Understanding the barriers to mental health services from a Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) homeless perspective

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ABSTRACT

Aim: There is a lack of research into the barriers that Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ+) homeless people encounter when accessing mental health services, despite psychological distress being highly prevalent but service use remaining low. Unique mental health challenges are thought to exist, but in order to recognise needs and enable services to improve accessibility, service user perspectives must be recognised. This study aimed to address this by exploring the mental health needs of LGBTQ+ homeless adults, the role of services, the barriers that exist and improvements that could be made.

Method: Semi-structured interviews were conducted with nine LGBTQ+ participants, who had experiences of past or present homelessness and self-identified mental health needs. Recruitment occurred via charities and social media. Thematic analysis was used to interpret the data.

Results: The analysis revealed three main themes: (1) ‘Rejection of identity’ referred to experiences of LGBTQ+ discrimination which can impact wellbeing, and contribute to homelessness and a fear of sharing identity when seeking help, (2) ‘Homelessness can strip away personhood’ described the detrimental impact of homelessness, which can result in isolation and loneliness and exacerbate existing mental health difficulties, (3) ‘A lack of appropriate support’ highlighted some of the multi-faceted barriers to mental health services faced by this population.

Conclusion: A range of mental health needs were identified in the research sample, including shame, hopelessness, low mood and a loss of self-worth. The role for services may include family interventions to address rejection, organisational work to reduce discrimination, and prevention of repeat homelessness through the provision of psychological support. A number of barriers were suggested, such as long waiting lists, limited awareness of services, and previous experiences of unhelpful interventions or being denied appropriate support. Services may increase flexibility in the type and delivery of intervention, address discrimination in practice, improve inclusivity and better account for social issues. The implications for recovery and prevention policy and future research have been discussed.

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1. CHAPTER ONE: INTRODUCTION

This chapter provides an overview of homelessness, local policies and frameworks and an exploration of common causes, before Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ+) homelessness is considered. LGBTQ+ homeless mental health is then explored to understand the prevalence, the needs of and responses to the population. The barriers for LGBTQ+ homeless individuals accessing general services are provided, before the scoping review outlines a focused account of the challenges faced when seeking mental health support. Finally, the research questions are presented based on gaps in existing literature.

1.1 Defining Homelessness

There are many different ways of understanding homelessness, with no single definition being adopted (Fazel et al., 2014). A variety of definitions have been developed both nationally and internationally, ranging from restrictive interpretations referring to those without a roof, through to experiences of substandard living (Busch-Geertsema et al., 2016). One of the most influential frameworks in Western society is the 'European Typology of Homelessness and Housing Exclusion' (ETHOS) developed by the European Federation of National Organisations Working with the Homeless (FEANTSA) (FEANTSA, 2017b). Rather than attempting to harmonise national definitions across Europe, ETHOS aims to provide a shared understanding of the categories used when each country defines homelessness and collects data (FEANTSA, 2017a).

ETHOS categorises homelessness as a lack of home (Fazel et al., 2014) which is defined by three main assumptions regarding the physical, legal and social domains (Busch-Geertsema et al., 2016). This refers to the absence of a physical space to meet the needs of the individual and family, privacy to enjoy social relations and legal security (Anderson et al., 2002). A person can be classified as homeless if excluded from a legal and physical domain, such as having no occupation or private space (Fazel et al., 2014). However, a person would not be considered homeless if excluded from the physical and social domain only. Based on this understanding of homelessness, FEANTSA provided a conceptual definition based on four categories: rooflessness, houselessness, insecure housing and inadequate housing (FEANTSA, 2017a). Whilst ETHOS has encouraged wider thinking about the breadth and nature of homelessness, highlighting the more invisible forms, it has been criticised for inconsistencies in the detail, for example, ideas of what constitutes unacceptable housing varies significantly across Europe (Hermans & Pleace, 2020).

In the UK, The Housing Act (1996) which informs the Local Authorities' understanding, refers to homelessness primarily as a loss of a home. The criteria determining this includes: rooflessness, availability of accommodation but no legal status, challenges in seeking residence despite existing legalities meaning that this should be possible and reasonable accommodation, free from abuse and violence. Whilst informed by ETHOS (FEANTSA, 2017b) it does not provide sufficient detail regarding the characteristics of adequate housing or insight into the causes, all of which can hinder the development of strategies to prevent homelessness (Xenophontos, 2020).

Some definitions have been criticised for viewing housing as a commodity and a way to increase wealth, resulting in it becoming detached from the social function (United Nations Human Rights, 2017a). As such, the capability approach attempts to reconcile this by providing a conceptual understanding of homelessness (Nussbaum, 2011). It argues that homelessness occurs when people's needs are compromised due to lack of stability, risk of, or actual, violence and abuse, and/or dangerous and inadequate living conditions (Evangelista, 2010); all of which can breach human rights, including Article 12 referring to interference of privacy, family and home life, and Article 25 outlining the right to standard of living (United Nations Human Rights, 2017b). Capabilities are defined as needs which allow humans to thrive, such as having bodily health, affiliation with others, play and emotions; the ability to fulfil these is contingent on whether people or nations have been provided with opportunities to engage (Wells, 2012).

Housing allows people to meet their capabilities, however sufficient conditions are as important, acknowledging whether people have choice or opportunity in how they wish to live (McCarthy, 2018). It is thought that aspects of home and housing can be grouped into broad dimensions which consider the physical adequacy of the living space, the stability and control that the individual has over the environment, and the safety and connection it provides (Batterham, 2019). It is therefore assumed that homelessness exists on a spectrum of living conditions which incorporate many of these dimensions, influenced by the opportunities provided. Some argue that the capabilities approach to understanding homelessness could be used as a unifying framework across nations (Evangelista, 2010).

1.1.1 Critique of the Definition

Homelessness is not a uniform experience, with variations across cohorts and geographies (Crisis, 2021). As legal definitions tend to dominate, many types of homelessness are ignored, such as ‘hidden homelessness’, which is excluded from official statistics (Matthews et al., 2019). Many believe that the definition should represent the experiences and views of people with lived experience, to avoid misconceptions (Crisis, 2021). Ethical questions have been raised around imposing ideas of homelessness on groups who may have a different understanding (Hermans & Pleace, 2020). For example, Crisis highlight that whilst some may view overcrowding as a form of homelessness, those living in that situation may not.

It has also been argued that no consistent definition results in dissociated or conflicting aims with regards to funding, intervention and policy across England, Wales and Scotland (Crisis, 2021). Additionally, the ability to measure homelessness and track reduction becomes more difficult (Fazel et al., 2014) and current explanations do not allow comparability of homelessness data across the UK (Government Statistical Service, 2019). Without a concise definition, problems remain regarding how to define where homelessness starts and stops and whether to continue to use a broad or narrow approach (Hermans & Pleace, 2020).

1.2 Homelessness in the United Kingdom

1.2.1 Types of Homelessness

Adopting a broad perspective, many forms of homelessness exist. These include rough sleeping which has been defined as residing ‘in areas deemed unfit for human habitation' (Homeless Link, 2018) including open air spaces (MHCLG, 2020). This is considered the most visible type of homelessness which has a severe impact on physical and mental wellbeing (Homeless Link, 2018) and can often result in long-term 'revolving door' homelessness (McDonagh, 2011). Statutory homelessness refers to those in 'priority need' for which local authorities have a duty to secure housing (Crisis, 2021). Hidden homelessness can broadly refer to those living in hostels, squats, B&Bs, overcrowded accommodation and on strangers', friends', partners' or family members' sofas (sofa-surfing) (Reeve, 2011). There have been suggestions to make the term 'hidden homeless' redundant to avoid categorising levels of homelessness in accordance with severity which suggests one is worse than the other, and due to a lack of consensus around the term and what it entails (Hermans & Pleace, 2020). However, abandoning this term is likely to result in even less attention and awareness being placed on a group which is already largely excluded.

1.2.2 Statistics

Homelessness figures vary across England, Wales, Scotland and Ireland as data is often gathered through systems built on each country's definition (Government Statistical Service, 2019). In the UK, homelessness has continued to rise (Dobson, 2019) with rough sleeping figures estimated to have increased from 1,766 to 4,677 between 2010 to 2018 (Aldridge, 2020). As well as increases in rough sleeping, data recording those homeless or at risk of homelessness has risen, with 400,000 recorded in 2019. The number of homeless households is also estimated to have increased from 207,600 in 2018 to 219,000 in 2019 (MHCLG, 2020).

In Autumn 2020, amid coronavirus, the figures recording homelessness showed a decrease of people sleeping rough, at approximately 2,688, which was down by 37% from the previous year (MHCLG, 2020). However, it is possible that the Everyone In scheme, designed to protect vulnerable people during the pandemic by asking local authorities to offer accommodation, has skewed the findings and may not provide an accurate long-term forecast. As a result of the Everyone In scheme, 33,139 people were brought into accommodation (MHCLG, 2021a). Since June 2021, local authorities and charities have reported an increase in rough sleeping, which may also be partly due to those with no resource to public funds facing greater challenges in moving to more permanent accommodation (MHCLG, 2021a).

Whilst data show an important, largely upward trend, many argue that these figures underestimate the number affected and are inaccurate. This is because some populations are not recorded in the count, such as people experiencing hidden homelessness (Aldridge, 2020), which has previously been estimated at 380,000 (Vasiliou, 2006). Homelessness figures being incorrectly counted risks imposing stigmatising or reductionist ideas on people who may feel unrepresented or incorrectly defined (Jolley, 2020). Crisis state that there is no national figure across the UK due to each nation recording it differently and because of the ‘snapshot’ approach used to collect data (Crisis, 2021). It is thought that accurate data might increase the total figure by thousands (Fitzpatrick et al., 2013). The Big Issue (Geraghty, 2021) highlights that the way rough sleeping data have been collected nationally is no longer suitable and has resulted in long-term underinvestment of services and support.

1.2.3 Demographics

The government snapshot approach suggests that the UK demographic of rough sleepers is majority male, over 26 years of age and 72% UK nationals (MHCLG, 2021b). It has been suggested that many White men aged 25-44 experience rough sleeping (Bramley & Fitzpatrick, 2018) as well as a disproportionate representation of people from racialised backgrounds and identifying as LGBTQ+, with limited investigation of both causes and service responses to this (Netto, 2006). The demographic of the hidden homeless population is not entirely clear (Kauppi et al., 2017), however it is thought that many experience mental health difficulties and addiction (Crawley et al., 2013).

