1997; Smith, 2005; Bowden et al., 2019). Alcohol use being part of a homeless identity may maintain drinking behaviour and act as a barrier to accessing alcohol treatment. Additionally, Grazioli et al.’s (2015) twelve-step peer support study suggested that homeless identity was a barrier to benefitting from the group.

Rationale

Literature suggests that there are many barriers and facilitators to accessing alcohol treatment for PHAD, but no research has explicitly explored the subject in the UK. Thus, the current study aims to explore what helps and hinders access to alcohol treatment for PHAD in the UK.

There is a lack of literature carried out in the UK to represent the views of PHAD and supporting staff in the context of government funded healthcare. Acquiring insight into the capability, opportunity, and motivational factors for accessing alcohol treatment may facilitate alcohol behaviour change and improve access to alcohol treatment for PeH. This is important for reducing the costs AD places on both the individual and society (Collins et al., 2018; Phillips et al., 2019; Nutt et al., 2010). This study would be the first to use a sample of PHAD and the staff who work alongside them in the UK to understand their perspectives on what helps and hinders PHAD engagement with alcohol services. Both PHAD and the staff that work alongside them have a unique perspective in presently experiencing or observing the factors that help and hinder access to alcohol treatment; therefore, facilitating a current and relevant understanding of the experiences faced by PHAD. A further aim is that by amplifying the voices of PHAD and those who support them in the literature to understand the role alcohol plays for PHAD, alongside the opportunities and capabilities that impact motivation and access to alcohol treatment in this group, the perception of their drinking behaviour may be viewed through a more compassionate lens by society, service providers and fellow service users.

Research questions

What role does alcohol play for PHAD?

What physical and psychological capabilities help or hinder PHAD accessing alcohol treatment?

What physical and social opportunities help or hinder PHAD accessing alcohol treatment?

What influences PHAD’s motivation to access alcohol treatment?

Method

Design

Due to the paucity of rich data within this topic, and the aim to amplify the voices of PHAD and those who support them in the literature, the study was a qualitative design utilising semi-structured interviews. The design was informed by a constructivist epistemology (Ültanir, 2012; Appendix B).

Sample

A sample of 7 participated in the study between April-July 2021. The sample combined PHAD (sample 1) and homeless outreach and key workers (sample 2). The inclusion criteria for sample 1 were: (a) 18+ years-old; (b) homeless as defined by NHS (2020); (c) alcohol dependent as measured by the Mini-International Neuropsychiatric Interview Section J (M.I.N.I; Sheehan et al., 1998); (d) alert and oriented to place and time; (e) able to understand and speak English. The exclusion criteria for sample 1 were: (a) grossly intoxicated; (b) acutely mentally unwell; (c) too threatening to approach. The inclusion criteria for sample 2 were: (a) 18+ years-old; (b) homeless outreach or key workers; (c) minimum 1-year direct experience with PHAD; (d) able to understand and speak English. There were no exclusion criteria.

Participants were recruited from a city in the Yorkshire region of the UK. Sample 1 were recruited from one drug and alcohol service and one homeless hostel. Sample 2 were recruited from the same services and a homeless charity.

Procedure

Posters and information sheets were displayed and/or emailed via the recruiting services (appendices G & H). Purposive and voluntary methods were employed recruiting sample 1. Purposive sampling was employed as potential participants with selected characteristics of experiencing homelessness and alcohol dependence were invited by their key worker to participate in the study (Given, 2008). Additionally, potential participants could respond to the poster advertisements by leaving their (or a trusted person's) contact details in a secure box in the service or via email. Voluntary methods were employed for recruiting sample 2. Potential participants could respond to poster and email advertisements, similarly, by leaving their contacts in the secure box or via email.

Participation took place face-to-face for sample 1, to ethically assess participants' safety and ability to provide consent and due to the limited accessibility of remote methods for PHAD. Sample 2 participation took place face to face and remotely using Microsoft Teams. For face-to-face participation, a private room in the recruiting service was used.

The study information was repeated and provided in verbal and written form. There was opportunity to ask questions. Right to withdraw was explained. Once consent was recorded, data collection began (see appendix I for consent form). A semi-structured interview guide informed by the literature and COM-B model and developed between the researchers and an individual with lived experience of homelessness was utilised (appendix J). Sample 2 were asked to take the perspective of PHAD, and questions were adapted such as "what role does alcohol play for PHAD?" from "what role does alcohol play for you?".

An encrypted laptop audio recorded the interviews. The interviews lasted between 25 and 88 minutes.

Demographic data was collected. Quantitative measures were used to contextualise the sample, but not for analysis. To measure the severity of alcohol dependence and associated alcohol problems, sample 1 completed the Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell et al., 1979; Appendix K) and the Alcohol Problem Questionnaire (APQ; Drummond, 1990; Appendix L). The SADQ includes measures of physical and affective withdrawal, withdrawal relief, alcohol consumption and rapidity of reinstatement. Stockwell, Murphy and Hodgson (1983) evidenced the SADQ to be a reliable and valid measure. The APQ is a reliable and valid measure of the alcohol-related problems associated with alcohol dependence (Williams & Drummond, 1994). To measure the attitudes towards working with people with alcohol dependence, sample 2 completed the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ; Shaw, Cartwright, Spratley & Harwin, 1978; Appendix M). The AAPPQ is a reliable and valid measure of staff perceptions towards working with problem drinkers (Puskar et al., 2013). Participants were signposted to housing support, alcohol use support, or mental health support if necessary (Appendix N). Sample 1 were thanked with a £5 supermarket voucher. There was no reference to the voucher prior to completion of the study to avoid unintentional coercion.

Ethical considerations

A university ethics committee approved the study (appendix F). The recruitment materials (posters, information sheets) were reviewed by a recruiting site staff member to facilitate accessibility. Informed consent was recorded following written and verbal explanation of the research purpose and procedure. Inclusion and exclusion criteria ensured participants had the capacity to consent to the interview. Right to withdraw was explained at the point of interest given, the time of consent provided and the time of completing participation. Pseudonyms were given to protect anonymity, and demographic data described using ranges to remain unidentifiable. The secure box and direct contact to the researcher facilitated private expression of interest to participate. The recruiting services were chosen to ensure that participants were receiving support for housing and alcohol needs and further signposting was offered, if necessary, alongside mental health signposting. Though this was never needed, the information sheet stated the procedure that would be followed should the participant disclose risk. Participants were informed that declining or withdrawing participation or expressing negative views would not impact their care.

Data analysis

Reflexive thematic analysis (Braun & Clarke, 2006) informed by a constructivist epistemology (Ültanir, 2012) was used to analyse the data. Such analysis is applicable for a heterogeneous sample (Braun & Clarke, 2019). Therefore, deeming the approach suitable for analysing the two samples as one pool of data. Braun and Clarke's (2006) six phases of thematic analysis were followed (see table 1 for the application of the six phases). An inductive approach was used to code the data, with the use of NVivo software, allowing for experiences to be derived from the data freely. Both inductive and deductive processes occurred during theme generation and development, as the COM-B model was influential in their construction and themes were defined as relevant to the research questions, whilst still representing shared meaning. Using the COM-B model to allow for organisation of the experiences into themes could arguably reduce experiences to fit into a behavioural model. However, the model was used as one perspective and no experience was sacrificed on account of fitting the model. Representing the experiences fully in the findings took priority over staying true to a rigid model. The themes were reviewed and discussed in supervision. Braun and Clarke's (2021) tool for evaluating thematic analysis facilitated quality assurance.

The write up of reflexive thematic analysis is accessible, facilitating distribution of findings across stakeholders.

Table 1. *The procedure applying Braun and Clarke's (2006) six phases of reflexive thematic analysis.*

Six phases	Procedure
1. Familiarisation with the data	Audio recordings were transcribed. The transcripts were re-read multiple times. Initial observations were recorded.
2. Generate initial codes	The data was systematically coded, using open coding. All codes were collated. NVivo was used for this step.
3. Search for themes	Meaningful patterns were identified and used to construct themes. Themes were constructed as relevant to the research questions and influenced by the COM-B model. Manual thematic mapping and written descriptions were used for this step.
4. Review themes	Pertinent subthemes were developed. Relationships and divergence within and between themes were reviewed. Themes were merged or divided as necessary.
5. Define themes	The essence of each theme was identified. Informative names for the themes and subthemes were finalised.
6. Write up	The themes were written to be coherent and inclusive of original data that is appropriately referenced.

Researcher's context

The researcher was a white British middle class young female, external to the recruiting services. This position may have aided or been a barrier to the generation of data, dependent on whether social comparison generated feelings of trust, mistrust, comfort, discomfort and so forth. The researcher carefully balanced inviting participants to ask questions about the researcher and the research, to facilitate trust and openness, whilst minimising the demonstration of the researcher's position. This was done with the hope that a truth may come to be known with less inaccuracy posed by the researcher, following the constructivist epistemology (Ültanir, 2012).

The researcher was a trainee clinical psychologist, holding a value of inclusivity and psychologically informed views. The researcher reflected on their own beliefs and assumptions about why alcohol may be used disproportionately by people experiencing homelessness and what may help or hinder their access to alcohol treatment. Interviews were transcribed simultaneously to data collection; this increased researcher awareness for their phrasing of questions and prompts. Both processes facilitated the researcher to increase their awareness on their position and context, and how this may impact the meaning co-constructed by the researcher and the participants/data. A reflective diary was kept throughout the research process.

Results

Sample characteristics

Due to COVID19 safety procedures, there were no visitors to the homeless hostel during the data collection period. Therefore, this limited recruitment of the sample. Of 11 people registering their interest for sample 1, 1 person participated. Of 7 people registering their interest for sample 2, 6 people participated. The PHAD participant scored 0 out of 60 on their self-reported SADQ. However, this was incongruent with responses provided for the inclusion criteria M.I.N.I interview. The APQ score showed the PHAD experienced 6 out of 23 alcohol-related problems in the past 6 months. Outreach and key workers demonstrated overall attitude scores of 29-65 out of 175, where a low score indicates a more positive attitude. There was an equal gender distribution and a range of age and experience represented in the sample. Though this was not directly asked, two participants in sample two described their lived experience of homelessness and addiction. See table 2 for further demographic details.

Table 2. *Participant characteristics*

Characteristic	Range or descriptor
PHAD	
Number of participants	1 (Graham)
Age	30 – 40 years
Gender	Male
Ethnicity	White British
Sleeping arrangements	Sofa surfing and staying with parents
Duration of alcohol dependence	10 – 15 years
Duration of homelessness	2 – 3 years
Types of alcohol consumed	Wine and spirits
SADQ score	0
APQ score	6
Outreach and key workers	
Number of participants	6 (Ben, Lian, Mark, Sam, Sheila, Zoey)
Age	23-49
Gender	3 Male 3 Female
Ethnicity	5 White British 1 Mixed British
Duration of time working with PHAD	1 year 10 months – 23 years
Educational and training background	Peer mentor – MSc degree
AAPPQ overall attitude scores	29 – 65

Table 3. *Summary of themes, subthemes, and contributory participants.*

Theme	Subtheme	Contributory participants
Alcohol’s role		
	Coping	Ben, Graham, Lian, Mark, Sam, Sheila, Zoey.
	Impact and relationship with other issues	Graham, Lian, Mark, Sam, Sheila, Zoey.
Motivation		
	The process of weighing up	Ben, Graham, Lian, Mark, Sam, Sheila, Zoey.
	Contributory factors to fluctuating motivation	Ben, Graham, Lian, Mark, Sam, Sheila, Zoey.
Capability		
	Psychological capability	Ben, Graham, Lian, Mark, Sam, Sheila, Zoey.
	Physical capability	Ben, Graham, Mark, Sheila, Zoey.
Social opportunity		
	Interaction with others	Ben, Graham, Lian, Mark,

		Sheila, Zoey.
	Wider context	Ben, Graham, Lian, Mark, Sam, Sheila, Zoey.
Physical opportunity		
	Service factors	Ben, Graham, Lian, Mark, Sam, Sheila, Zoey.
	Treatment factors	Ben, Graham, Lian, Mark, Sam, Sheila.
	Physical opportunity in context	Graham, Lian, Mark, Sam, Sheila, Zoey.