1.3 Local Policies and Frameworks

1.3.1 Homeless Policies

The Homelessness Reduction Act (2017) was implemented in April 2018 outlining updated legislation regarding the responsibility of authorities to intervene earlier to prevent or relieve homelessness. Eligibility criteria includes actual and threatened homelessness. The ‘duty to refer’ places responsibility with all public bodies and local authorities. This results in an integrated response for those at risk of or facing homelessness, to reduce the chance of people ‘falling through the gap’. Such support involves assessments and development of holistic personalised housing plans which have clear actions of how accommodation can be secured (UK Parliament, 2017). ‘Relief duty’ which allows individuals interim accommodation can be provided to those categorised as priorities; priority need can be determined through a combination of factors according to the Code of Guidance (UK Parliament, 2017) which includes mental health difficulties, drug and alcohol addiction and prior homelessness. Whilst the Act works towards the reduction of homelessness by holding authorities to account, challenges exist, such as joint working, varied implementation (Dobson, 2019) and a prior over-reliance on mental health diagnoses as evidence when considering priority need. This has led to a long term perpetuation of a medical model (Mills, 2018).

The Rough Sleeping Strategy (MHCLG, 2018) addresses plans to end homelessness by 2027 by increasing coordination of relevant bodies and improving affordable housing. It identifies the mental health needs of the homeless population and recommends that services use integrated models, joint working with outreach teams and hostels, and for rough sleepers to seek support through community health services (MHCLG, 2018). Authorities have an obligation to eliminate rough sleeping through coordinated support provided by health and social care, the criminal justice system and third sector services. In early 2020, the Ministry of Housing, Communities and Local Government identified a need to review the strategy, however this is currently pending (MHCLG, 2021a).

The ‘Everyone In’ scheme (MHCLG, 2020) which sought to support people sleeping rough by providing emergency accommodation through coronavirus exposed the extent of homelessness. It was also praised by some for its success, such as offering people who previously had to prove entitlement for support an open door (Geraghty, 2021). Many organisations including Crisis, St Mungo’s and Shelter have urged the government to publish a more specific long-term strategy on how it plans to end rough sleeping, as it claims in the Rough Sleeping Strategy, and to use the success of ‘Everyone In’ as a catalyst to do so (Geraghty, 2021).

1.3.2 Health Policies

The Care Act (2014) can also be considered with regard to homelessness, although it is not principally set out to target housing. The Act centres on improving access to resources for adults according to individual wellbeing. As such, criteria consider physical, emotional and environmental risk factors and entitlement hinges on these needs. The threshold for support is met when people experience physical or mental health difficulties and are unable to achieve two or more of the listed criteria, causing a significant impact on wellbeing. This Act is thought to support homelessness as it addresses ‘complex needs’ (Cornes et al., 2016). However, uneven implementation, support being provided based on location as well as need, and a lack of resources due to cuts to social care budgets, has meant that this is often not the case (Dobson, 2019). Some social workers suggest that rough sleepers are often not successfully referred, due to appearing more ‘resilient’ than others, such as older adults, and to increase the likelihood of a referral, legal terminology must be adopted (Dobson, 2019).

Other legislation refers to mental health needs, which often overlap with homelessness. The NHS Long Term Plan (NHS, 2019) makes references regarding this. Introduced in 2019, it highlights the upward trend of homelessness and the complexity of needs in this population. It shows how engagement with mainstream services is often impeded by financial, emotional and interpersonal needs. Although approximately 50% of rough sleepers have mental health difficulties, as outlined in the plan, there is a lack of specialist support available. As such, the plan sets out to invest in specialist services to ensure better access for this population (NHS, 2019).

Whilst these policies aim to improve homelessness, arguably many focus on rough sleeping and do less to account for hidden homelessness. The Big Issue (Geraghty, 2021) has documented people feeling the need to ‘prove’ homelessness by rough sleeping in order to access support. Although it can be difficult to provide assistance to a population who are often made invisible by their housing situation, it has long been suggested that local authorities refer all individuals to relevant agencies and provide early intervention at the point of help being requested (Reeve, 2011). In order to provide effective support and refer to appropriate services, it is important to understand an individual's context and the factors that have contributed to homelessness.

1.4 Causes of Homelessness

The causes of homelessness have previously been separated into individual and structural accounts. Where structural accounts focus on issues in the wider system, individualistic perspectives consider 'personal vulnerabilities' (Bramley & Fitzpatrick, 2018). Criticisms of individualistic accounts have centred on the development of a blame-worthy culture being cultivated by an over-emphasis on personal agency (Bramley & Fitzpatrick, 2018). As such, academic literature shifted its focus to structural accounts. More recently, a blended approach has been adopted. This suggests that the risk of homelessness increases when vulnerable people experience adverse social and economic circumstances (Benjaminsen & Andrade, 2015).

Before exploring the structural and individual factors in detail, it is important to consider the narrative around the causes of homelessness. Some of the dominant ideas refer to homelessness as 'happening to anyone' or 'almost anyone' which may falsely embed the notion that it is randomly distributed, rather than acknowledging how some groups face higher risks, such as those living in poverty and experiencing systemic inequality (Bramley & Fitzpatrick, 2018). Homelessness has also been described as a by-product of 'hugely complex factors', which may be true, but can perpetuate a sense of hopelessness on a preventative level (Fitzpatrick et al., 2013). It is therefore important to consider the language around homelessness and how causes and consequences are framed and addressed, particularly in policy development. Whilst the following is not an exhaustive list, many of these factors interact and can be exacerbated by homelessness (Ecker et al., 2020) highlighting the bi-directional nature (Moschion & van Ours, 2021).

1.4.1 Individual

Individual factors, categorised as people's histories and experiences, have been well documented. The following have been suggested as contributors to homelessness: drug and alcohol misuse (Schutz, 2016), poor physical and mental health (Martens, 2001), violence, abuse and neglect (Mar et al., 2014), bereavement (Burns et al., 2018), experiences of care (Fazel et al., 2008), leaving prison (Gorden et al., 2020); refugee status (Hermans et al., 2020) and family problems (Reeve et al., 2018). Causes may also include a fear of hostels as a result of anticipated violence (Hynes et al., 2019). The role of childhood trauma and distress is a major contributing factor (Davies & Allen, 2017). Strong associations have been noted between adverse childhood experiences, health related outcomes and risk of or actual homelessness (Liu et al., 2020). Such research has led to an argument around screening of Adverse Childhood Events at an early age (Liu et al., 2020). The availability of social support has been identified as protective, highlighting how supportive families can act as a buffer (Johnson et al., 2015). For the youth population in particular, the primary factors identified include conflict, victimisation and experience with the child welfare system (Fazel et al., 2014). Parental presence can be a vital factor in remaining housed in the youth population and a death of a parent may trigger homelessness in the adult population (Moschion & van Ours, 2021).

Individuals with cognitive impairments (CIs) (such as dementia, traumatic brain injury and learning disabilities) are also thought to be at greater risk of experiencing homelessness, with a systematic review revealing an over-representation in the population with little understanding of co-morbidity and overlapping aetiology (Stone et al., 2019). Risk factors are assumed to be the same for the general population but exaggerated by CIs which impact specific abilities such as problem solving, making it harder to manage the bureaucracy of maintaining employment and housing (Andersen et al., 2014). Additionally, risk factors such as increased substance misuse are thought to increase the likelihood of sustaining a traumatic brain injury (Beaulieu-Bonneau et al., 2018), which may affect the ability or extent to work and contribute to homelessness (Stone et al., 2019). Structural factors also impact; research suggests a lack of understanding of the complex needs of people with CIs by those working in housing and homelessness services result in inadequate support being provided (Stone et al., 2019). Such structural factors will now be considered in greater detail.

1.4.2 Structural

Some of the structural factors thought to contribute to homelessness include poverty, low availability of housing (Bramley & Fitzpatrick, 2018), inequality (Byrne et al., 2021) and unemployment (Burke et al., 2013). Child and adulthood poverty have been listed as both a cause and reinforcer of homelessness (Reeve et al., 2018). Whilst accounts of homelessness causation have altered over time, poverty has remained a consistent factor with it being influenced by wider structures such as the welfare regime (Stephens et al., 2010). These factors can subsequently interact with individual determinants, such as poor health.

Discrimination and exclusion is another structural factor which has been highlighted as a contributor to homelessness (Lurie et al., 2015). Those with a marginalised identity such as individuals seeking asylum (Watson & Nipperess, 2019) and racialised populations (Watts et al., 2015) are considered to be at higher risk. People seeking asylum can often be refused support as a result of Section 55 and can therefore end up homeless (Vasiliou, 2006). Individuals with racialised identities can face criminal justice discrimination, such as racial profiling, employment discrimination and job loss (Jacoby et al., 2018). Previous racial segregation of neighbourhoods has resulted in some racialised groups living in disadvantaged areas, where there is exposure to crime and violence and limited housing options (Jacoby et al., 2018). The LGBTQ+ community are also considered at higher risk of homelessness as a result of discrimination (Dunne et al., 2002).

Research in the LGBTQ+ community has highlighted how fear and discrimination within the family context, housing providers and in employment (Agocs, 2016) can negatively impact income and choice of accommodation (Romero et al., 2020). Discrimination in employment and housing has been frequently documented, with gay cisgender men thought to earn 10-32% less than heterosexual cisgender men (Sun & Gao, 2019). Discrimination is considered to be even greater for transgender individuals (Romero et al., 2020). For LGBTQ+ individuals from a racialised background, the intersecting marginalised identities further increase the risk of homelessness, through greater discrimination and victimisation (Ecker et al., 2020). Systemic racism is thought to contribute to homelessness, with gay, bisexual and queer (GBQ) African American men estimated to be six times more likely to live in poverty compared with White GBQ men, and African American GBQ women three times more likely to live in poverty, compared with White GBQ women (Ecker et al., 2020). Such a multitude of experiences can result in poor health and social outcomes (Fraser et al., 2019) and alongside other listed causes, can place the LGBTQ+ population at a much higher risk of becoming homeless (Wilson & Cariola, 2020). This will now be explored in further detail.