Thematic analysis

Five themes were identified. The opportunity aspect of the COM-B model represented two themes, due to the quantity of references associated with it. See table 3 for a summary of themes.

Theme one: Alcohol's role

Alcohol was understood as being a coping mechanism and understood in terms of the impact and relationships it has with other issues.

Subtheme: Coping

All participants outlined alcohol consumption to be a form of coping.

"…You can still default back to, I think like it's always going to be that primary coping mechanism of, if it gets too much have a drink." (Graham, PHAD)

The effects of alcohol enabled it to be *an escape*. This was linked to trauma, the lifestyle associated with experiencing homelessness, and health. Alcohol was also described as being *like an anaesthetic* in cold conditions. The use of alcohol was considered in relation to loss and isolation experienced by PHAD.

"…They've had a lot of past trauma in their life that they've experienced that have kind of landed them where they are, or they've had relationship breakdowns or family breakdowns that have kind of left them socially isolated as well. Erm so the alcohols maybe been a constant when nothing else in their life has." (Zoey, key worker)

Alcohol was described as something dependable for PHAD. It could provide safety in the form of comfort and consistency, but also provide structure and routine. Conversely, it was thought that those who feel happiness and have meaning in life, such as by being integrated in their community, may not use alcohol. One participant discussed at length 'blue zones' and how the sense of community in such places is strong whilst addiction prevalence is low.

"…I feel that they feel some benefit from using alcohol if they're street homeless. For that comfort and that routine really…" (Sam, key worker)

"…If you can work out a way to be happy, you know, you find that people live longer, they are less likely to take up addictions." (Mark, key worker)

Alcohol consumption is necessary to manage the withdrawal symptoms for PHAD, and protect from mortality.

"…Having a drink and settling their withdrawals could like potentially save their lives…" (Ben, key worker)

Subtheme: Impact and relationship with other issues

Alcohol use was described to impact on physical health, cognition, mental health, housing, relationships, and finances. Alcohol was described a contributing factor to PHAD's vulnerability.

"Physically alcohol is a lot more harmful than a lot of drugs. And also harmful in relationships, and violence, and erm crime…" (Mark, key worker)

The relationship between alcohol and homelessness was explored, as homelessness can lead to alcohol dependence and vice versa.

"…Alcohol dependence can lead to homelessness and vice versa, so I guess in that sense, for the sake of this argument it could be two of the same…" (Zoey, key worker)

Often (but not always), alcohol use was conceptualised as being associated with substance use.

"…I think it goes hand in hand with drugs as well." (Lian, outreach worker)

Social network and friendships were considered as relating to alcohol use, as alcohol is often present and normalised within social circles and a PHAD's environment.

"… They end up in the hostels, you know drink drugs everywhere ready available…" (Sam, key worker)

Theme two: Motivation

The theme motivation highlights the process of weighing up costs and benefits to alcohol treatment and important factors in fostering motivation.

Subtheme: The process of weighing up

The process of weighing up the costs and benefits of accessing alcohol treatment was apparent. A key point was that PHAD need a reason to give up. Though, a barrier is the limited availability of opportunities.

"If there isn't a clear indication as to why they're stopping, I think that can put people off. So it's not like I can go up to a rough sleeper and say, "wait you know what if you quit drinking, I've got a job lined up for you…" its not, it's just stopping drinking." (Lian, outreach worker)

There are competing health and social needs for PHAD to weigh up. Some participants considered it priority to have basic needs met, whereas others considered mental health to be a priority, of which alcohol use was associated. Sometimes substance use was prioritised over alcohol use due to the societal and legal context.

"I don't always think that alcohol treatment may be a priority for them right there and then, you know they're homeless, you know one of their priorities will most likely be finding suitable housing." (Sheila, key worker)

"My primary goal was to keep my mental health stable. To keep my mental health stable, I've then got to keep my alcohol use stable. And as in terms of goals that's, that's my top 2." (Graham, PHAD)

Additional to risk evaluation for entering alcohol treatment, there was reference to risk evaluation of drinking, and PHAD or people in their network not having knowledge of the risks.

"...Not many people know that if you're dependent drinking you're not supposed to just cold turkey and stop drinking…" (Zoey, key worker)

The understanding that recovery is difficult and multifaceted can contribute to the weighing up process. Conversely, when the alcohol is a noticeable cost to them, particularly their health, alcohol treatment is more favourable.

"They're wanting the tablet quite often that will just take everything away, all their problems away, just give them a pill and that will sort it. Unfortunately, it's a lot harder work than

that. You know, they need to kind of try build up social support networks, get on top of the financial situation, you know all the health issues they have to deal with." (Mark, key worker)

"I think a lot of them often come to us with the motivation to stop due to realising the effects that the alcohols having on them around them…" (Sam, key worker)

Subtheme: Contributory factors to fluctuating motivation

Motivation was described to vary across time, and multiple factors could impact this. The stages of change were referred to as processes that needed to occur.

"…Health declining, changes in alcohol use, trauma, a significant event happening, you know that could that could kind of be their main focus at the time and they may not want to continue with alcohol treatment, a decline obviously in their mental health, I don't know if I said physical health but yeah there's obviously a lot of things that can impact on motivation and I suppose, every day that can change…" (Sheila, key worker)

"…I wasn't in the position of, I was sort of like, pre-contemplative." (Graham, PHAD)

The importance of self-motivation was discussed. Whilst it was highlighted as important for motivation to be overloaded with multiple avenues of support, ultimately the person entering alcohol treatment needs to have the belief they can recover. Self-efficacy played in important role in this. The collaborative support from others helped to foster self-efficacy, with extra support necessary at times.

"I think definitely, kind of, covering all bases in terms of support is the best thing that you can do in keeping someone engaged." (Zoey, key worker)

"The motivation thing I think it has to, it can be encouraged, but it has to come from yourself." (Graham, PHAD)

Support where the power dynamic is balanced and PHAD remain at the centre of the work appeared the most effective for PHAD being motivated to access support. Coercion and lack of choice was not favourable.

"You don't want to come across, you know, like you're better than them because you're not. You're just there to offer a service" (Lian, outreach worker)

Prior experience with alcohol or substance treatment, as well as with other health services, was described as influential on their motivation for accessing alcohol treatment.

"…So I think it depends on if they've had healthy relationships with these services or not." (Lian, outreach worker)

Theme three: Capability

Capability factors included psychological and physical capabilities.

Subtheme: Psychological capability

Psychological capability referred to cognitive abilities and emotional functioning. There was shared data considering alcohol's role, and how this impacts the psychological capability of PHAD. For example, alcohol as a means of self-medication has an inverse relationship with the psychological capability of PHAD accessing alcohol treatment. Therefore, the role alcohol has can inform the psychological capability of PHAD accessing alcohol treatment. Similarly, motivational aspects such as self-efficacy were linked with how capable PHAD may feel to enter alcohol treatment.

The cognitive functioning of PHAD was viewed as a hindrance for accessing alcohol treatment. Decreased memory abilities could impact attending appointments; challenges with reading and writing impact accessing treatment.

"…Obviously with alcohol use it comes, you know, memory loss, forgetfulness, not attending appointments on time, so yeah it kind of acts against support." (Sam, key worker)

Mental health difficulties and a conditioned mistrust were viewed as barriers to accessing treatment. Conversely, one participant highlighted the mental resilience of PHAD and how this can be a help and a hindrance, due to having a level of confidence in their ability to survive independently.

"…So obviously, you know, there's big rates in England of depression and anxiety, so it could be a psychological like block of like, they've been turned down or they've been hurt that many times before and they're like "oh well if I go access the service are they gonna fulfil me sort of promises"…" (Ben, key worker)

There were emotional experiences that hindered accessing alcohol treatment. Specifically, fear of the unknown, anxiety, frustration and pride.

"…Some people are quite averse to, kind of, getting that help. It might be through like a fear thing of the unknown…" (Zoey, key worker)

Subtheme: Physical capability

The physical dependence on alcohol can be a barrier due to the timeline of recovery and the danger of sudden abstinence. The careful reduction can be incongruent with motivation. For example, if PHAD want to immediately enter abstinence they cannot. The dependence severity increases the longer PHAD continue without treatment, perpetuating this difficulty.

"…And even if you wanna sort of like say right I'm gonna stop tomorrow, it's like you can't because you've gotta reduce it down otherwise you get all the side effects and it can cause you proper damage." (Graham, PHAD)

PHAD's focus may be drinking to manage their alcohol withdrawals rather than attending treatment. Alcohol withdrawals can also impact attendance at appointments.

"…If somebody's feeling that they are in withdrawal, their priority will more likely be to get alcohol to feel better. Erm, you know not necessarily accessing treatment." (Sheila, key worker)

The comorbid health conditions and often malnourishment of PHAD can be a barrier to entering detox, which is often a preferred treatment. Health conditions, alongside losing sleep, can also be a barrier to travelling to and attending appointments.

"…Quite often people who are homeless may have other health conditions, other co-morbidities which would then not enable them to have a community detox…" (Sheila, key worker)

Once engaged with alcohol treatment, the health monitoring can offer the benefit of feeling safe knowing one's physical health is being looked after.

"…Coming here does give you much more awareness of just like erm I think personal safety as well because it's like you, as I say, I've been to the hospital and they're monitoring my liver…" (Graham, PHAD)

Theme: Social opportunity

Social opportunity focussed on the interaction with other people and the impact of PHAD's wider context.

Subtheme: Interaction with others

Staff attributes were highlighted as facilitating access and engagement. For example, consistency, encouragement, normalisation, nonjudgement, and sympathy. The importance of building a trusting therapeutic relationship was discussed. The development of rapport combats the conditioned mistrust referred to within psychological capability.

"I think some of them can be demotivated by prejudgement from their past I guess. We go in with a completely blind eye and we'll treat them as they are as individuals there and then." (Lian, outreach worker)

PHAD have concerns about whether the training received by professionals is representative of their lived experience, and how such an incongruency may impact the care professionals provide. Similarly, one key worker highlighted this difference. Seeing people with a similar journey that have benefitted from alcohol treatment can facilitate PHAD accessing alcohol treatment. As such, alcohol groups can be beneficial. However, there are barriers to groups such as attendees being at different stages in recovery, the compulsory nature of them to gain access to other avenues of treatment, mixed substance and alcohol groups, and concerns about confidentiality.

"I think it's really easy when you're looking at the academic side of things to forget maybe like… the whole holistic approach of it, like how much someone could have gone through to get where they are…" (Zoey, key worker)

"I think that, you know, recovery can be infectious..." (Sheila, key worker)

"…They want confidentiality, they don't know if there's people that's gonna be in the groups they might be afraid of..." (Mark, key worker)

Community (or a lack of for PHAD), such as family and friends, were highlighted as impactful on accessing alcohol treatment. It was considered important to include the social network in recovery, but this is a limited opportunity for PHAD.

"…They don't have access to erm family, friends, support, social networks that others might have that could help them in their recovery." (Zoey, key worker)

Subtheme: Wider context

Wider context refers to culture, discourse, and societal norms. Drinking as a societal norm was frequently highlighted as a barrier to treatment, with more indication of exploiting people living with alcohol dependence than supporting them.

"You know you've got your advertising of it, you've got erm, it available in every corner shop. Erm you don't see much alcohol support information in the corner shops, in the off licenses. And quite often they set themselves up near drug and alcohol services." (Mark, key worker)

PHAD were considered as often experiencing isolation. This can impact their awareness of available support and instead they may gain knowledge about what treatment may look like from homeless discourse about treatment, rather than information that may be accessed through conversations with professionals or online.

"…Having the means to finding the right information and even coming across the right information. I suppose, if somebody's homeless or has unstable housing erm you know what conversations are they having and who are they interacting with?" (Sheila, key worker)

Stigma barriers were highlighted in terms of: homeless stigma, alcohol dependence stigma, and mixed services presenting substance use and alcohol use stigma issues. Internalised stigma can lead to PHAD feeling undeserving of support.

"…A barrier though erm to treatment I would say erm perception I think, of homelessness and alcohol dependence, stigma, not just held by erm the service users but services, erm, and society in general." (Zoey, key worker)

PHAD were described as a socioeconomic issue. Sometimes alcohol workers outlined that the best support they could give is with housing and re-integration with society. Unless provision for this is in place, alcohol-specific support will not achieve recovery.