1.5 LGBTQ+ Homelessness

1.5.1 Terminology

LGBTQ+ has been used as an umbrella term to refer to Lesbian, Gay, Bisexual, Transgender, Questioning and Queer plus individuals. The acronym has been used in an attempt to be inclusive of all sexual and gender characteristics (McCann & Brown, 2019). However, there is recognition that it may not be accepted by every stakeholder and language can change over time. At times, part of the acronym has been used to reflect the literature and to differentiate which groups have been included and excluded from research. Homelessness will refer to no access to permanent accommodation, including a multitude of experiences, such as sofa-surfing, staying with friends, family or partners, hostels and rough sleeping.

1.5.2 Prevalence

In the UK, LGBTQ+ individuals are 14 times more likely to become homeless when compared with the general population (McCann & Brown, 2021). Once homeless, there is a disproportionate representation, with an estimation of 20-45% of the population identifying as LGBTQ+ (Romero et al., 2020). For homeless youth, it is believed that 24% identify as LGBT (The Albert Kennedy Trust, 2021). A quarter of transgender people experience homelessness, with 25% experiencing discrimination in the process of attempting to rent or buy accommodation (McCann & Brown, 2021). Approximately 80% of the LGBTQ+ youth population cite disclosure of sexual identity as a cause of homelessness (McCann & Brown, 2021). One factor which may be implicated with this is family rejection.

1.5.3 Understanding Higher Prevalence Rates

Family rejection has continued to be consistently demonstrated as a key contributing factor to homelessness (Ecker, 2019; McCann & Brown, 2019; Robinson, 2018). The top three reasons for homelessness as provided by LGBTQ+ individuals (The Albert Kennedy Trust, 2021) are family rejection, abuse, and aggression or violence in response to disclosure (The Outside Project, 2020). Such hostility and abuse can often be exacerbated through homelessness with continued isolation, victimisation and exploitation (Gutman et al., 2021). It is thought that such responses are a cause of higher rates of homelessness, increased risk of poverty and mental and physical health difficulties (Reczek & Bosley-Smith, 2021). Whilst emotional rejection can be common, physical abuse is also documented as a consequence of sharing sexual orientation within the family setting, forcing youth to leave (Ecker et al., 2020). A nationwide sample of LGBTQ+ youth using mental health crisis services found that a third who had experienced homelessness felt that this was a result of parents not accepting their orientation (Rhoades et al., 2018). Similarly, semi-structured interviews with 14 young gay adults highlighted the role of family disintegration in homelessness and disclosure of identity as worsening pre-existing conflict (Castellanos, 2016).

Whilst family rejection is shown to negatively affect mental health and act as a main contributor to homelessness (Willoughby et al., 2010), the context surrounding conflict and the nuances of the mediating socioeconomic environment must be considered (Schmitz & Tyler, 2018). Research suggests that rejection is often more likely in families with long-standing and ongoing fragile, unstable or abusive relationships and/or parents using substances, living in poverty, and having experienced time in prison (Castellanos, 2016). This highlights the need to focus on these factors and to provide a structural account of how rejection and gay hate might take place (Robinson, 2018). This is particularly important given that in the US, LGBTQ+ homeless youth include an overrepresentation of racialised individuals, which if understood in light of the family rejection narrative, risks perpetuating systemic racism as it may suggest that poorer racialised families are more prejudiced than White middle class families (Robinson, 2018). Additionally, focusing too narrowly on family rejection may neglect how intersecting stressors and forms of discrimination shape these experiences, and reduce social support which is thought to protect against homelessness (Robinson, 2021).

Others argue that LGBTQ+ homelessness is likely to rise only if people are exploring their sexuality in an environment where they are relying on their family system for support (Matthews et al., 2019). Additionally, it is argued that rejection should be seen in combination with the response to discrimination, such as whether an individual engages with substance use as a coping mechanism; this further increases the risk of homelessness for LGBTQ+ youth and adults (Ecker et al., 2019). Youth homelessness is also thought to be a risk factor for LGBTQ+ adults becoming homeless (Ecker et al., 2020). Prior family rejection can persist into adulthood, reducing the likelihood of reunification, thus highlighting how its effects continue (Ecker et al., 2020). Overall, it is suggested that overarching conflict within families, combined with societal discrimination, can perpetuate homelessness (Ecker et al., 2020).

1.5.4 Needs of the Population

As a result of these experiences, the needs of the LGBTQ+ homeless population are varied; a safe space, housing support, effective medical care and training aimed at alleviating the effects of discrimination have all been deemed as necessary (Coolhart & Brown, 2017). Arguably, one of the most prominent needs of the population is mental health support. This is due to the negative psychological impact of the factors which cause homelessness, such as systemic discrimination and rejection. Homelessness itself increases psychological need, with problems increasing in severity once the individual is homeless (Martijn & Sharpe, 2006). It is thought that the longer the episode, the increased risk of developing further mental health difficulties (Bender et al., 2015). Daily survival can also mean that mental health is not always prioritised, and often, there is a small period of time to effect change which is incompatible with waiting lists in support services, increasing the likelihood of problems worsening (Reeve et al., 2018). Psychological problems can also emerge for the first time and be triggered by: daily stressors, the emotional impact of being homeless, as well as harassment and witnessing of abuse and violence (Padgett, 2020).

1.6 LGBTQ+ Homeless Mental Health

Research into mental health has often been a main focus due to high prevalence rates (Padgett, 2020), as well as suicide being a leading cause of death in the homeless population (Perry & Craig, 2015); this is indicated by the UK Office for National Statistics following a 22% yearly increase in rates of mortality since 2013 (Aldridge, 2020). In recent years, the association between mental health and homelessness has been better acknowledged; Clinical Commissioning Groups (CCG) and the National Health Service (NHS) have increased their focus, as demonstrated in the NHS Long Term Plan. Whilst LGBTQ+ homeless mental health has been researched, they have often been considered and documented as independent concepts. The research that does exist tends to focus predominantly on a younger age group.

1.6.1 Prevalence

Research suggests there is an increased likelihood of mental health difficulties in LGBTQ+ homeless youth when compared to heterosexual peers (Rhoades et al., 2018, Kokkevi et al., 2014, Cochran et al., 2011). This population is thought to show higher levels of suicidality and have several mental health diagnoses (Rhoades et al., 2018). A disproportionate number of mental health difficulties and suicide ideation and intention have been recorded (Keuroghlian et al., 2014). The cycle of rejection, and simultaneous barriers in overcoming homelessness and managing stigma and discrimination associated with identity, further contributes to poor mental health (Cunningham et al., 2014). As such, it has been concluded that LGBTQ+ homeless youth are at heightened risk of negative outcomes. These include physical health issues, as well as mental health difficulties and addiction (Cochran et al., 2011), with the percentage of homeless youth providers supporting LGBT people increasing (Durso & Gates, 2012).

Suicidality is thought to be increased in general for LGBTQ+ youth; average rates showed 28% of LGBTQ+ youth reported a history of suicidality, compared with 12% of heterosexual peers (Marshal et al., 2011). A review of 62 papers identified higher rates of depression, suicidality and a correlation between substance use and minority stress (Mongelli et al., 2019). This is further supported by a research sample of 572 LGBTQ+ 12-24-year olds, which concluded that minority stress is associated with suicidality both directly and indirectly, through symptoms of depression and PTSD, which often link to hopelessness (Fulginiti et al., 2021). Similarly, suicidality has been explored in transgender and non-transgender groups, with it being reported as approximately twice as high comparing the former population with the latter (Perez-Brumer et al., 2017), thus highlighting the impact of gender-based stigma (Hendricks & Testa, 2012). It is thought that transgender people, particularly those experiencing homelessness (James et al., 2016), face disproportionately more negative mental health outcomes than LGB peers (Carmel & Erickson, 2016). This may be due to the impact on mental health when working with services to transition, as well as rejection and discrimination both within society and in the LGB community (Carmel & Erickson, 2016). The results outline the need for inclusive policies, mental health care professionals to help LGBTQ+ people overcome barriers, and the benefit of community-based interventions which increase social support (Mongelli et al., 2019).

LGBTQ+ adults are also thought to be at higher risk of developing depression and anxiety; in a survey of 2917 adults, gay and bisexual men were recorded as being three times more likely to have depression and five times more likely to experience panic attacks (Pitoňák, 2017). Similar statistics were recorded for females, as LGBTQ+ women were four times more likely to experience generalised anxiety than heterosexual women (Pitoňák, 2017). Such difficulties are also thought to be ongoing across the lifespan. A meta-analysis revealed that LGBT groups are 2.5 times more likely to have a persisting psychological difficulty, particularly with mood and anxiety (Meyer, 2003).

Other research has focused on the link between discrimination, drug and alcohol use and mental health difficulties (Vu et al., 2019). Findings suggest that LGBQ White women experienced higher risks of depression, alcohol and substance use, whereas

LGBQ Black women experienced elevated risk of substance use only (Vu et al., 2019). A National Alcohol Survey found lower abstention rates and more alcohol problems in lesbian and bisexual women, when compared with heterosexual females (Drabble et al., 2005). Similarly, substance use and dependence appeared greater in lesbian and bisexual women in both an adult and undergraduate population (McCabe et al., 2009).

LGBTQ+ asylum seekers are also thought to be at greater risk of developing mental health difficulties in light of the minority stress theory and reduced social connectedness (Ozeren & Aydin, 2016). Social support is thought to protect against the effects of discrimination, particularly for individuals who have been subjected to trauma (Ozeren & Aydin, 2016). Such groups may have left countries with significant stigma regarding LGBTQ+ identity, violence and persecution, and enter countries which pose barriers on a discriminatory, cultural and linguistic level, making it more difficult to form robust social networks (Reczek & Bosley-Smith, 2021). Loneliness and isolation are thought to contribute to low mood (Leigh-Hunt et al., 2017) and hypervigilance of social threats (Hawkley & Cacioppo, 2010). As such, high rates of suicidality, difficulties with mood, anxiety and psychological distress have been recorded in this population (Fox et al., 2020).

1.6.2 Understanding Why Mental Health Needs Exist

As demonstrated, there appears to be significant mental health needs in the LGBTQ+ population and particularly so for those experiencing homelessness, due to increased stigmatisation (Abramovich, 2017). In order to understand why mental health needs exist, different intersections of identity need to be considered and experiences cannot be understood in isolation (Seng et al., 2012). Such attempts focusing on single factors are limited in explaining health disparities (Seng et al., 2012). Intersectionality refers to the effects of race, religion, ability, sexuality and gender, amongst other characteristics which contribute to identity (Crenshaw, 1991). Central to this theory are the multiple social identities listed which relate to structural inequalities, such as poverty (Vu et al., 2019). This concept is shared with the minority stress theory (Meyer, 2003), as both consider how adverse health effects can occur through these macro inequalities and via social processes such as homophobia, racism, sexism and other forms of discrimination (Seng et al., 2012).

The minority stress theory (Meyer, 2003) considers the negative impact of discrimination on health, which is widely documented (Pascoe and Richman, 2009). Discrimination is thought to explain health differences between heterosexual and LGBTQ+ groups (Vu et al., 2019). The term was first used by Brooks (Brooks, 1981) who studied a lesbian population in 1981 (Mongelli et al., 2019). Meyer (2003) described stress as stemming from social processes and institutions and used this concept for LGB populations which has subsequently been expanded to include transgender individuals and other minoritised groups (Mongelli et al., 2019). It is thought that stigma from heterocentrism and gender-normative societies subject minoritised groups to chronic stress and this impacts health (Carmel & Erickson, 2016).

The theory suggests that LGBTQ+ individuals experience minority stressors which are specific to this population, as well as stressors experienced by heterosexual individuals. The main factors referred to in the minority stress model include: experiences of rejection, discrimination and victimisation, concealing sexual identity and internalised homophobia (Mongelli et al., 2019). Perceived discrimination is thought to increase the stress response, elevating cortisol, blood pressure and triggering an exaggerated cardiovascular reaction which can lead to hypertension, obesity and substance use (Pascoe & Smart Richman, 2009). Constant discrimination can be defined as a chronic stressor which increases vulnerability to both mental and physical health issues and erodes an individual’s protective resources (Taylor et al., 1997). Such sources of discrimination may stem from LGB identity being criminalised, previously in the UK and continuing in some countries globally, as well as being listed as a ‘mental illness’ in the DSM-IIIR until 1974 (Cromby et al., 2013). Research suggests that the number of marginalised identities held and the frequency of discrimination can explain 15% of variance in PTSD and 13% of variance in quality of life; these results were based on a group of 619 women with varying ethnicities, sexual orientations, religions and disabilities (Seng et al., 2012).

The theory has been further developed by amalgamating specific minority stressors with general psychological processes (Hatzenbuehler, 2009). The framework suggests that LGBTQ+ populations experience increased exposure to stress as a result of stigma. This stigma contributes to emotion dysregulation, conflict and impacts cognitive processing. Increased vigilance and internalised stigma can exacerbate psychological distress (Pascoe & Smart Richman, 2009). As a result, the risk of developing mental health difficulties increases (Mongelli et al., 2019).

Disclosing identity and a lack of social support are thought to be major factors associated with distress (Meyer, 2003). Research suggests that LGBTQ+ asylum seekers, who shared their identity in all areas of life, were three times more likely to be diagnosed with a mental health difficulty compared to those whose identity was concealed (Fox et al., 2020). However, it is possible that the high levels of trauma which asylum seekers often face may mediate this, and for many, the opposite is also true; having to suppress identity can also be a huge source of distress (Pearson & Wilkinson, 2013). Such listed stressors can range from distal, such as discrimination, to proximal, such as rejection, and both can negatively affect mental health, contributing to higher rates of depression, suicidality and substance use (Mongelli et al., 2019). Research suggests that lower education attainment, transgender identity, being female and bisexual are all associated with greater psychological distress (Perez-Brumer et al., 2017). Protective factors are thought to include strong social support networks related to LGBTQ+ identity and as identified, community connectedness (Frost & Meyer, 2012).

There has been much evidence in support of the minority stress theory, and the concept of ‘double discrimination’ for LGBTQ+ individuals who are older, from racialised backgrounds and for bisexual groups (Mongelli et al., 2019). However, whilst support grows, it has been suggested that longitudinal designs are needed to establish causality and the model needs to be used in a variety of cultural contexts as much research is based on a White population (Mongelli et al., 2019). Additionally, research has highlighted the limitations in assuming that disadvantages accumulate in an additive fashion; varying intersections need to be considered without automatically assuming that belonging to a marginalised group equates to a negative experience (Vu et al., 2019). This highlights the issue with assuming that identity and experience are synonymous and how explanations can often be too simplistic (Vu et al., 2019).

1.6.3 Responses to Needs

The extent to which the homeless population are seen within mental health services is lower than expected (despite the high level of need evidenced), with less than one third receiving treatment (Healthwatch, 2018b). This is even greater for LGBTQ+ homeless individuals, who utilise services to a lesser extent despite facing considerable mental health needs and substance use (Prock & Kennedy, 2020). Despite growing interest in the LGBTQ+ homeless population, concerns remain about the availability and accessibility of services which address physical, emotional and social care needs (Mayock & Parker, 2017). It has been questioned whether excessive discrimination impacts how the LGBTQ+ homeless population access and use health services (McCann & Brown, 2019). Other gaps in services are also referenced, such as in housing, education, employment, family support, training and advocacy (Hudson-Sharp & Metcalf, 2016). Whilst services may not offer adequate support (Mayock & Parker, 2017), there may be additional reasons as to why service use is low. It is therefore important to understand what barriers exist for the LGBTQ+ homeless population in general.

1.7 Barriers to Services

Research with homeless transgender individuals highlights that whilst many social care services provide ‘life saving’ programmes, many institutional barriers exist; these include cisgender, discriminatory policies and difficulties navigating systems which often do not recognise or affirm gender expression (Shelton, 2015). This has been expanded on in later research which identifies staff ignorance, discrimination and binary gender classification as barriers (Cameron, 2017). Such demands signal a lack of respect and flexibility for individuals transitioning.

For LGBTQ+ individuals living in shelters globally, concerns have been raised regarding safety due to levels of violence (Abramovich, 2017), sexual assault and theft (Grainger & Cagle, 2016). Discriminatory gender divided living spaces have also been noted as barriers to seeking accommodation (Abramovich, 2017). It has been assumed that systemic discrimination and hegemonic masculinity (which is often present in shelters), along with ‘excessive bureaucratic regulation’, can create barriers to accessible, caring and safe services for LGBTQ+ homeless youth (Abramovich, 2017).

In America, homeless bisexual and gay men listed the following as barriers to physical healthcare: interruptions with the government benefit scheme, difficulties with transportation, inaccessible locations of healthcare services and misperceptions of what healthcare services offer (Gunness, 2019). For many transgender individuals, significant barriers can be faced when seeking medical intervention, particularly around hormone therapy (Safer et al., 2016). Societal transphobia can infiltrate services and contribute to a misunderstanding and limited knowledge; a lack of acknowledgement of gender identity on hospital forms may suggest non-acceptance and unimportance (Spicer, 2010). Financial, legal, personal and cultural barriers have also been listed as impacting access to US healthcare, with discrimination in employment further contributing; all of which reduce the likelihood of ascertaining healthcare insurance and accessing services (Spicer, 2010).

There is some research regarding homeless individuals’ access to mental health support, however this is not specific to the LGBTQ+ population (St Mungo’s, 2016). Findings referred to budget cuts in services resulting in longer waiting times and less resources for support. The report highlights that the structure and referral criteria of secondary care services (which accept a certain level of presentation, severity and complexity) further discriminates against homeless individuals seeking early intervention. Overall, more than half of service users were deemed unable to access NHS mental health services, and those with comorbid addiction difficulties experienced even greater challenges. This was supported by a quarter of staff who felt that local NHS mental health services were ill-equipped to meet homeless service user needs (St Mungo’s, 2016).

Interviews with homeless individuals in Nottingham further contributed to this, as support from mental health services was said to be sporadic and only a quarter of people receiving treatment felt that it met their needs (Reeve et al., 2018). The research revealed that people often struggle to get an appointment, experience long waiting lists, are unsure where to seek help or are delayed treatment due to drug and alcohol use. It was also suggested that mental health needs are not always acknowledged by GPs or hospitals, as some were discharged despite personal beliefs that they were not well enough. Others spoke about their needs not being right for a service, often not severe enough or too complex. Once accessing support, many found assessments to be variable, with treatment terminating sooner than they would have liked, in addition to reduced continuity of care and challenges in repeating their story multiple times for professionals. The following was deemed helpful: a navigator to support communication, holistic services to provide support with mental health and housing needs, and increased availability of crisis services (Reeve et al., 2018).

Whilst these mental health barriers are important to consider as they may affect all groups regardless of identity, research suggests that there are likely to be unique mental health needs and challenges for the LGBTQ+ homeless population (Ecker et al., 2019). It is recommended that services should make adaptations, with staff increasing their knowledge and feeling more able to advocate on their behalf (Rice et al., 2013). In order to do this, LGBTQ+ service user perspectives must be explored. However, a systematic review suggested a significant gap in the views of the LGBTQ+ homeless with regard to their mental health needs and requirements (McCann & Brown, 2019).

1.8 Scoping Review

1.8.1 Objective

As such, and with the aim of exploring this further, a scoping review was conducted. The purpose was to identify evidence regarding the barriers to mental health support for LGBTQ+ homeless individuals. Due to there being no literature specific to this area in the UK, the scarce existing research included has been sourced from an international context. All papers included were restricted to English.

1.8.2 Search Strategy

The search terms focused on three broad areas with overlapping concepts that were searched for applying ‘OR’ and ‘AND’ Boolean phrases. Subject terms and key terms were utilised. The following databases were searched: EBSCO (Academic Search Complete, Child Development & Adolescent Studies, CINAHL Complete, APA PsychInfo), Scopus and Google Scholar.