"…I think, the majority of the problem is socioeconomic and psychological… I might have 20 detoxes and still be in the same situation." (Mark, key worker)

Theme: Physical opportunity

Physical opportunity referred to service factors, treatment factors, and placed physical opportunity in a context of homelessness, alcohol dependence and COVID19.

Subtheme: Service factors

All participants discussed the importance of joined up services, from advertising and signposting to actively joint working. There can be a responsibility struggle between alcohol and mental health services. It was suggested that having a team of support working simultaneously would benefit the service user. Taking the service to places of safety and convenience could help access to treatment.

"…Having a team around the individual is really important, cause its that, they've got then like 4, 5 people supporting them, so if they slip from one there's another." (Ben, key worker)

"…We're not really getting that support in terms of mental health. It's not integrated." (Mark, key worker)

A flexible service such as having different pathways into service, a less structured service or standby service, and having time for people was important.

"…You're sort of like standing on the edge of that cliff and you sort of like rang out for help to be told "oh I'll phone you back on Friday" was quite a big sort of like barrier. And then it

was just like, it comes to the phone and to be honest, I don't even know if I wanna speak to you." (Graham, PHAD)

Pathways into alcohol treatment referred to included online self-referral, GP, legal system, mental health services and charities. However, GPs were outlined as inaccessible unless they were specialist homeless GPs. The use of technology, long waiting times, and need to complete forms were viewed as barriers. Outreach can create a bridge between PHAD and services and increase compassion from services towards PHAD.

"...If we come across somebody that we know a service wants to work with, we will call that service and then pass them the phone. So that will really help build them bridges there as well." (Lian, outreach worker)

Understaffed services impacted the treatment provided to PHAD as risk management was prioritised. Frequent changes in key workers meant that PHAD must re-tell their story.

"...It's just like, "oh at the minute we are short staffed" so then... your sessions are reduced down to once a fortnight rather than once a week and "oh so-and-so is off sick" and this so it's once a month and that was sort of like erm, a barrier to service." (Graham, PHAD)

Subtheme: Treatment factors

Preferred treatment routes were highlighted, and this was individual preference rather than specific to PeH. For example, a desire for detox, medication, one to ones, or involvement with groups. It was considered that wider treatment options could be offered.

"...Do we have acupuncture, do we have Chinese medicine, do we have hypnosis, do we have counselling, do we have, erm you know, aromatherapy, do we have Thai chi? No we have none of them things. We have care planning, risk assessments, alcohol audits, nurse appointments, blood born virus tests..." (Mark, key worker)

Being given choice and person-centred treatment was important. It was thought that there was limited choice for treatment options, for when or where appointments were scheduled and with whom.

"…They're much more likely to succeed if they've had, you know part of the decision making about appointment times, about duration, and where it's going to be and when, who with…" (Sheila, key worker)

Subtheme: Physical opportunity in context

This subtheme considers physical opportunity in the contexts of homelessness, alcohol dependence and COVID19.

Advertisement of alcohol treatment was highlighted as particularly necessary in the context of homelessness. Increased visibility could include providing information and a physical presence in frequented locations. The harms of drinking could be more widely educated, including alcohol awareness at school age.

"...If they were there giving pick up food parcels, then they could be like "oh by the way such and such is there and he can help you."..." (Lian, key worker)

Travel is a financially and timely issue for PHAD, and the weather can be a barrier to accessing alcohol treatment if walking.

"…You sort of like taking either a morning or an afternoon out your day to access service…" (Graham, PHAD)

COVID19 impacted the resources available, such as by creating barriers to obtaining alcohol with procedures entering shops and pub closures. There were barriers to treatment, such as limited one to ones and limited routine health monitoring. Conversely, there were ways it facilitated access through phone provision.

"...And the other thing was, "oh we can only do one to ones," which I was having weekly, "we can only do them one to ones once every 6 weeks, you've got to go into a group session"." (Graham, PHAD)

"...We've been issuing them telephones if they don't have one and we have been doing over the phone work." (Sam, key worker)

Discussion

Overview of Findings

This study aimed to understand alcohol's role for PHAD, and acquire insight in the capability, opportunity and motivational factors that help or hinder access to alcohol treatment. The organisation of themes was influenced by the COM-B system and represented perspectives spanning across barriers and facilitators to engagement with alcohol treatment. The flow of interaction between the themes were evident. For example, social opportunity could contribute to the motivation weighing up process, such as, a benefit of sharing a recovery journey with people of a similar identity or a costly experience of stigma.

The consideration of alcohol as a coping mechanism for PHAD is congruent with previous qualitative research, and broader psychological theory on addiction (Collins et al., 2018; Chawla & Ostafin, 2007; Kohut, 1971; McGovern, Lambert-Harris & Acquilano, 2009; Reading, 2002). Whilst this mirrors how alcohol is used in the general AD population, higher rates of AD in the homeless population may account for the higher proportion of adverse life events experienced, higher rates of health and social issues and thus more difficulties to cope with (Fitzpatrick, Bramley & Johnsen, 2013; Wright & Topkins, 2006). Alcohol's reported impact and relationship with other issues for PHAD are aligned with the problems conceptualised as being associated with alcohol misuse (Drummond, 1990). For

PeH, these issues may be greater with perpetuating ongoing difficulties connected to being unhoused.

Weighing up costs and benefits of entering alcohol treatment was apparent for the motivation process. PHAD have multiple health and social needs that are weighed up alongside prioritising alcohol treatment (Fitzpatrick et al., 2013; Hewett & Halligan, 2010; Wright & Topkins, 2006). For motivation to be sustained, PHAD need a reason to give up. One participant discussed this in terms of the rat park experiments, where rats consumed more morphine when isolated compared to socialised in a ‘rat park’ enclosure (Alexander, Coambs & Hadaway, 1978). It was highlighted across participants that PHAD have limited opportunities and thus limited hope. Meaningful work was an example of opportunity that could motivate PHAD. Similarly to PeH in other healthcare contexts, it was suggested that power balance and prior experience of engagement with services influence PeH’s motivation for seeking support (Chaturvedi, 2016; Csikar et al., 2019; Gunner et al., 2019; Rae & Rees, 2015; Ungpakorn & Rae, 2020).

The role of alcohol was suggested to impact the psychological capabilities of PHAD accessing treatment and would support the literature outlined in the introduction (Collins et al., 2018; Reading, 2002). PeH experience a higher prevalence of cognitive difficulties (Depp et al., 2015), and the addition of AD was outlined by participants to further impact cognition. Cognition thus impacts keeping appointments and engaging with the literacy aspects of entering treatment. The emotional experiences surrounding accessing alcohol treatment (fear of the unknown, frustration, pride) mirror those identified in the wider literature of PHAD accessing health services (Chaturvedi, 2016; Csikar et al., 2019; Gunner et al., 2019; McConalogue et al., 2019; Paisi et al., 2020; Taylor et al., 2007; Ungpakorn & Rae, 2020). Physical capability identified that the means that PHAD may hope to address AD may not be safe for them and thus not an option. For example, limited ability to enter detox without stable housing or a healthy nourished body. Additionally, sudden abstinence is not possible due to the danger of withdrawal symptoms.

The interactions with people in PHAD’s network, whether that be within or outside of alcohol treatment, is influential on the engagement with treatment process. PHAD might have additional layers of mistrust and fear when it comes to the confidential nature of engaging with talking therapies or group intervention. This may provide insight into a preference for medical treatment and the barriers to attending group support (Grazioli et al., 2015; Watkins et al., 2018). Findings suggested that as people experiencing isolation, homeless discourse may be the best source of knowledge. When many people within their network also struggle with alcohol dependence, this can impact on their engagement with alcohol treatment (Neale & Stevenson, 2015). Stigma was identified in relation to homelessness, alcohol dependence, and mixed substance and alcohol services. This finding is supported by findings of stigmatising barriers for people experiencing AD (NICE, 2011), and in a review of health interventions for marginalised populations (Luchenski et al., 2018).

Despite guidance stating that mental health and alcohol services have joint responsibility and should work together to meet the needs of people experiencing alcohol dependence, this was suggested to not be taking place (Public Health England, 2017). The findings highlighted joint working to be important, including taking services to places of safety. The finding of flexible services being necessary for PeH has been replicated in homelessness research, alongside the barriers into services via GP (Gunner et al., 2019; McConalogue et al., 2019; Rae & Rees, 2015; Ungpakorn & Rae, 2020). The contexts of homelessness, alcohol dependence, and COVID19 create additional barriers. Although, one facilitator was highlighted in the context of COVID19 as PHAD were provided with phones to aid contact and remote treatment.

Strengths and Limitations

The researcher critically examined their own role throughout developing and conducting the research, as stated in the method. This process facilitated the co-construction of knowledge between researcher and participants, with the hope that the researcher would pose a minimal degree of inaccuracy. Nevertheless, it is important to consider the influence of the researcher on the findings.

Braun and Clarke (2019) recommend a sample size of 10-20 for doctoral research using thematic analysis. Unfortunately, due to barriers associated with COVID19, recruitment was limited to 7, with an imbalance between PHAD and outreach and key workers. A strength with the sample is that the interviews generated rich data of which common themes were identified. Although, some codes were unique to PHAD. This would have been interesting to explore whether they may have been shared with other PHAD. For example, the calorie content of alcohol being perceived as a suitable meal replacement for PHAD whilst homeless with little resource to purchase food.

The 6 participants from sample two had a range of ages, equal number of males and females, and range of experience. However, the 1 PHAD was already engaged in alcohol support and had a mild dependency. Although this participant's experience will not transfer to many PHAD, their voice should not be marginalised thus keeping them a vital member of the sample. The sample was majority White British, though this is representative of the geographical area.

There was inconsistency between the SADQ (pen and paper self-report), and the M.I.N.I (structured interview) as the SADQ scored 0, whilst similar questions on the M.I.N.I identified the participant as experiencing alcohol dependence. Literature suggests this is an unusual occurrence (Chantarujikapong, Smith, & Fox, 1997; Wiseman & Heithhoff, 1996).

Perhaps a more in-depth introduction to the SADQ could have improved the validity, as this does not reflect the participants dependency which was evident through their engagement with treatment for alcohol dependence and the M.I.N.I.

Implications for research and practice

The findings identified many barriers and facilitators for PHAD accessing alcohol treatment. The quantity of opportunity references may infer that there is the most work to be done to adapt physical and social opportunities. The facilitators should be fostered and embedded into services. For example, staff and services adopting the helpful approaches outlined within the 'interaction with others' subtheme and creating a space free from stigma could help PHAD accessing alcohol treatment. Flexible services are a necessity and can increase accessibility for people who struggle cognitively or need ad hoc support. Joint working across health, social and charitable organisations can benefit working with PHAD's complex needs. For people with little power and control, being given choice in the treatment process can encourage engagement. Solutions should be sought to overcome the identified barriers. Creating a service culture that values equality and inclusion from the point of induction, service user involvement and meaningful training are actions that could alter the stigmatising views of homelessness and alcohol dependence, in the context of community engagement (NICE, 2016). PHAD can be actively encouraged to enter group work and peer support to connect with communities of people with similar journeys. Providing work experience can foster motivation. Consistent practitioners can facilitate the development of trusting relationships.

The subtheme of 'coping' outlining alcohol's role to be an escape may conceptualise alcohol as a form of experiential avoidance; a similar association between experiential avoidance and substance misuse exists in the literature (Chawla & Ostafin, 2007). Within the ‘motivation’ theme, needing a reason to give up alcohol was consistently described, which may highlight a need for a values-led approach. Thus, Acceptance and Commitment Therapy could be an applicable model for working with PHAD, due to the focus on values and acceptance over avoidance (Hayes, Strosahl & Wilson, 1999). Alcohol’s role as dependable and a constant for PHAD suggests that alcohol may be used as a secure base, in a population that disproportionately has an avoidant attachment style (Reading, 2002). Increased psychology provision in alcohol and homeless services could support practitioners to deliver psychologically informed support, through supervision and joint formulation.

A gap in the literature remains for PHAD perspectives on what helps and hinders access to alcohol treatment, due to the sample in this study, particularly those who are not accessing alcohol treatment. Research needs to be conducted ethically whilst accessing people with multiple vulnerabilities who are not engaged with services. This would require time to connect people with support as part of the research process, due to NICE (2011) guidance stating that people who misuse alcohol should be referred to a service that can provide an assessment of need for an intervention. Unfortunately, the research being conducted within the context of a time constrained doctoral thesis and a pandemic, with a researcher external to supporting services limited the ability to achieve this.

Local qualitative studies can inform the clinical implications of the locality. Conducting similar research across urban and rural locations, additional to locations with varying socioeconomic status is important for a fuller picture. Additionally, the city studied has amongst the highest rates of alcohol dependency in the UK (Public Health England, 2020). Service provision may look different in other areas with differing demand, and it could contribute to knowledge to learn about what helps and hinders access to alcohol treatment in such contexts. It is important that qualitative research with PHAD continues, to bridge the gap between the lived experience of PHAD and the literature.

Conclusion

This study explored what helps and hinders access to alcohol treatment for PHAD. It highlighted the role of alcohol for PHAD and the capability, opportunity and motivation factors that are unique to PHAD accessing alcohol treatment. Such themes have implications for clinical practice and further research into homelessness and alcohol dependence. Consequentially, this may increase compassionate understanding, improve access to alcohol treatment and facilitate alcohol behaviour change for PeH.

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PART THREE: APPENDICES

Appendix A – Reflective Statement

Empirical Research

In deciding a research area, my mind jumped between a wide range of topics, reflective of my 4th year curiosity and interest in all the novel content I was learning. My research topic completely changed from the first proposal to the second. At the time, I had no idea that this would not be my biggest setback. Nick connected me with Tom in the addictions department, who highlighted there was a gap in research with people experiencing homelessness and alcohol dependence. I felt quickly invested in the area as I was involved in developing a social enterprise idea for people experiencing homelessness at undergraduate, and as someone who often would stop to talk to people experiencing homelessness. An empathic understanding for people experiencing homelessness and alcohol dependence was something that did not feel dominant in society, and I wondered if this could be an opportunity to contribute to a narrative that challenged the stigma. It was necessary for me to reflect on my position as a privileged middle class trainee clinical psychologist. I considered how I could use this privilege to make space for people experiencing homelessness in the literature.

During the development of the research, I attended a street kitchen. This aided my approach, language use and my sensitivity to the circumstances people were experiencing. One story stood out to me about the determined measures someone went to, to access mental health support. This experience linked with the context of people experiencing homelessness struggling to access support. I felt passionate about learning more about what helps and hinders access to health and social services more broadly. I seemed to experience a battle between the broad and narrow research questions in the research proposal processes. I remember having a conversation with whom provided my research proposal feedback about how my research cannot tackle and address improving support across all health and social services and achieve shifting societal discourse. I had big dreams! I reflected on my values of inclusivity. This was channelled into the narrower area of people experiencing homelessness and alcohol dependence and alcohol treatment.

In line with my epistemological stance, and the power that touched me from hearing people's experiences, a qualitative study was appropriate. One can read the statistics but, from my perspective, it does not have the same impact as the words of a person experiencing it. A similar statement was reflected in the findings of how theory-led knowledge compared with the lived experiences of people lacks a holistic understanding of the individual as a human being. This brought up thoughts about how it may feel less painful to create a separation between ourselves and those who are suffering, less painful to stigmatise rather than engage with the distress. I reflected on compassion and how courageous it is to engage with suffering.

During the proposal process, though I broadened the population to include people working alongside people experiencing homelessness and alcohol dependence, I remained determined to recruit from people currently experiencing these difficulties. The contribution from people currently experiencing homelessness and alcohol dependence felt so important for capturing the live experiences, thoughts and feelings, raw as they are happening. The words stubborn trainee were voiced, though I would like to reframe this as committed. Recruitment would have been feasible, and this was suggested through the proportion of people experiencing alcohol dependence in the homeless population and how readily the hostels were willing to connect me with potential participants for the research. However, this was prior to COVID19’s unprecedented impact, of which kept the hostels closed from March 2020 onwards. Between each wave, there was hope I would be able to visit. In the meantime, I recruited where I could with the alcohol service and charity. Recruiting staff and volunteers was almost equally as challenging. Although I am aware over 100 people viewed the advertisements from the recruiting services, the impact of COVID19 on the demands placed on staff limited participation. My persistence in advertising the study and trying to overcome barriers to recruitment was challenging. Hindsight suggested to me that I could have tried recruiting from my home city of Preston, or widen my population. However, on reflection I did not do this so as to stay true to the aims of the research and feasibly I could not be up and down the M62 for data collection.

Whilst eleven people put forward their interest as people experiencing homelessness and alcohol dependence, one person was able to follow through to participation. Though I was moved by the valuable perspectives and rich experiences shared by the sample of seven, I felt guilt that my sample included one person experiencing homelessness and alcohol dependence, due to the voices of other’s experiencing such a context not being represented in the study. However, I remind myself that this is one voice that is not marginalised. The efforts of persistent liaison, attempts at solution seeking, physical presence where I was allowed, and waiting until the final minute to end data collection was the best I could do in the circumstances to achieve this.

Throughout the participation process, it was necessary for me to reflect on my various insider and outsider positions. I had to consider how the outsider position of me not experiencing homelessness or alcohol dependence or being an employee within the field of homelessness or alcohol dependence may impact the co-construction of the research findings. Similarly, I had to consider my insider positions. Sometimes my identity as a female, in her

20s, educated at university, working within health, a sibling, a partner, or a daughter aligned me as an insider or outsider across the participants.

I felt sadness, anger, helplessness and beyond at the exploration of what helps and hinders access to alcohol treatment, particularly in association with considering homelessness and alcohol dependence as a socioeconomic issue. In a society where opportunities are few and far between, and greed of those with more prevails, how can we foster motivation and facilitate people experiencing homelessness and alcohol dependence working towards a reason to give up alcohol? Nevertheless, there were clear implications from the research which I feel passionate about distributing in the hope of contributing to change.

Systematic literature review

For any 4th or 5th year reading this… do not underestimate the time and energy you must dedicate to your systematic literature review. For me, though time consuming, I found the systematic literature review an overall pleasurable experience. I used the review as an opportunity to tune back into my broader questions about people experiencing homelessness' experiences of seeking support across multiple services. Thankfully, the review had not been completed with a UK population. I was excited by how timely it was, having come across a paper from a stakeholder event which identified a research priority area to be qualitatively identifying the barriers people experiencing homelessness face in accessing healthcare services – something which would undoubtedly be covered within my review.

During the background reading, I was particularly struck by a website dedicated to remembering people experiencing homelessness that have died. I thought, in any other context would someone's death go unrecognised or unnoticed? The isolation of people left me feeling a sadness and emptiness. These were feelings I channelled into raising the recognition of the experiences of people experiencing homelessness.

Whilst the empirical paper was on pause, this gift of time allowed me to become immersed in the systematic literature review. I was (almost too) dedicated to the screening process and full-text assessment (again, a timely process that I underestimated), scouring the information available to a great extent. Here at least I can reflect on one benefit from COVID19, as unlimited library article requests were allowed, of which I gleefully took full advantage. I allowed my creativity to illustrate the hallway floor with sticky notes of coded quotes… apologies to my housemates.

In organising the themes, again inclusivity popped in, I wanted to include everything, even if there was no evidence of shared meaning. Dropping data felt like marginalisation. It was necessary for me to remind myself that I was identifying themes and they would never represent every person experiencing homelessness. Nevertheless, my results section remained large with the aim to represent the themes to the best of my efforts. I had to be mindful of my training and reflect on my position within the psychology profession, to minimise the influence of bias on data extraction and synthesis of themes. I ensured equal attention was given to physical, social, practical and medical issues, alongside psychological issues. Discussions in supervision and the process of developing, revisiting, discussing and developing the themes again over time facilitated the reflective process to ensure the findings encapsulated the meaning from the original articles and addressed the review question.

As a healthcare worker myself, the discovery of barriers challenged me to consider my own practise and consider how myself, or the systems I work in, could be helping or hindering the help-seeking experience of people experiencing homelessness. I reflected on my position as someone housed, with a family and social network to support me should I need it, and the unfathomable resilience I would need to survive without them.

Due to the findings covering a broad range of experiences, at multiple levels, and relevant across most health services, the piece of work was something I felt pride attached to. I hope the applicability to a wide range of contexts was reflected in the implications. After being so immersed in the data, writing such implications seemed almost automatic, as I believed the links to be so clear. I was mindful of any bias I may be demonstrating through this process and continued to refer back to the introduction and findings to ensure the links between the review's purpose, data, interpretation and conclusions were clear. Overall, the process gave me a raised appreciation for systematic literature reviews.

Final thoughts

Compassion falls within my therapeutic approach. That is, Paul Gilbert's definition of compassion as *'a sensitivity to suffering in self and others with a commitment to try alleviate and prevent it'*. It became apparent I was taking this approach to my research too. Hearing the perspectives of people through qualitative data, both in the systematic literature review and the empirical paper, to me is the closest means of understanding somebody's suffering, or just understanding their inner and outer worlds. Subsequent to this understanding, using such information to consider the implications of the research and suggest improvements and recommendations seems in line with the commitment to try alleviate and prevent suffering.

… And now as I write the final words of my thesis (it was only right that I wrote the reflective statement last) I feel a concoction of emotion. Disbelief, relief and hope stand out. Disbelief that it has been completed in 2021 with all the COVID19 curveballs. Relief that I now have a space to breathe alongside full-time placement and I can look forward to the future. Hope that the findings and implications can create meaningful ripples in the literature and in service delivery.

Appendix B – Epistemological Statement

Whilst ontology relates to the belief and nature of reality, epistemology refers to how knowledge is acquired, thus guiding the theoretical underpinnings and research methods utilised by a researcher (Al-Saadi, 2014). The epistemological statement outlines the philosophical underpinnings of the portfolio thesis, and how such assumptions guided the research design and methodology.

Following from the ontological position of critical realism, the portfolio thesis was guided by a constructivist epistemology. The critical realist position states that there is a real world and an observable world (Fleetwood, 2014). Congruently, constructivists believe in an existing world. However, the only means truth can come to be known is through human construction, with differing degrees of accuracy (Piaget 1967; Ültanir, 2012).

This position guided the methodology and reflective processes that flowed throughout. A qualitative paradigm is suited to the constructivist position, as knowledge is derived from people's experiences and the subjective skills of the researcher interact with such data to construct meaning. Therefore, both the systematic literature review and empirical paper followed a qualitative design. Additionally, qualitative research was in line with the researcher's passion for learning from the human experience, aligned with gaining a rich insight for their inner worlds and outer context. Reflective processes such as diary keeping and self-reflection facilitated the construction of knowledge whilst posing a minimal degree of inaccuracy. Such self-reflection included recognition of biases, consideration of insider and outside positions and the belief systems and assumptions held by the researcher. Despite such reflections, there will be elements of all of the above that remain unknown to the researcher and contributory to the construction process.

The use of theory can be viewed as useful through a constructivist lens, as theories are a revisable representation of an observable world; therefore, a reflection of knowledge with an assumed degree of inaccuracy. Thus, it was appropriate to consider a theory of behaviour when constructing an understanding for what contributes to the behaviour of accessing and engaging with alcohol treatment for people experiencing homelessness and alcohol dependence. Combined with inductive processes, as influenced by the cognitive and social context of the researcher, the COM-B system influenced the construction of the empirical findings (Michie, Stralen & West, 2011).

Whilst the results were discussed with the research supervisor, this was not in an attempt to seek reliability, but rather to ensure coherency. This is guided by both the constructivist epistemology, and the congruent reflexive thematic analysis method. Constructivism states that each understanding an individual (in this context, the researcher) attempts, creates a world of its own (Ültanir, 2012). The results are a co-construction between the participants and researcher, with the researcher as the observer communicating their understanding (Ültanir, 2012). Thus, an outsider to the process could not contribute to the understanding. Similarly, reflexive thematic analysis values the subjective skills the researcher applies to the process, and a research team is neither required nor desirable for quality (Braun & Clarke, 2021).

In summary, as characterised by the critical realism constructivist underpinnings, the systematic literature review and empirical research would have been impacted by the researcher's own cognitive and social context. Specifically, their assumptions and meanings already held about: barriers and facilitators, experiences of people experiencing homelessness, alcohol use, and service delivery, amongst others. It was hoped the reflections held by the researcher minimised the degree of inaccuracy during the construction of knowledge.