1. Homeless terms ("homelessness" OR “homeless” OR "temporary accommodation" OR “unstable accommodation” OR "hidden homelessness" OR “shelters” OR “hostels” OR “rough sleeping” OR “sofa surfing” OR “squats”)

2. LGBTQ+ terms ("LGBTQ" OR “LGBT” OR “sexuality” OR "lesbian" OR "gay" OR "bisexual" OR “transgender” OR "queer" OR “pansexual” OR “questioning” OR “intersex”)

3. Mental health terms (“mental health” OR “depression” OR “anxiety” OR “trauma” OR “mental health services”)

1.8.3 Databases and Findings

The process of extracting data based on specific exclusion criteria and a list of databases used can be referred to in Figure 1. After filtering the literature, the scoping review highlighted five papers relevant to the topic area which have been outlined in Table 1 followed by a detailed exploration. These papers listed barriers to mental health support from a LGBTQ+ homeless perspective. The quality was assessed using criteria from different sources (CASP, 2017; Rutter et al., 2013). Quantitative papers were assessed on the basis of research design, sample size validation of data collection measures, amongst other factors. Qualitative papers were assessed based on categories such as rigour, credibility and transferability and considered the centrality of service user views (Guba & Lincoln, 1994; Spencer & Ritchie, 2011).

Figure 1

Process of Data Extraction

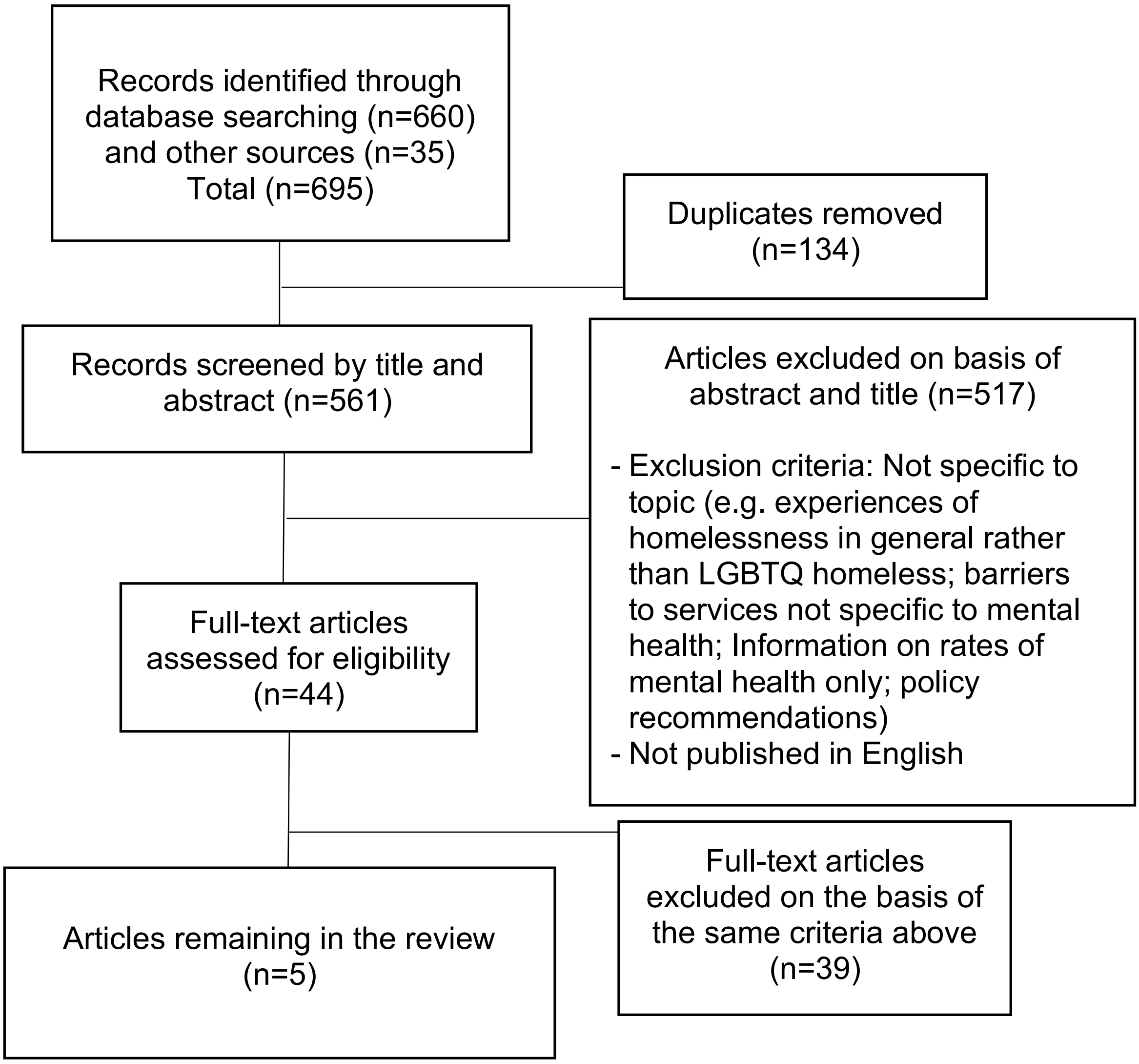


Table 1

Overview of Studies in Scoping Review

Study Title	**Year/ Researcher**	**Country**	**Methodology and Design**	**Sample Size**	**Sample Type**
An exploratory look at the experiences of lesbian, gay, bisexual and transgender homeless youth in accessing social services	Vernon (2008)	California, USA	Qualitative Interview questionnaire Thematic content analysis	14	18-24 years
Attitudes towards mental health services among homeless and matched house youth	Martin and Howe (2016)	California, USA	Quantitative Chi square analysis to compare groups	153 (56 homeless and 97 at risk)	12-21 years
iTEAM: Outcomes of an affirming system of care serving LGBTQ youth experiencing homelessness	Powell et al., (2018)	Arizona, USA	Quantitative Baseline and 6-month postbaseline self-report assessments	210	13-18 years
Characteristics, experiences, and service utilization patterns of homeless youth in a transitional living program: Differences by LGBQ identity	Prock and Kennedy (2020)	Michigan, USA	Quantitative Secondary data from closed case files between 2011-2018	101	16-20 years
Health and Healthcare Service Use: The Experiences of Runaway Trans Adolescents Compared to their Peers	Ferguson et al., (2021)	Canada	Quantitative Secondary data analysis of a survey	30	18 + years

1.8.4 Relevant Studies

A US based study conducted 14 qualitative interviews with LGBT 18-24-year-olds experiencing homelessness, as defined by housing instability (Vernon, 2008). Participants were asked whether they felt that mental health and social services were sensitive to LGBT issues. Thirty five percent of participants responded that they were not responsive, citing issues with service providers failing to ask about sexual identity and making heteronormative assumptions. Others spoke about the lack of consideration around transgender difficulties, environmental issues and how substances are often used as a way to self-medicate. The majority of participants responded to this question by saying that it depended on the service provider and the geographic location, whilst 14.2% of people felt that services were sensitive to LGBT needs. Reasons for this included familiarity with the LGBT community and being directed to appropriate services for housing. Whilst the findings suggest that discrimination and lack of awareness and understanding may impact access, the feedback does not always clearly differentiate whether these barriers are specific to mental health services or social services.

In California, a survey distributed to ‘56 homeless youth and 97 matched at-risk housed youth’, aimed to determine attitudes toward mental health services (Martin & Howe, 2015). The analysis compared LGBQ youth with heterosexual peers. Whilst both indicated favourable attitudes towards mental health services on the premise that they were tailored to meet their needs, more positive attitudes and less concern regarding stigma were identified in LGBQ homeless youth. However, the researchers highlighted that the findings may have been influenced by the places which they recruited from. These included drop-in support groups and services all advertised as safe places for LGBQ youth, tailored to specific needs, with LGBQ counsellors providing support. Therefore, recommendations for future research suggested including LGBQ youth who access a wide variety of services, including those offering non-specific LGBQ support.

A US study with 210 LGBTQ+ homeless youth was conducted to evaluate the effectiveness of a programme called iTEAM (Powell et al., 2018). iTEAM provides support aimed to improve mental health, access to housing, education, involvement and increase links to services. They are described as a ‘one-stop-shop’ specific to the LGBTQ+ homeless community. Baseline and 6-month follow up self-report assessments listed many benefits of the programme, such as substance use remaining low, increased engagement in employment, and improvement in mental health. However, some barriers were also identified including concerns around young people remaining anonymous, (such as being able to access the service without providing their name, perhaps due to immigration status or illegal activity as hypothesised by researchers), parental or guardian consent to use the service and being deterred by professionals needing to write reports on neglect, abuse and suicide ideation. All of which were deemed to impact the engagement of LGBTQ+ youth. As a result of the feedback, iTEAM were able to address some of the barriers, such as waiving the need for parental or guardian consent, allowing more autonomy and privacy for young people. Whilst these findings are an important addition to the field of research, they are specific to this organisation due to being based on individualised policies and structures which limits transferability.

Secondary data from 101 case files of homeless 16-20-year-olds, who accessed a transitional living programme in the US between 2011 and 2018, were analysed and differentiated by LGBQ identity (Prock & Kennedy, 2020). Within this programme, youth were offered a variety of services, such as life skills, education, employment and counselling three times a week. At intake, 80.2% of youth indicated a mental health diagnosis, with 50.5% reporting that their mood was stable at the time. Results highlighted that LGBQ homeless youth underused the service, despite being strongly encouraged, with an average of less than one session per week. Reasons for this were based on distrust of the service provider, lack of awareness of available services and staff being inadequately trained to meet their needs. LGBQ youth were reported to underutilise the service to a greater degree than heterosexual peers. This conclusion was based on data recording higher mental health needs amongst the LGBQ group. Overall, psychiatric and substance use services received lowest engagement when compared with other support, such as recreational activities and community involvement. The researchers concluded that homeless youth are more likely to access support which meets other basic needs rather than mental health related services, even when both are provided. This was even more apparent for homeless youth identifying as LGBQ. As acknowledged by the researchers, the secondary nature of the data can be critiqued; this involved a third-party documenting youth reports which may have been different to the reality. Additionally, the lack of transgender participants limits the awareness of potential barriers experienced by this population.