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Appendix C – Submission Guidelines for submission to 'Health & Social Care in the Community'

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Health and social care in the community is a fast-moving field in the context of empirical papers we normally would expect the last data point to be no more than 5 years old at the point of submission.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online

at https://mc.manuscriptcentral.com/HSCC

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For help with submissions, please contact: HSCCoffice@wiley.com

Transferable Review: *Health Science Reports*

This journal works together with Wiley's Open Access Journal, Health Science Reports to enable rapid publication of good quality research that is unable to be accepted for publication by our journal. Authors may be offered the option of having the paper, along with any related peer reviews, automatically transferred for consideration by the Editor of Health Science Reports. Authors will not need to reformat or rewrite their manuscript at this stage, and publication decisions will be made a short time after the transfer takes place. The Editor of Health Science Reports will accept submissions that report well-conducted research that reaches the standard acceptable for publication. Health Science Reports is a Wiley Open Access journal which is indexed on PubMed/MEDLINE and Scopus. For more information please go to **www.healthsciencereports.org**.

We look forward to your submission.

Data Protection

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more **here ...**

Preprint Policy

Health and Social Care in the Community will consider for review articles previously available as preprints. Authors may also post the **submitted version** of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

ORCID

The submission system will prompt authors to use an ORCID iD (a unique author identifier) to help distinguish their work from that of other researchers. This journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete.

Click here to find out more.

2. AIMS AND SCOPE

Health and Social Care in the Community is an international peer-reviewed journal with a multidisciplinary audience including social workers, health care professionals with a community or public health focus e.g. public health practitioners, GP's, Community Nurses and Social Care researchers and educators.

The Journal promotes critical thinking and informed debate about all aspects of health and social care. Original papers are sought that reflect the broad range of policy, practice and theoretical issues underpinning the provision of care in the community.

Health and Social Care in the Community publishes systematic and other types of reviews, policy analysis and empirical qualitative or quantitative papers including papers that focus on professional or patient education.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Quantitative Articles

WORD LIMIT: *5000* (excluding abstract, figures, tables and the reference list) double-spaced with a wide margin on either side.
RESEARCH REPORTING CHECKLIST: May be required – see section 5 EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Qualitative Articles

WORD LIMIT: 5000 (excluding figures, tables and the reference list) double-spaced with a wide margin on either side.
MAIN TEXT: Should be structured under the following headings: Introduction; Methods; Findings; Discussion. See **here** for details on what *HSCC* requires in a qualitative article.
RESEARCH REPORTING CHECKLIST: May be required – see section 5 EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Review Papers

WORD LIMIT: 7000 (excluding figures, tables and the reference list) double-spaced with a wide margin on either side.
MAIN TEXT: See **here** for details on what *HSCC* requires in a review article.
RESEARCH REPORTING CHECKLIST: May be required – see section 5 EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Policy Papers

Authors should be mindful that *HSCC* is an international journal and where possible the discussion should draw from international sources.

4. PREPARING THE SUBMISSION

Cover Letters

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

Title Page

The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips); include country of origin of data collection if not UK, in the title.
ii. The full names of the authors and contact information of corresponding author;
iii. The author's institutional affiliations where the work was conducted;
iv. Acknowledgements;
v. Conflict of Interest statement (for all authors);
vi. Funding or sources of support in the form of grants, equipment, drugs etc

The present address of any author, if different from where the work was carried out, should be supplied in a footnote.

Title

Titles should include the country of data collection, if data has not been collected in the UK

Authorship

Please refer to the journal's **Authorship** policy in the **Editorial Policies and Ethical Considerations** section for details on author listing eligibility.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section at the end of the paper. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the '**Conflict of Interest**' section in the Editorial Policies and Ethical Considerations section below. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

i. Title, abstract, and key words;
ii. What is known about this topic and what this paper adds;
iii. Main text;
iv. References;
v. Tables (each table complete with title and footnotes);
vi. Figure legends;

Figures and supporting information should be supplied as separate files.

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.

Keywords

Please provide seven keywords. When choosing keywords, Authors should consider how readers will search for their articles. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **www.nlm.nih.gov/mesh**.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the **APA FAQ**. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings. Tables should be submitted one per page, numbered using Arabic numbers, e.g. Table 1, Table 2, etc, at the end of the manuscript

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements. Figures should be referred to in the text as figures using Arabic numbers e.g., Fig. 1, Fig. 2, etc., in order of appearance, and submitted one per page at the end of the manuscript.

Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Additional Files

Appendices

Appendices are published as supporting information online. For submission they should be supplied as separate files but referred to in the text.

Supporting Information

Supporting information is online only information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc. **Click here** for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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The following points provide general advice on formatting and style.

- **Language and Spelling:** The journal uses British UK English; however, authors may submit using either UK or US options, as spelling of accepted papers is converted during the production process.
- **Excerpts:** (other than a short sentence within quotation marks in the text) should be single spaced and indented in the text. A colon is used at the end of the text prior to the quoted data excerpt.
- **Quotations:** Authors should include the code number (or facsimile, i.e. pseudonym) in brackets at the end of the quote. When there is more than one category of participants in the study (such as social workers and clients or particular age groups), authors should use an identifier (i.e. SW01 could refer to the first social worker participant; C03 could refer to the third client participant; YA 10 could refer to the tenth young adult participant). Including the participant number and/or participant group helps the reviewer ascertain the range of the sample used to report the findings, which assists in assessing the credibility of the findings. Occasionally, authors prefer to include quotes in a box or table at the end of the paper. This is acceptable providing the data are well organised and presented.
- **Footnotes**: to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at bipm.fr for more information about SI units.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.
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Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher; however, in signing the author license to publish, authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form available** for use.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are required to adhere to the following research reporting standards.

- CONSORT checklistfor reports of randomised trials and cluster randomised trials
- TREND checklist for non-randomised controlled trials
- PRISMA checklist for systematic reviews and meta-analyses
- STROBE checklist for observational research
- COREQ checklist for qualitative studies
- SQUIRE checklist for quality improvement

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Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

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Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

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The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

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3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section (for example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

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10. EDITORIAL OFFICE CONTACT DETAILS

HSCCoffice@wiley.com

Appendix D – Data Extraction Form

Study Title:
General Article Information
Author(s):
Year of Publication:
Research Aims:
Methodology
Design:
Geographical location & recruitment setting:

Participant sample size:

Participant demographics:

PeH

Sleeping arrangements:

Length of time homeless:

Age:

Sex:

Ethnicity:

Health status:

Health service accessed / described:

Other participants

Relation to PeH:

Recruitment methods:

Inclusion criteria:

Exclusion criteria:

Data collection:

Interview duration:

Interview guide:

-

Data analysis:

Quality checklist score

Findings and Conclusions

Health service referred to in findings:

Main findings:

Limitations:
Conclusions:

Appendix E – Quality Assessment Tool

Quality Appraisal Checklist – Qualitative Studies

Appendix H Quality appraisal checklist – qualitative studies | Methods for the development of NICE public health guidance (third edition) | Guidance | NICE

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?	Appropriate Inappropriate Not sure	Comments:

- Could a quantitative approach better have addressed the research question?		
2. Is the study clear in what it seeks to do? For example: - Is the purpose of the study discussed – aims/objectives/research question/s? - Is there adequate/appropriate reference to the literature? - Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/methodology? For example: - Is the design appropriate to the research question? - Is a rationale given for using a qualitative approach? - Are there clear accounts of the rationale/justification for the sampling,	Defensible Indefensible Not sure	Comments:

data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?		
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered?	Clearly described Unclear Not described	Comments:

• Does the paper describe how the research was explained and presented to the participants?		
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		

8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments: .
10. Is the analysis reliable? For example:	Reliable Unreliable Not sure/not	Comments:

• Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	reported	
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:

13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising	Appropriate Inappropriate Not sure/not reported	Comments:

expectations, changing behaviour? - Was the study approved by an ethics committee?		
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments: of the criteria were fulfilled. of the criteria were unclear. of the criteria was unfulfilled (), *statement for whether this is likely to alter the conclusion of the study*.

Appendix F – Documentation of Ethical Approval

Page removed for digital archiving.

Appendix G – Recruitment Posters (for sample 1 and sample 2, respectively)

Date: 30/07/2020
Version Number: 2.1

Are you experiencing homelessness and alcohol dependence?

If you are over 18 years old, you may be able to take part in this research study

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Are you able to take part?

- 18 + years-old
- Experiencing homelessness (rough sleeping, squatting, staying in a hostel, sofa surfing, placed in temporary accommodation, staying with friends or family short-term)
- Experiencing alcohol dependence (this will be assessed using a short questionnaire)
- Able to understand and speak English
- Participants must be alert at the time of participation

If you are unsure if you can take part or want further information, email the researcher:

- Emma Robinson
- E.L.Robinson-2018@hull.ac.uk

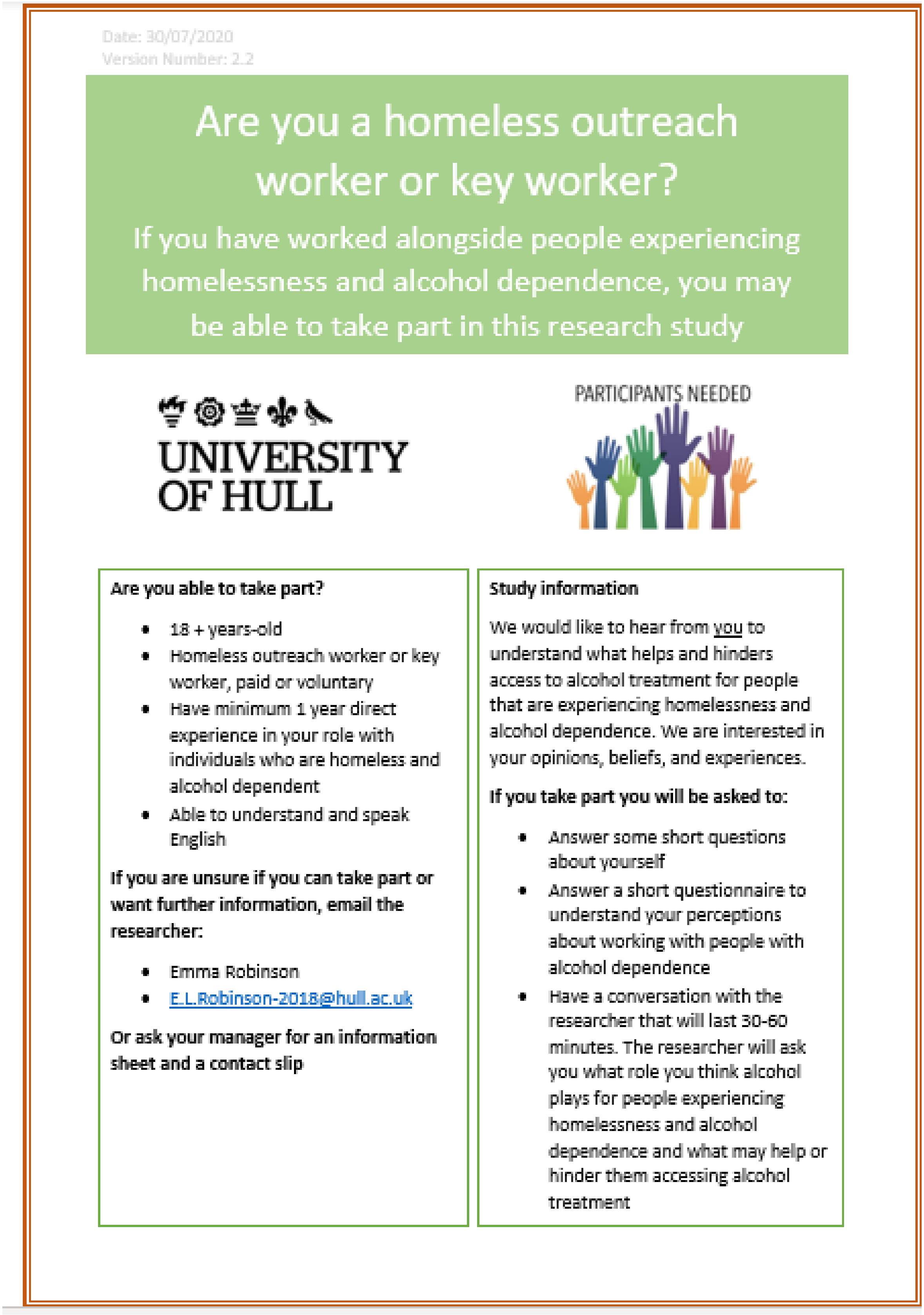
Or ask your key worker for an information sheet and a contact slip

Study information

We would like to hear from you to understand what helps and hinders access to alcohol treatment for people that are experiencing homelessness and alcohol dependence. We are interested in your opinions, beliefs and experiences.

If you take part you will be asked to:

- Answer some short questions about yourself
- Answer two short questionnaires about your alcohol use
- Have a conversation with the researcher that will last 30-60 minutes. The researcher will ask you about what role alcohol plays for you and what helps or hinders your access to alcohol treatment



Date: 30/07/2020
Version Number: 2.2

Are you a homeless outreach worker or key worker?

If you have worked alongside people experiencing homelessness and alcohol dependence, you may be able to take part in this research study

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PARTICIPANTS NEEDED

Are you able to take part?

- 18 + years-old
- Homeless outreach worker or key worker, paid or voluntary
- Have minimum 1 year direct experience in your role with individuals who are homeless and alcohol dependent
- Able to understand and speak English

If you are unsure if you can take part or want further information, email the researcher:

- Emma Robinson
- E.L.Robinson-2018@hull.ac.uk

Or ask your manager for an information sheet and a contact slip

Study information

We would like to hear from you to understand what helps and hinders access to alcohol treatment for people that are experiencing homelessness and alcohol dependence. We are interested in your opinions, beliefs, and experiences.

If you take part you will be asked to:

- Answer some short questions about yourself
- Answer a short questionnaire to understand your perceptions about working with people with alcohol dependence
- Have a conversation with the researcher that will last 30-60 minutes. The researcher will ask you what role you think alcohol plays for people experiencing homelessness and alcohol dependence and what may help or hinder them accessing alcohol treatment

Appendix H – Information sheets (for sample 1 and sample 2, respectively)

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INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: What helps and hinders access to alcohol treatment for people experiencing alcohol dependence? Perspectives from people experiencing homelessness and alcohol dependence and homeless outreach and key workers.

I would like to invite you to take part in a research project being carried out as part of a Doctorate in Clinical Psychology. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any questions or if you would like more information, then you can ask me (Emma Robinson, Researcher).

What is the purpose of the study?

This study aims to understand:

1. What role alcohol plays for someone experiencing homelessness and alcohol dependence.
2. What may help or hinder access to alcohol treatment for people experiencing homelessness and alcohol dependence.

We currently know little about this. We hope that by understanding these issues, alcohol services may be able to better engage with people experiencing homelessness to help them change their alcohol use.

Why have I been invited to take part?

You are being invited to participate in this study because you are able to understand and speak English, above the age of 18 and have experienced or are experiencing homelessness and alcohol dependence. Staff members at *Recruiting service* give this information sheet to people who may fulfil the criteria to take part in the study, as they may be interested in taking part.

What will happen if I take part?

If you choose to take part in the study, please contact me directly (E.L.Robinson-2018@hull.ac.uk) or leave your contact details in the secure box at *recruiting service* reception desk. You will be contacted using these details to arrange a convenient meeting time and date. If you do not have contact details due to your living situation, please alert your key worker of your interest to take part in the study and I can contact them to agree a convenient meeting time and date. At the time of the interview it is important that you are alert so you can consent and take part. If for any reason you are not able to consent to take part in the study on the day, or you may put yourself or me as the researcher at harm, then I may rearrange or tell you that you are not able to take part.

First, I will ask you some questions about your alcohol use to measure whether you are classified as being alcohol dependent. If the measure concludes that you are alcohol dependent you will be able to take part in the study. The study will take place in a private room with a staff member present so that you can speak safely and openly. Firstly, I will ask you to answer some short questions about yourself, for example your age, gender, ethnicity, and questions about experiencing homelessness, alcohol dependence and services you have accessed. Then we will have a conversation that will last 30-60 minutes. I will ask you about what role alcohol plays for you and what helps or hinders your access to alcohol treatment. The interview will be audio recorded and stored safely. There are no right or wrong answers, I am only interested in your opinions, beliefs and experiences. Finally, you will be asked to complete two short questionnaires to understand the severity of the alcohol dependence you experience and what other alcohol-related problems you may experience.

Do I have to take part?

Taking part is completely your choice. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you decide if you want to take part. If you decide to take part, I will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

Taking part in the study will take up to 90 minutes of your time and this may be inconvenient for you. Some people may find talking about their experiences of alcohol dependence and homelessness upsetting, because it may bring to mind difficult issues. If this happens to you the researcher and your key worker will offer support and help you to access further help if needed.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, it is hoped that the information you provide will help us to understand more about alcohol use for people experiencing homelessness and what may be helpful or not helpful for them to access alcohol treatment. It also hoped that it has the potential to improve relevant treatment plans and support from services. Sometimes people find it useful to have the opportunity to talk about their experiences.

Data handling and privacy

Your data will be processed as per the General Data Protection Regulation 2016 (GDPR).

All the personal information that you give will be kept private. Any information that could be used to identify you will not be used in the research. Direct quotes from the interview may be used in research publications and presentations but these will be anonymous. To protect your anonymity, you will be given a different name from your own. This will ensure it will not be possible to identify you from the information you provide.

To keep the audio recordings secure, an encrypted recording device will be used. Once the audio recording is typed out and coded using a different name, it will be deleted so only anonymous data exists. This information will remain securely stored online at the University of Hull for ten years.

The only time that information cannot be kept private is if you say something that suggests that you or someone else is at risk of harm or if there is an illegal disclosure. If this happens during the interview, the researcher may seek advice from their research supervisor, speak to appropriate staff from *recruiting service* or gain advice from the local safeguarding team, to ensure that you and other people are safe. If this needs to happen, the researcher will try to discuss this with you.

Your contact details will be held securely for the duration of the research then destroyed when the research is complete.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until the audio recording is in written printed form, approximately 4 weeks after the interview, after which withdrawal of your data will no longer be possible as the data will be anonymised and therefore unidentifiable. If you choose to withdraw from the study before this point, the data collected will be destroyed.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's online storage space https://hydra.hull.ac.uk . The research may also be published in academic journals or presented at conferences.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by The Faculty of Health Sciences Research Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions or would like more information about this study, please contact me using the following contact details:

Emma Robinson

Clinical Psychology Doctorate Programme

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Email: E.L.Robinson-2018@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Nick Hutchinson

Clinical Psychology Doctorate Programme

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Email: N.Hutchinson@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

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INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

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I would like to invite you to take part in a research project being carried out as part of a Doctorate in Clinical Psychology.

Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any questions or if you would like more information, then you can ask me (Emma Robinson, Researcher).

What is the purpose of the study?

This study aims to understand:

1. What role alcohol plays for someone experiencing homelessness and alcohol dependence.
2. What may help or hinder access to alcohol treatment for people experiencing homelessness and alcohol dependence.

We currently know little about this. We hope that by understanding these issues, alcohol services may be able to better engage with people experiencing homelessness to help them change their alcohol use.

Why have I been invited to take part?

You are being invited to participate in this study because you are able to understand and speak English, you are above the age of 18 and you have at least a year of experience in your role as an outreach worker or key worker working with individuals experiencing homelessness and alcohol dependence.

Staff members in *recruiting services* are given this information sheet if they may fulfil the criteria to take part in the study, as they may be interested in participating.

What will happen if I take part?

If you choose to take part in the study, please contact me directly (E.L.Robinson-2018@hull.ac.uk) or leave your contact details in the secure box at the reception desk. You will be contacted using these details to arrange a convenient meeting time and date.

The study will take place in a private room so that you can speak safely and openly. Firstly, you will be asked to complete a short questionnaire to understand your attitudes towards working with people experiencing alcohol dependence. Secondly, I will ask you to answer some short questions about yourself, for example your age, gender, ethnicity, and questions about your paid or voluntary role. Then we will have a conversation that will last 30-60 minutes. I will ask you what role you think alcohol plays for people experiencing homelessness and alcohol dependence and what may help or hinder them accessing alcohol treatment. The interview will be audio recorded and stored safely. There are no right or wrong answers, I am only interested in your opinions, beliefs and experiences.

Do I have to take part?

Taking part is completely your choice. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you decide if you want to take part. If you decide to take part, I will ask you to sign a consent form and you will be given a copy of this consent form to keep.

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What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, it is hoped that the information you provide will help us to understand more about alcohol use for people experiencing homelessness and what may be helpful or not helpful for them to access alcohol treatment. It also hoped that it has the potential to improve relevant treatment plans and support from services. Sometimes people find it useful to have the opportunity to talk about their experiences.

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Your contact details will be held securely for the duration of the research then destroyed when the research is complete.

Data Protection Statement

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You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until the audio recording is in written printed form, approximately 4 weeks after the interview, after which withdrawal of your data will no longer be possible as the data will be anonymised and therefore unidentifiable. If you choose to withdraw from the study before this point, the data collected will be destroyed.

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Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by The Faculty of Health Sciences Research Ethics Committee, University of Hull.

Who should I contact for further information?

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Emma Robinson

Clinical Psychology Doctorate Programme

Aire Building

The University of Hull

Cottingham Road

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HU6 7RX

Email: E.L.Robinson-2018@hull.ac.uk

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Dr Nick Hutchinson

Clinical Psychology Doctorate Programme

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Email: N.Hutchinson@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix I – Consent form

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CONSENT FORM

Title of study: What helps and hinders access to alcohol treatment? Perspectives from people experiencing homelessness and alcohol dependence and homeless outreach and key workers.

Name of Researcher: Emma Robinson

Please initial box

1. I confirm that I have read the information sheet dated 30th July 2020 (*version number stated*) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected. I understand that once my interview is in written printed form, I cannot withdraw my anonymised data as it will be unidentifiable. ☐

3. I understand that the research interview will be audio recorded and that my anonymised quotes may be used in research reports and conference presentations. ☐

4. I give permission for the collection and use of my data to answer the research question in this study. ☐

5. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Person taking consent	Date	Signature

Appendix J – A semi-structured interview guide informed by the literature and developed between the researchers and an individual with lived experience of homelessness

Interview for people experiencing homelessness and alcohol dependence

1. **What role does alcohol play for you?**

Prompts: How does it benefit you? How does it disadvantage you?

2. **What forms of alcohol treatment or services do you know you have available to you?**

Prompts: What do you know about social support or medication or talking to a professional?

3. **What are your thoughts on using those available treatments?**

Prompts: What makes you want to use those treatments? What holds you back? What makes it easier to use those treatments or what makes it harder?

4. **How do you think experiencing homelessness affects you accessing alcohol treatment?**

Prompts: Are there practical issues such as transport? Are there societal views or beliefs you think others have about people experiencing homelessness and alcohol dependence?

5. **What skills or abilities do you feel you have to access alcohol treatment?**

Prompts: What psychological skills or limitations do you think you have when it comes to accessing alcohol treatment? What physical skills or abilities do you think you think will help or limit your access to alcohol treatment?

6. **How do you prioritise alcohol use in comparison to other health or social problems?**

Prompts Do other problems get in the way of you focusing on treating your alcohol use or vice versa?

7. **What affects your motivation to work on your alcohol use?**

Prompts: What has helped to keep you going in the past if you have tried alcohol treatment? If you have stopped treatment in the past, what stopped you?

8. **How do you think services could better engage people experiencing homelessness with alcohol treatment?**

Prompts: Could they do something to make it more practical? Could they do something to increase the opportunities for people experiencing homelessness like join up with other services? Any recommendations for the people working in alcohol services?

<u>Interview for homeless outreach worker and key workers</u>

1. **What role does alcohol play for PHAD?**

Prompts: How does it benefit PHAD? How does it disadvantage PHAD?

2. **What forms of alcohol treatment or services do think PHAD know they have available to them?**

Prompts: What do you think PHAD know about social support or medication or talking to a professional?

3. **What do you think PHAD thoughts on using those available treatments are?**

Prompts: What do you think makes PHAD want to use those treatments? What holds PHAD back? What makes it easier to use those treatments or what makes it harder?