A quantitative analysis of secondary data from the '2013 BC Adolescent Health Survey' compared results for runaway transgender and cisgender youth, to peers living at home in Canada (Ferguson et al., 2021). In the paper 'runaway' refers to youth who left home and sought temporary residence in shelters, which is considered as homeless according to aforementioned definitions. The focus of the research was to determine the barriers to accessing physical and mental health care. A total of 29,832 adolescents in grades seven to twelve completed the survey. The most frequently cited reasons why runaway transgender adolescents did not engage with mental health care included: concerns that someone who knew them might see them, worries about family knowing, hope that the difficulty would go away, too busy to attend, no parent or guardian to transport them, did not know where to go. The results concluded that both cisgender and transgender runaway adolescents were more likely to experience poor access to health services compared to peers living at home. The measures which were used may be critiqued, as the survey which was distributed provided lists of example barriers to healthcare which participants could tick as applicable. Although it helped to appreciate some of the barriers that exist for transgender homeless adolescents, the restrictive nature may have led to missed responses and unidentified areas due to there being no open-ended questions.

1.9 Rationale

Based on the scoping review, there is a lack of research into the barriers regarding access to mental health support from a LGBTQ+ homeless perspective. Five papers reference this in the international context. Whilst the findings are an important addition to international literature, there is limited utility in the UK. This is due to services being structured differently; insurance is not required in order to access UK NHS mental health care, unlike US services. The papers outline some LGBTQ+ voices using quantitative measures, but the lack of literature highlights the need for more qualitative research prioritising those with lived experience. Finally, the existing research has tended to focus on subsections of the LGBTQ+ population and predominantly adolescents, meaning that some groups are missed. This highlights the need for research to include adults and all LGBTQ+ identities. Whilst the aim is not to homogenise one group, there is a limited rationale in justifying a focus on one subsection of the population above another.

Overall, it is recommended that more research is undertaken directly asking homeless individuals about their experiences of NHS mental health services and the type of multi-faceted barriers experienced (Healthwatch, 2018b). There is a need to explore individual perspectives to determine how appropriate and responsive support can be developed within services and made more accessible (McCann & Brown, 2019). Whilst access to healthcare has been researched among people experiencing homelessness, or gender/sexually diverse young people, in general there have been few studies which examine these aspects together (sexuality, homelessness and healthcare) (Robards et al., 2018).

1.10 Clinical Relevance

Clinical psychologists are in a position to pursue the above recommendations by using their skills in research and practice. It is important to understand how people view services and what the difficulties are. Understanding the barriers to mental health services for the LGBTQ+ homeless population will increase awareness of specific needs and encourage thinking about service accessibility. It is vital that people with lived experience are central to service development as the right to health refers to “participation of the population in health-related decision-making at the national and community level” (World Health Organisation, 2017).

Additionally, clinical psychologists have a responsibility to ensure timely access to health care. The National Institute for Health and Care Excellence (NICE, 2016) highlights the importance of early intervention for individuals experiencing mental health difficulties. Understanding the barriers to services may help to improve early intervention and subsequently reduce difficulties persisting into adulthood, which may impact homelessness. Whilst it is important to recognise that not every

LGBTQ+ homeless individual with mental health needs will require psychological support, help should be readily available for those that wish to engage.

In addition to the collective responsibility to prevent homelessness under the Homelessness Reduction Act (2018), clinical psychologists have a specific role to: ascertain the risk of homelessness for people who have mental health difficulties, reduce the effect on health from homelessness and achieve better health results for people experiencing homelessness (Public Health England, 2019). This would help to reduce barriers to finding accommodation (Public Health England, 2019). Clinical psychologists also have a duty to increase awareness of the psychological processes that can contribute to homelessness and consider how to best meet this population's needs effectively (Jarrett, 2010).

Understanding this, and the forms of oppression, which may contribute to homelessness for LGBTQ+ clients, is a prerequisite for facilitating and advocating for access to healthcare (The British Psychological Society, 2019). Such an outcome is contingent on data; therefore, the following research is proposed.

1.11 Research Aims

This research will seek to understand the barriers to mental health services from a LGBTQ+ homeless perspective (18 years +). This will be achieved by asking LGBTQ+ individuals (who have lived experience, which is defined by experiences of homelessness and mental health needs) research questions which aim to understand the role of and barriers to mental healthcare for this population.

- What are the mental health needs of LGBTQ+ homeless adults?
- What do LGBTQ+ homeless adults view as the role for mental health services?
- What do LGBTQ+ homeless adults think are the barriers to accessing mental health services?
- What do LGBTQ+ homeless adults think that mental health services could do differently?

2. CHAPTER TWO: METHOD

This chapter will outline the methodology, including the study's epistemological and ontological position, the study design and procedure and the rationale and process of Thematic Analysis.

2.1 Ontology and Epistemology

Ontology and epistemology refer to philosophical, meta-theories that underpin all research (Braun & Clarke, 2021b). Understanding the epistemological and ontological position enables an appreciation of the researcher's values and aims, which can influence methodology (Greenwood & Terry, 2012). The questions asked, the description of experiences and the process of data analysis are all impacted by the position taken (Mauthner & Doucet, 2003).

Ontology considers what there is to know and what exists (Braun & Clarke, 2021b). Epistemology refers to the nature and theory of knowledge production, the characteristics of knowledge and its scope and limitations (Willig, 2019a). It focuses on how to acquire knowledge and develop an understanding of the experience whilst considering the relationship between the researcher and what there is to know (Denzin & Lincoln, 2011).

For this research, a critical realist position has been adopted. Such an approach seeks to understand how and why an encounter occurs by assuming the existence of underlying structures (Willig, 2019a). Critical realism adopts a mode of discovery and aims to identify the relationship between the observable and unobservable, providing a deeper explanation of an individual's account beyond that reported at face-value (Willig, 2019a). As such, an understanding of people's experiences of homelessness and barriers to support have been investigated, making the assumption that 'homelessness' and 'barriers' are real concepts, whilst simultaneously acknowledging that the data might not accurately reflect reality (Willig, 2019a). This is due to people's experiences being influenced by different cultural and social contexts which impact participant accounts, and the researcher's interpretation of the data (Bisman, 2010).

2.2 Design

Qualitative methods have been employed as they are suitable for exploration of the nature and quality of individual experiences and enable meaning making (Willig, 2019b). Qualitative research aims to increase understanding of a particular phenomenon, in this instance, LGBTQ+ homeless mental health, in order to contribute to the knowledge base (Willig, 2019b).

2.2.1 Rationale for Thematic Analysis

Thematic analysis (TA) is a method for systematically exploring, interpreting and reporting relevant patterns of meaning across data (Braun & Clarke, 2021b). It allows the researcher to identify shared and idiosyncratic meanings across experiences that relate to the research question (Braun & Clarke, 2012). TA has been identified as an accessible, flexible and useful method which can work with a variety of research questions in a number of different ways, such as inductively and deductively (Braun & Clarke, 2012). An inductive approach, which has been adopted in this research, occurs when coding and analysis are driven by the data, centralising people's experiences and meanings. This contrasts with a deductive approach, where the researcher may approach the data with preconceived ideas and concepts based on existing literature (Braun & Clarke, 2012). However, it must be acknowledged that it is unattainable to take a purely inductive approach, as researchers bring their own bias to the process of data interpretation (Braun & Clarke, 2012).

2.3 Participants

Nine LGBTQ+ individuals with experiences of homelessness and self-identifying as having mental health needs were recruited via purposive sampling techniques. Whilst the number of participants is below the suggested 10 to 12 to meet data saturation, recruitment proved challenging. Therefore, a focus was maintained on collecting rich, thick data. Furthermore, attempts to operationalise numbers by stating how many participants should be recruited has been critiqued. This is on the basis that providing such concrete guidance contradicts the values and assumptions of reflexive TA; here, meaning is generated through the interpretation of data as opposed to the number of interviews conducted which is thought to be subjective (Braun & Clarke, 2021a).