4. **How do you think experiencing homelessness affects PHAD accessing alcohol treatment?**

Prompts: are there practical issues such as transport? Are there societal views or beliefs you think others have about people experiencing homelessness and alcohol dependence?

5. **What skills or abilities do you feel PHAD have to access alcohol treatment?**

Prompts: What psychological skills or limitations do you think PHAD have when it comes to accessing alcohol treatment? What physical skills or abilities do you think you think will help or limit PHAD access to alcohol treatment?

6. **How do you think alcohol use is prioritised in comparison to other health or social problems?**

Prompts Do other problems get in the way of PHAD focusing on treating their alcohol use or vice versa?

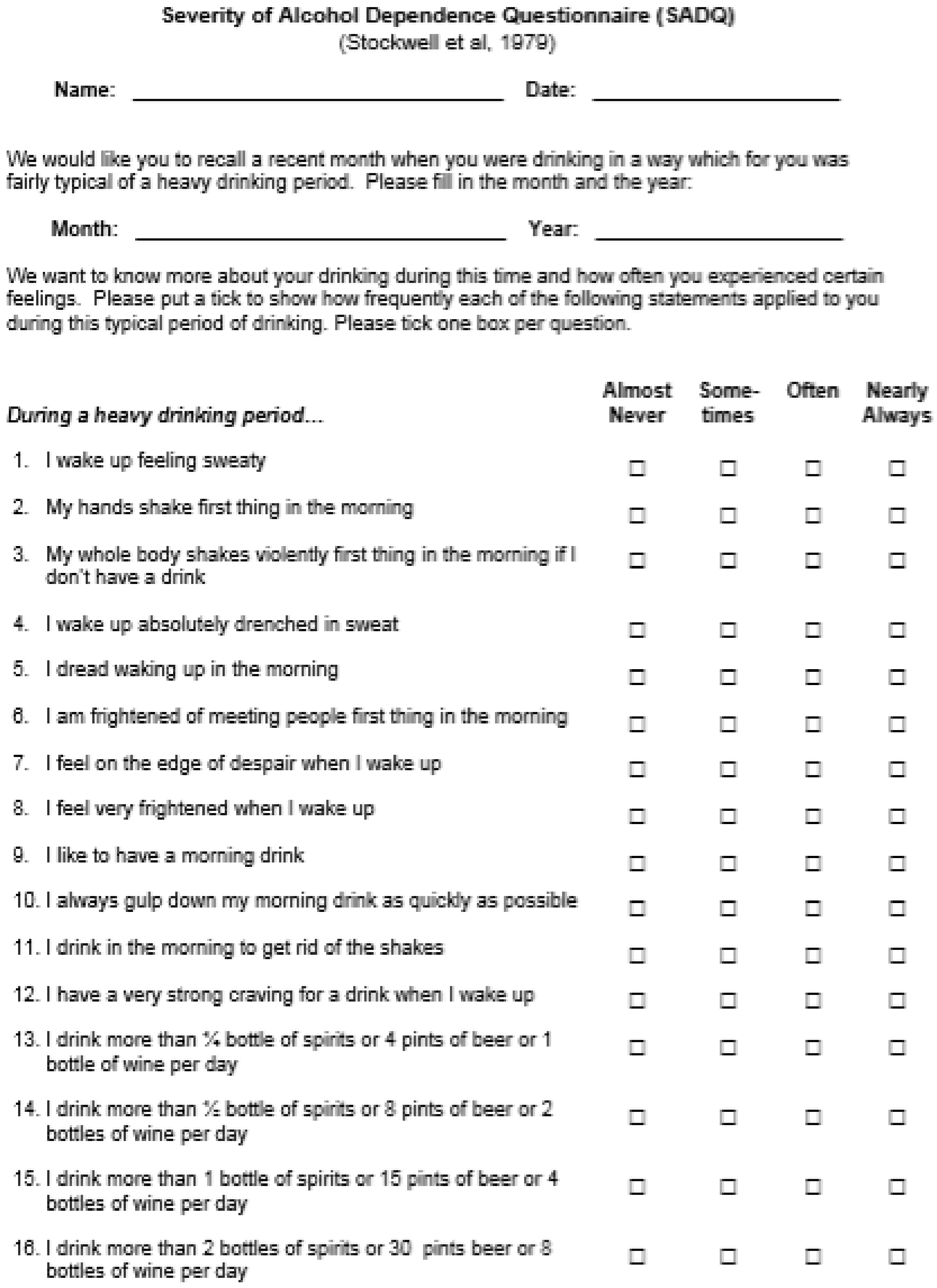
7. **What affects PHAD motivation to work on their alcohol use?**

Prompts: When someone has engaged with alcohol treatment, what has helped them to keep going? When someone has stopped treatment, what stopped them?

8. **How do you think services could better engage people experiencing homelessness with alcohol treatment?**

Prompts: Could they do something to make it more practical? Could they do something to increase the opportunities for people experiencing homelessness like join up with other services? Any recommendations for the people working in alcohol services?

Appendix K – The SADQ (Stockwell et al., 1979). A measure of consumption and severity of alcohol dependence, used to characterise sample 1.



Severity of Alcohol Dependence Questionnaire (SADQ)
(Stockwell et al, 1979)

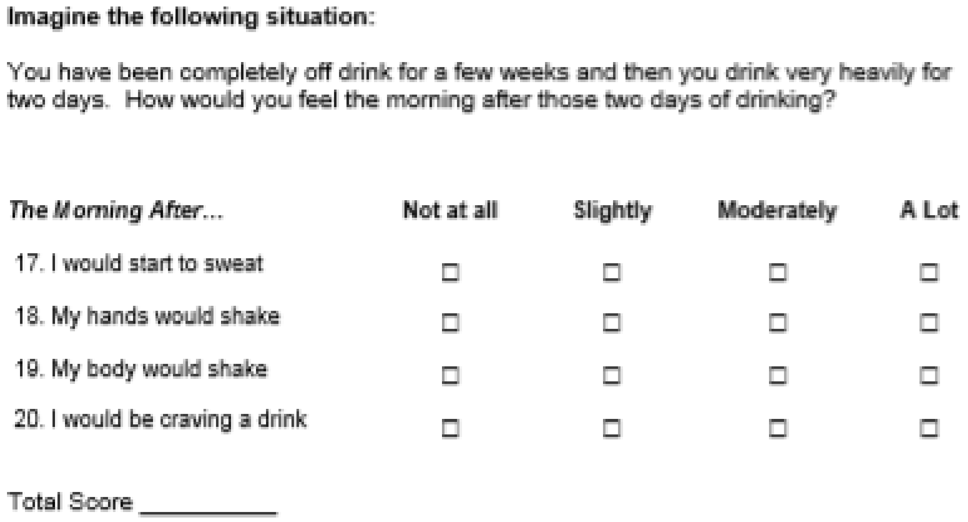
Name: ______________________ **Date:** ______________

We would like you to recall a recent month when you were drinking in a way which for you was fairly typical of a heavy drinking period. Please fill in the month and the year:

Month: ______________________ **Year:** ______________

We want to know more about your drinking during this time and how often you experienced certain feelings. Please put a tick to show how frequently each of the following statements applied to you during this typical period of drinking. Please tick one box per question.

During a heavy drinking period…	**Almost Never**	**Some-times**	**Often**	**Nearly Always**
1. I wake up feeling sweaty	☐	☐	☐	☐
2. My hands shake first thing in the morning	☐	☐	☐	☐
3. My whole body shakes violently first thing in the morning if I don't have a drink	☐	☐	☐	☐
4. I wake up absolutely drenched in sweat	☐	☐	☐	☐
5. I dread waking up in the morning	☐	☐	☐	☐
6. I am frightened of meeting people first thing in the morning	☐	☐	☐	☐
7. I feel on the edge of despair when I wake up	☐	☐	☐	☐
8. I feel very frightened when I wake up	☐	☐	☐	☐
9. I like to have a morning drink	☐	☐	☐	☐
10. I always gulp down my morning drink as quickly as possible	☐	☐	☐	☐
11. I drink in the morning to get rid of the shakes	☐	☐	☐	☐
12. I have a very strong craving for a drink when I wake up	☐	☐	☐	☐
13. I drink more than ¼ bottle of spirits or 4 pints of beer or 1 bottle of wine per day	☐	☐	☐	☐
14. I drink more than ½ bottle of spirits or 8 pints of beer or 2 bottles of wine per day	☐	☐	☐	☐
15. I drink more than 1 bottle of spirits or 15 pints of beer or 4 bottles of wine per day	☐	☐	☐	☐
16. I drink more than 2 bottles of spirits or 30 pints beer or 8 bottles of wine per day	☐	☐	☐	☐



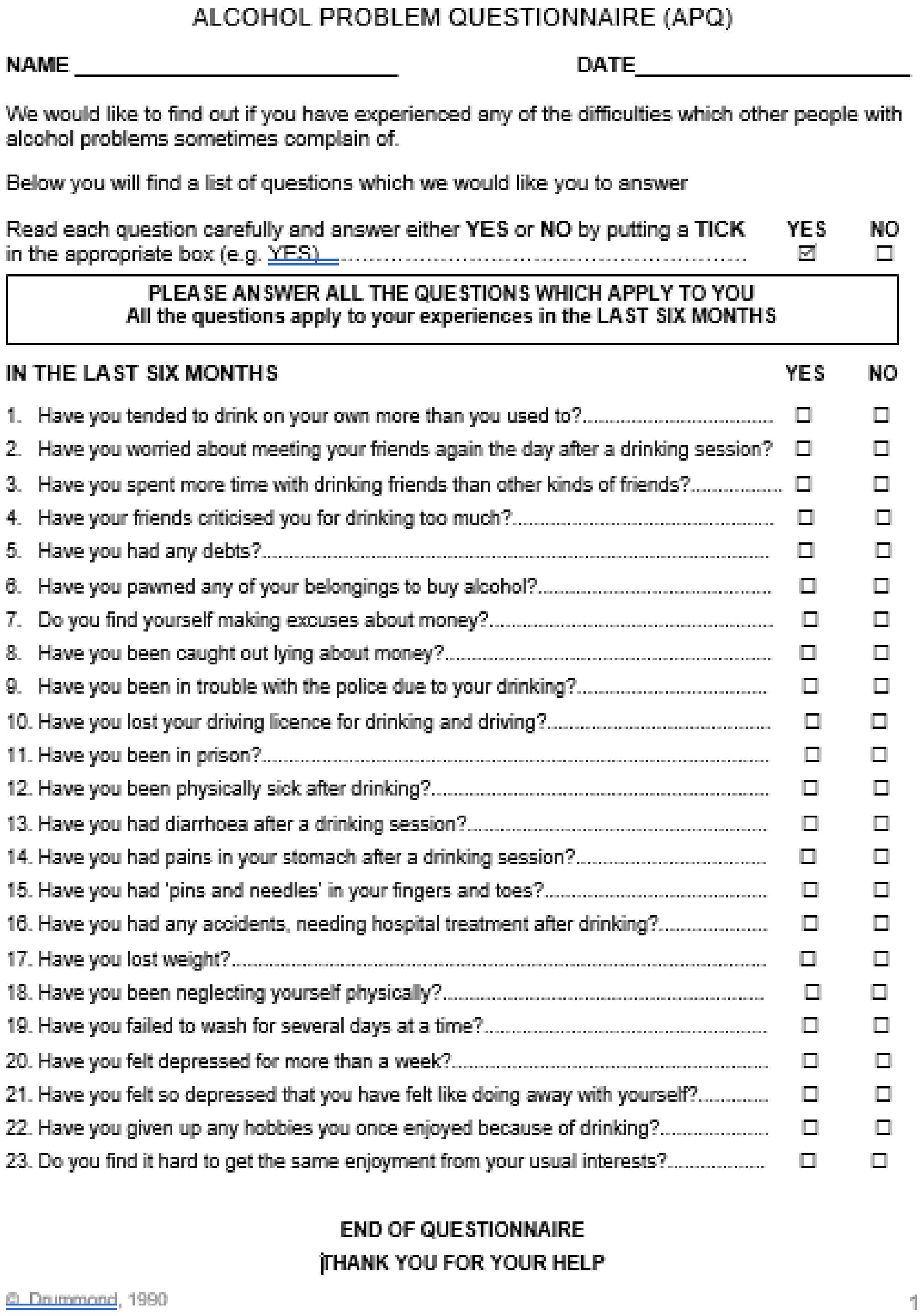
Imagine the following situation:

You have been completely off drink for a few weeks and then you drink very heavily for two days. How would you feel the morning after those two days of drinking?