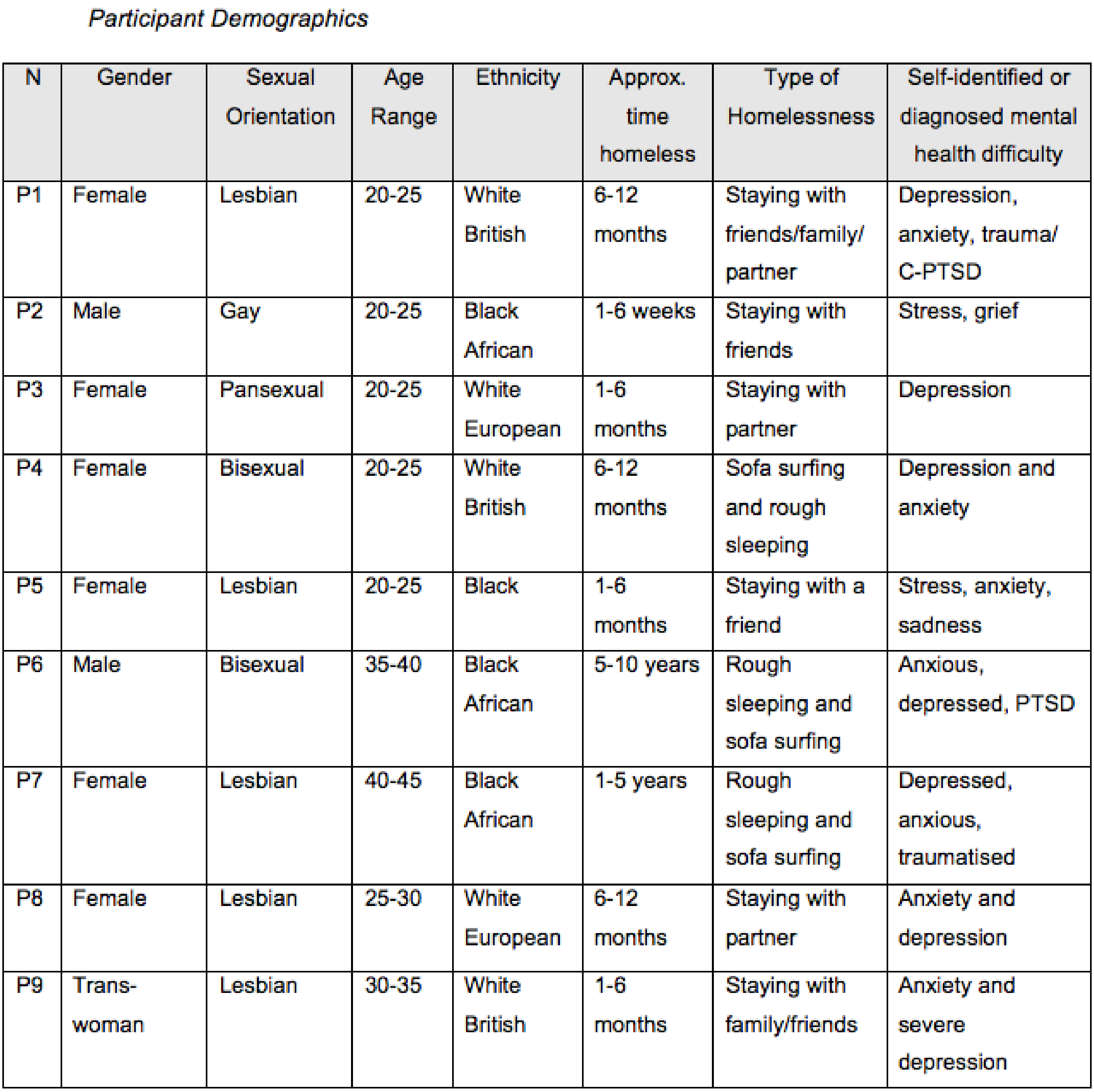
Homelessness was defined broadly and included a variety of experiences such as sofa-surfing, staying with a partner, friend or family, hostels and rough sleeping. As stated, LGBTQ+ has been used as an umbrella term. There are limitations with this; not all stakeholders may agree and there is an assumption that there may be commonalities between different sexual and gender identities. However, a strength of the term is that it has been used in an attempt to be inclusive of all groups (particularly due to the lack of literature which resulted in little justification for focusing on a specific subgroup). It is also a term which the charity (where consultation took place) use.

All participants were required to meet the following inclusion criteria:

- 18+ years or older
- Living in the UK
- Identify as LGBTQ+
- Self-identify as having mental health needs (with or without a diagnosis)
- Experienced homelessness, as defined above (past or present)
- Access to a device to complete the interview remotely

The mean age for participants was 28, ranging from 22 to 44 years. Participant demographics, reflective of individual language, have been included in Table 2. There was variability in participants' experiences of homelessness, such as the type and length. This, along with other variabilities, will be discussed in the final chapter.

Table 2



Participant Demographics

N	Gender	Sexual Orientation	Age Range	Ethnicity	Approx. time homeless	Type of Homelessness	Self-identified or diagnosed mental health difficulty
P1	Female	Lesbian	20-25	White British	6-12 months	Staying with friends/family/ partner	Depression, anxiety, trauma/ C-PTSD
P2	Male	Gay	20-25	Black African	1-6 weeks	Staying with friends	Stress, grief
P3	Female	Pansexual	20-25	White European	1-6 months	Staying with partner	Depression
P4	Female	Bisexual	20-25	White British	6-12 months	Sofa surfing and rough sleeping	Depression and anxiety
P5	Female	Lesbian	20-25	Black	1-6 months	Staying with a friend	Stress, anxiety, sadness
P6	Male	Bisexual	35-40	Black African	5-10 years	Rough sleeping and sofa surfing	Anxious, depressed, PTSD
P7	Female	Lesbian	40-45	Black African	1-5 years	Rough sleeping and sofa surfing	Depressed, anxious, traumatised
P8	Female	Lesbian	25-30	White European	6-12 months	Staying with partner	Anxiety and depression
P9	Trans-woman	Lesbian	30-35	White British	1-6 months	Staying with family/friends	Anxiety and severe depression

2.4 Procedure

2.4.1 Involvement in the Development of the Research

An initial meeting with the Campaigns, Policy and Research lead from a LGBTQ+ homeless charity provided an opportunity to obtain feedback on the focus of the research and confirm the important areas to address, as well as the feasibility of recruitment. The charity explained that from previous experience recruitment may prove difficult. However, they agreed to support the research by sharing the advert in the newsletter, as they felt that this was an important, under studied area. They also agreed to help shape the development of an interview schedule. Therefore, a consultation was subsequently arranged.

Three individuals attended the consultation, some of whom had lived experience. This helped to recognise ‘blind spots’ as a draft schedule was presented and feedback was provided regarding the types of questions, the phrasing and the sensitivity. Specifically, it was advised that the definition of homelessness should be made clear in the advert as people may assume rough sleeping is the only form and not realise that they are eligible. It was recommended that questions generally refer to third person broader experiences to reduce distress of recounting personal stories. Finally, it was suggested that a question about the impact of help on homelessness be included, alongside a question about how services are communicated. A template from the charity helped inform the collection of demographic information. Questions regarding the type and length of homelessness were also included, as the charity felt these were important factors to consider. The charity confirmed that their contact details could be provided in the debrief letter, should participants feel that they require further support or information.

2.4.2 Development of Interview Schedule

The completed semi-structured interview schedule consisted of 15 questions, designed to reflect the research questions, the evolving context of the pandemic and based on the gaps in existing literature (Appendix A). A final copy was sent to the charity and feedback was provided by the research supervisor. A semi-structured approach enabled the researcher to ask participants about their experiences in a standardised way, whilst allowing each person flexibility to detail their account and raise unanticipated issues, permitting follow-up questions unique to that experience (Braun & Clarke, 2021b).

2.4.3 Recruitment

The study was advertised through a LGBTQ+ homeless charity newsletter, Twitter platform and mailing group (Appendix B). Subsequently, three other LGBTQ+ homeless and/or mental health charities working with adults, older adults, refugee and asylum seekers were approached and advertised the research on their social media and mailing sites. One university forum shared the research via Twitter. A personal social media page was set up dedicated to the research which led to further general LGBTQ+ organisations re-sharing posts. Snowballing techniques were also employed as one participant shared the advert with another.

All participants seeking to register their interest and arrange an interview contacted the researcher via email. Responding quickly with a flexible time schedule seemed to improve engagement, along with a follow-up email for those who did not respond. Across the recruitment period, 22 potential participants emailed the researcher. Eleven people did not respond to subsequent contact with more information, or a follow-up email sent two to four weeks later. Two people did not attend arranged interviews.

2.4.4 Consent and Confidentiality

An information sheet (Appendix C) and consent form (Appendix D) were emailed to participants approximately one week before the interview. The consent form was completed by participants and emailed back prior to the meeting. Verbal consent was also sought at the beginning of the interview with an opportunity for participants to ask questions. All participants consented to participate, for the interview to be recorded, transcribed and for anonymised extracts and quotes to be included in the thesis. Participant data were stored on a password-protected computer and any identifiable information, such as names of people, places and services were removed and replaced with numbers and titles.

2.4.5 Interviews

Semi-structured interviews were conducted via phone call or video conferencing, all of which were recorded via Microsoft Teams. The length of the interviews ranged from 27.37 to 59.35 minutes with an average of 45.02 minutes. The format of the interviews was as follows: the rationale for research was outlined, consent was gathered, and data management and confidentiality were re-capped. Participants were reminded that the interview would be recorded and were advised that they could withdraw at any time during, and up to three weeks after, the study. Participants were informed that they could take as many breaks as they wished to and that they could decline answering any question. Demographic information was collected before the main questions were asked. At the end of the interview, a debrief was conducted providing an opportunity for questions and for the researcher to identify any risk. The debrief form (Appendix E), which included names and numbers of support, was emailed to the participant, along with a £10 Amazon voucher to thank people for their time.

2.4.6 Transcription

Interviews were transcribed verbatim from the audio recordings. The quality of data and accuracy were checked by listening again once a draft transcript had been completed. The extracts included were improved in clarity by removing all non-linguistic features, whilst ensuring that the content remained unchanged (Willig, 2019b).

2.5 Ethics

Ethical approval was provided by the University of East London Ethics Committee (Appendix F). The application contained an overview of the research and included details regarding the support that would be provided to participants should they become distressed during or after the interview. It was assumed that some distress could be experienced by participants. However, with the focus broadly being about the experience of mental health services, the risk of distress was not deemed to be significantly high.

2.6 Approach to Analysis

2.6.1 Process

The process of TA was informed by the six phases outlined by Braun and Clarke (2006) and their practical guide to thematic analysis (Braun & Clarke, 2021b). The first stage involved familiarisation with the data, which was achieved by re-reading transcripts on multiple occasions and documenting any initial thoughts through note taking. This included questioning what sense the person was making of the topic and why, what assumptions existed, what world was revealed through their account, alongside researcher reflexivity (Braun & Clarke, 2021b).

Sub-sections of the text and individual sentences were assigned codes which aimed to capture the meaning of the text. Once codes had been identified, they were grouped into themes to identify shared patterns of meaning across the data. Diagrams were employed to help compare themes and identify any connections, whilst also scrutinising each individual theme to establish any hierarchy, helping to create sub-themes.

After this had been achieved, existing themes were reviewed in terms of utility and coherence by the researcher and overseeing supervisor which led to some adaptations. The final steps of the process involved checking the validity of the themes against the complete data, developing a thematic map and confirming names for each theme and sub-theme.

2.7 Evaluating Quality

Evaluating the quality of research is essential due to the influence of personal biases, different epistemological stances which can be taken (Madill et al., 2000), and as a result of the researcher’s relationship to the research (Gold, 2010). In particular, a study’s contribution, credibility, transferability and rigour have been listed as key principles to adhere to when evaluating the quality of research (Spencer & Ritchie, 2011). These principles focus on what the research adds to the field, and the need to provide a clear rationale and plausible evidence to support research claims and ensure methodological validity and reliability (Spencer & Ritchie, 2011). These concepts will be explored in further detail in the discussion.