The Morning After…	**Not at all**	**Slightly**	**Moderately**	**A Lot**
17. I would start to sweat	☐	☐	☐	☐
18. My hands would shake	☐	☐	☐	☐
19. My body would shake	☐	☐	☐	☐
20. I would be craving a drink	☐	☐	☐	☐

Total Score __________

Appendix L – The APQ (Drummond, 1990) a measure of alcohol problems, used to characterise sample 1.



ALCOHOL PROBLEM QUESTIONNAIRE (APQ)

NAME ____________________________ **DATE**________________________

We would like to find out if you have experienced any of the difficulties which other people with alcohol problems sometimes complain of.

Below you will find a list of questions which we would like you to answer

	YES	NO
Read each question carefully and answer either **YES** or **NO** by putting a **TICK** in the appropriate box (e.g. YES)..	☑	☐

PLEASE ANSWER ALL THE QUESTIONS WHICH APPLY TO YOU
All the questions apply to your experiences in the LAST SIX MONTHS

IN THE LAST SIX MONTHS	YES	NO
1. Have you tended to drink on your own more than you used to?	☐	☐
2. Have you worried about meeting your friends again the day after a drinking session?	☐	☐
3. Have you spent more time with drinking friends than other kinds of friends?	☐	☐
4. Have your friends criticised you for drinking too much?	☐	☐
5. Have you had any debts?	☐	☐
6. Have you pawned any of your belongings to buy alcohol?	☐	☐
7. Do you find yourself making excuses about money?	☐	☐
8. Have you been caught out lying about money?	☐	☐
9. Have you been in trouble with the police due to your drinking?	☐	☐
10. Have you lost your driving licence for drinking and driving?	☐	☐
11. Have you been in prison?	☐	☐
12. Have you been physically sick after drinking?	☐	☐
13. Have you had diarrhoea after a drinking session?	☐	☐
14. Have you had pains in your stomach after a drinking session?	☐	☐
15. Have you had 'pins and needles' in your fingers and toes?	☐	☐
16. Have you had any accidents, needing hospital treatment after drinking?	☐	☐
17. Have you lost weight?	☐	☐
18. Have you been neglecting yourself physically?	☐	☐
19. Have you failed to wash for several days at a time?	☐	☐
20. Have you felt depressed for more than a week?	☐	☐
21. Have you felt so depressed that you have felt like doing away with yourself?	☐	☐
22. Have you given up any hobbies you once enjoyed because of drinking?	☐	☐
23. Do you find it hard to get the same enjoyment from your usual interests?	☐	☐

END OF QUESTIONNAIRE
THANK YOU FOR YOUR HELP

Appendix M – The AAPPQ (Shaw, Cartwright, Spratley & Harwin, 1978) as a measure of attitudes towards working with people with alcohol dependence, to characterise sample 2.

Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ)

Please indicate how much you agree or disagree with each of the following statements about working with *problem drinkers.*

Please circle one number for each question.	Strongly agree						Strongly disagree
1 I feel I have a working knowledge of alcohol and alcohol-related problems.	1	2	3	4	5	6	7
2 I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.	1	2	3	4	5	6	7
3 I feel I know enough about the alcohol dependence syndrome to carry out my role when working with drinkers.	1	2	3	4	5	6	7
4 I feel I know enough about the psychological effects of alcohol to carry out my role when working with drinkers.	1	2	3	4	5	6	7
5 I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with drinkers.	1	2	3	4	5	6	7
6 I feel I know how to counsel drinkers over the long term.	1	2	3	4	5	6	7
7 I feel I can appropriately advise my patients about drinking and its effects.	1	2	3	4	5	6	7
8 I feel I have a clear idea of my responsibilities in helping drinkers.	1	2	3	4	5	6	7
9 I feel I have the right to ask patients questions about their drinking when necessary.	1	2	3	4	5	6	7
10 I feel that my patients believe I have the right to ask them questions about drinking when necessary.	1	2	3	4	5	6	7
11 I feel I have the right to ask a patient for any information that is relevant to their drinking problems.	1	2	3	4	5	6	7
12 If I felt the need when working with drinkers I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	1	2	3	4	5	6	7
13 If I felt the need when working with drinkers I could easily find someone who would help me clarify my professional responsibilities.	1	2	3	4	5	6	7
14 If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drinker.	1	2	3	4	5	6	7
15 I am interested in the nature of alcohol related problems and the responses that can be made to them.	1	2	3	4	5	6	7
16 I want to work with drinkers.	1	2	3	4	5	6	7
17 I feel that the best I can personally offer drinkers is referral to somebody else.	1	2	3	4	5	6	7
18 I feel that there is little I can do to help drinkers.	1	2	3	4	5	6	7
19 Pessimism is the most realistic attitude to take toward drinkers.	1	2	3	4	5	6	7

20 I feel I am able to work with drinkers as well as others.	1	2	3	4	5	6	7
21 All in all I am inclined to feel I am a failure with drinkers.	1	2	3	4	5	6	7
22 I wish I could have more respect for the way I work with drinkers.	1	2	3	4	5	6	7
23 I feel I do not have much to be proud of when working with drinkers	1	2	3	4	5	6	7
24 At times I feel I am no good at all with drinkers.	1	2	3	4	5	6	7
25 On the whole, I am satisfied with the way I work with drinkers.	1	2	3	4	5	6	7
26 I often feel uncomfortable when working with drinkers.	1	2	3	4	5	6	7
27 In general, one can get satisfaction from working with drinkers.	1	2	3	4	5	6	7
28 In general, it is rewarding to work with drinkers.	1	2	3	4	5	6	7
29 In general, I feel I can understand drinkers.	1	2	3	4	5	6	7
30 In general, I like drinkers.	1	2	3	4	5	6	7

Thank you for completing this questionnaire

Appendix N – Sources of support sheets provided to signpost participants following completion of the study, if necessary.

Appendix Ni – Sources of support for alcohol use

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Date: 20/08/2020
Version Number: 2.1

Sources of support and information regarding alcohol use

The East Riding Partnership offers advice, assessment and support for alcohol and substance use in Hull and East Riding. More information about their teams can be found at:

https://www.humber.nhs.uk/services/east-riding-partnership.htm or https://ads-uk.org/services/east-riding-partnership/

Contact for further information: **01482 336675** or **01482 344690**

-

ReNew offers dedicated support for anyone struggling with alcohol in Hull. More information about their support can be found at:

https://www.changegrowlive.org/hull-renew/alcohol-hub

Contact for further information: **01482 839009**

Email: earlyhelp.hull@cgl.org.uk

Address: Trafalgar House, 41-45 Beverley Road, Hull HU3 1XH

-

Alcoholics Anonymous has a free national helpline:

Contact number: **0800 9177 650**

Email: help@aamail.org

-

Other sources of support in Hull and East Riding for a range of difficulties can be found at:

https://relatehull.org.uk/useful-contact-numbers/

-

You can also seek advice from your GP

Appendix Nii – Sources of support for housing

Date: 20/08/2020
Version Number: 2.3

Sources of support and information regarding housing

Council support from either **The East Riding Council** or **Hull City Council** provide help for people experiencing homelessness. This includes: information on where to get help, making a homeless application, what to do if you have been kicked out by family or face eviction and information on temporary accommodation and rehousing. More information can be found at:

https://www.eastriding.gov.uk/housing/housing-advice/help-homeless-people/

http://www.hull.gov.uk/benefits-support-and-welfare-advice/welfare-advice/homelessness-prevention

Contact number for advice and support in East Riding: **01482 393939**
Or out of normal office hours call in East Riding: **01377 241273**

Contact number for advice and support in Hull: **01482 300300**
Or out of normal office hours call in Hull: **01482 300304**

Email East Riding: housing.services@eastriding.gov.uk
Email Hull: info@hullcc.gov.uk

-

Humbercare provides housing related support to individuals who are considered vulnerable. Humbercare supports people struggling with alcohol use and can help with referrals to relevant services. More information can be found at:

http://www.humbercare.org.uk/housingsupport.php or
http://www.humbercare.org.uk/downloads/Futures%20Leaflet.pdf

Address: 81 Beverley Road, Hull HU3 1XR

Contact number for further information: **01482 586633**

Email: **info@humbercare.org.uk**

-

Emmaus Hull offers support for people experiencing homelessness, including housing and meaningful work. More information can be found at:

https://emmaushull.org/

Address: 32 Lockwood Street, Hull HU2 0HN

Contact number for rough sleeper support: **0800 066 2169**

-

Other sources of support in Hull and East Riding for a range of difficulties can be found at:

https://relatehull.org.uk/useful-contact-numbers/

Date: 20/08/2020
Version Number: 2.3

Addresses for council support from either **The East Riding Council** or **Hull City Council:**

The Wilson Centre (Hull)
Alfred Gelder Street, Hull HU1 2AG.

Beverley Customer Service Centre
7 Cross Street, Beverley, HU17 9AX.

Bridlington Town Hall
Quay Road, Bridlington, YO16 4LP.

Brough Petuaria Centre
Centurion Way, Brough, HU15 1DF.

Cottingham Centre
Cottingham Centre, Market Green, Cottingham,
HU16 5QG.

Driffield Centre
Cross Hill, Driffield, YO25 6RQ.

Goole Council Offices
Church Street, Goole, DN14 5BG.

Haltemprice Library and Customer Services
120 Springfield Way, Anlaby, HU10 6QJ.

Hedon Centre
31 St Augustine's Gate, Hedon, HU12 8EX.

Hessle Centre
Southgate, Hessle, HU13 0RB.

Hornsea Customer Service Centre
75 Newbegin, Hornsea, HU18 1PA.

Howden Centre
69 Hailgate, Howden, DN14 7SX.

Market Weighton Wicstun Centre
14 Beverley Road, Market Weighton, YO43 3JP.

Pocklington Pocela Centre
23 Railway Street, Pocklington, YO42 2QU.

Withernsea Centre
Queen Street, Withernsea, HU19 2HH.

Appendix Niii – Sources of support for mental health

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Date: 20/08/2020
Version Number: 2.2

Sources of support and information regarding mental health

Hull and East Yorkshire Mind is a mental health charity that offers mental health support in Hull and East Riding. More information can be found at:

https://www.heymind.org.uk/

Contact number for further information: **01482 240200** Email: info@heymind.org.uk

Address: 108 Beverley Road, Hull HU3 1YA

-

Samaritans offers a free listening service to help you work through what is on your mind. More information can be found at:

https://www.samaritans.org/branches/hull/

Contact number for a listener: **116 123**

-

Let's Talk offers support and advice to people experiencing mental health difficulties. More information can be found at:

https://www.letstalkhull.co.uk/

Contact number for further information: **01482 247111**

Address: 5 Beacon Way, Hull HU3 4AE

-

The Mental Health Response Service is an access and crisis service for people experiencing mental health difficulties in Hull and East Riding. They can refer you to the right service for you. More information can be found at:

https://www.humber.nhs.uk/services/MHRS

24-hour contact number: **01482 301701**

-

Other sources of support in Hull and East Riding for a range of difficulties can be found at:

https://www.humber.nhs.uk/Services/support-services-for-you.htm
https://relatehull.org.uk/useful-contact-numbers/

-

You can also seek advice from your GP

Appendix O – Submission Guidelines for submission to 'International Journal of Qualitative Studies on Health and Well-being'

Instructions for authors

COVID-19 impact on peer review

As a result of the significant disruption that is being caused by the COVID-19 pandemic we understand that many authors and peer reviewers will be making adjustments to their professional and personal lives. As a result they may have difficulty in meeting the timelines associated with our peer review process. Please let the journal editorial office know if you need additional time. Our systems will continue to remind you of the original timelines but we intend to be flexible.

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Supporting Taylor & Francis authors

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Contents

- Data Sharing Policy
- Publication Charges
- Copyright Options
- Complying with Funding Agencies
- My Authored Works
- Article Reprints

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