2.8 Reflexivity

It has been suggested that in order to conduct reflexive TA well, the researcher must be clear about possible options for coding, the rationale of choices made and remain consistent in their approach to analysis throughout (Braun & Clarke, 2021b). This was enabled through peer supervision and reflection with the research supervisor. To ensure the quality of the research, it is recommended that the researcher acknowledges their position, standpoint and relationship to the study and how this can shape the process (Willig, 2013). As such, personal reflections have been shared and reflexivity has continued to be explored in the final chapter, with reference to the expectations and assumptions held and actions taken throughout the process (Braun & Clarke, 2021b).

2.8.1 Reflections

My interest in the research has been based on a collection of experiences. Growing up, I became aware of the difficulties some peers had in sharing their sexuality due to fears of how people would respond or following harmful reactions, which for some negatively impacted their mental health. However, it was also clear how protective a supportive network could be. The connection to homelessness was not one I had considered until moving to a city where rough sleeping was stark, and I began to think more about the context and potential causes of homelessness. I reflected on the narrative of rough sleepers often being labelled as dangerous or as having addiction difficulties and how this can result in a societal unwillingness to engage with the population.

Although the context of homelessness has been present in clinical work, it has often felt distant and detached, with homeless clients being seen predominantly by social care. In my experience, psychology interventions have tended to be provided indirectly through consultation with other services. In preparation for the research, I spoke with five people from different homeless charities, some working in clinical or social work capacities, and others as advocators having had lived experience. Although all experiences were different, the common factor across all interactions was the gravity and extent of hidden homelessness and how people’s voices are so unheard, particularly those with multiple marginalised identities. Hidden homelessness was an aspect I felt less familiar with, having placed more focus on rough sleeping.

My belief is that services are often not always designed or informed by individuals with lived experience. Whilst we can understand experiences of homelessness from a social and psychological perspective, we do less to meet these needs and at times may actively cause harm through lack of inclusivity. Although I have hypotheses about LGBTQ+ homelessness being impacted by the social context, particularly discrimination, I attempted to remain reflexive by maintaining curiosity and reflecting on the factors which could impact data interpretation. This was supported through use of a reflective log. However, it is likely that despite this, the nature of such influences will have impacted the process.

3. CHAPTER THREE: RESULTS

This chapter will present the themes identified following the completion of the analysis. Three main themes were identified, with nine sub-themes (see Table 2). All participants were associated with each theme and the participant numbers associated with each subtheme have been included in parentheses in the table. Each theme will be described in detail and supported by quotes from the participants. A thematic map has been included (Appendix G).

Table 3

Outline of Themes and Subthemes

Themes	Subthemes
Rejection of identity (all pps)	Lack of family acceptance associated with homelessness (pps 1, 2, 3, 4, 5, 6, 7, 8, 9) Stigmatised and excluded (pps 1, 2, 3, 4, 5, 6, 7, 8, 9) Managing the fear of sharing identity (pps 2, 3, 4, 5, 6, 7, 8)
Homelessness can strip away personhood (all pps)	Shame, hopelessness and low self-worth (pps 1, 2, 3, 4, 6, 7, 8) Loneliness and isolation (pps 1, 2, 3, 4, 5, 6, 7, 8, 9)
A lack of appropriate support (all pps)	Long and overwhelming processes to access help (pps 1, 2, 3, 4, 6, 7, 8, 9) Denied appropriate help (pps 1, 3, 6, 7, 8, 9) Basic needs not met (pps 1, 2, 3, 4, 6, 7, 8, 9) The importance of choice and flexibility (pps 1, 2, 4, 5, 7, 8, 9)

3.1 Theme One: Rejection of Identity

Rejection of identity was highly prevalent for all participants, impacting many areas of life. Identity referred to being LGBTQ+ and rejection encapsulated a multitude of experiences whereby power was exerted by another. This ranged from acceptance, invalidation, denial and more explicit forms of harm. Rejection of identity was associated with becoming homeless, experiences of discrimination and consequently, a fear of sharing a true self. Suggestions were made to address discrimination in order to reduce a fear of sharing and enable help-seeking.

3.1.1 Subtheme One: Lack of Family Acceptance Associated with Homelessness

All participants spoke about the lack of acceptance and conflict from families regarding their identity and shared that this had been the main cause of homelessness. Many cited it as a contributor to homelessness for other LGBTQ+ people too.

> *I would say sort of conflicts with family especially around their sort of sexuality or gender identity is going to be a big one… it's been very much a lot of young people with family issues.*
>
> Participant 1

> *Maybe some of their family can't accept them the way they are. Yeah, that's the main reason.*
>
> Participant 5

Some participants suggested that LGBTQ+ individuals might be actively forced out of their home, with another having recalled personal threats.

> *I think a lot of LGBTQ people are kicked out from their families because of being part of LGBTQ community.*
>
> Participant 8

> *I think it's just that the family won't accept it, my dad actually said to me a year before he threw me out, "if you don't like it, you can fuck off then".*
>
> Participant 9

Others spoke of experiencing 'unintentional homelessness'. This was characterised by the need to leave to seek safety, due to fears of disclosing identity, highlighting the nuances of individual circumstances.

> *They don't want the family members to know that and don't want to come out and they end up becoming homeless. Rather than them coming out, they prefer to move out, and by moving out they might end up not getting support that they wanted.*
>
> Participant 7

> *Some people just don't feel safe to come out…Or maybe they just felt like they weren't allowed to be themselves and maybe they kind of make a conscious decision, maybe not to become homeless, but to leave the home.*
>
> Participant 3

Different forms of family acceptance were referred to, including being unable to be an authentic self and therefore leaving home to fulfil this, or needing to hide identity to fit in and prevent homelessness.

> *I know people who've moved to [area] to come to university who were very gay. But obviously they could never be themselves back at home.*
>
> Participant 3

> *There was a time I was hiding things away from them [family], you know, the places, the people you are meeting, so I had to do something to fit in.*
>
> Participant 6

There was recognition that for some parents the ability to accept identity and offer support, such as continuing to provide their offspring a home, seemed contingent on their social context and influential relationships.

> *Apparently, she [mother] accepted who I am but because of the society and my father, she couldn't embrace me, she couldn't support me in how she planned.*
>
> Participant 7

There was a shared desire for services to work with families to provide education on LGBTQ+ rights, with a focus on normalising identity and improving family acceptance, therefore reducing the likelihood of homelessness.

> *Talking to our parents and telling the community that we are normal people and we are the same, we are not different from others… Someone to advice my parents that we are important to society, having some posters and having some classes to educate them.*
>
> *Participant 2*

> *They should talk to our parents to guide them, to accept us. To accept our situation.*
>
> *Participant 4*

3.1.2 Subtheme Two: Stigmatised and Excluded

Experiences of stigma and discrimination regarding LGBTQ+ identity were described by all participants, across all aspects of society. This was experienced to different degrees and on a spectrum, which highlighted how insidious and systemic the issue is.

Invalidation, heteronormativity and gender normativity were recalled, with the effect of making people feel excluded and unimportant. These experiences were reported in everyday life, as well as in mental health services.

> *Occasionally in my therapy sessions I had to explain that this thing [information] doesn't quite apply to me, 'cause I'm not actually dating men, you know.*
>
> Participant 1

> *You know, just yesterday I signed up for a gym and they said what's your gender, female or male? Someone who feels like they don't really fit into those categories, they don't feel included, and if you're going somewhere like a charity to get help with your mental health and you are filling out a self-referral form, you're already not feeling included at such an early stage of the way, you're not going to feel very positive about it.*
>
> Participant 3

Experiences of homophobia, biphobia and transphobia were described with people being subjected to ridicule and feeling punished. These experiences were seen as inconsequential to families who prioritised their own discomfort.

> *He [family member] didn't allow me to join the LGBT group I interact with, he said he doesn't want his children to be afraid by my preference so basically, the way people are, they look at us as that we are not in a right way, and bad to society, so it is better to see us suffering than to see us being happy and successful.*
>
> Participant 7

> *My eldest brother said 'why don't you drop this transgender madness?' which I can't. You can't help being trans, if you're trans, you're trans. You feel a massive disconnect with how your body is, how your gender is inside of you.*
>
> Participant 9

This type of discrimination was also described as present in society, impacting access to accommodation and help. Instead of the root problem being addressed, the participants said that LGBTQ+ people had been forced to find ways to manage.

> *The fact that you are gay, they [landlords] wouldn't even accept you even if you got your money to rent a place. Instead of someone to help you out with accommodation or something, the person will realise who you are and will then start treating you with no respect.*
>
> Participant 6

> *When I went to the Pride event in [area] my dad really did kick off and when I spoke to [organisation] one other person said to me 'we should not have to have pride, but we do because we get so much discrimination'.*
>
> Participant 9

> *I'm pretty sure every, almost every, LGBTQ person has had some kind of queerphobic experience which might have impacted their mental health.*
>
> Participant 8

More extreme forms of violence were also described, with the danger of coming out being made explicit. This was apparent for one transgender individual who described experiencing multiple levels of discrimination, such as denial of gender and sexuality.

> *When I got my hair extensions my dad threatened to rip them all out and shave all my hair off…when I tried coming out when I was eight, my mum hit me and she broke my eye socket.*
>
> Participant 9

> *I had all the gay slurs…my family is like 'oh transwomen can't be lesbians, you're not a proper woman, no matter how much, no matter how long you take hormones or have surgery the chromosomes never lie'.*
>
> Participant 9

Such harmful experiences listed impacted people's sense of self. This was expanded on further, as some recounted experiences of disgust from others with LGBTQ+ identity being equated to having mental health difficulties.

> *It reminds me of the names my husband has been calling me in the past, he tells me that I am sick in the head, I'm not in the right place, because if I am in the right place I will not be thinking of other females like me as a girlfriend or as a partner. I cannot see them in that way.*
>
> Participant 7

> *People think that we are mentally ill and that we are sick in the head.*
>
> Participant 9

For many, being made to feel abnormal, different or 'the odd one out' was common. This perpetuated low self-esteem and a sense of isolation from others.

> *So then it was just double the confidence issue because I'd get teased about obviously looking different and then internally I knew I was different… so I definitely felt a bit like a black sheep always.*
>
> Participant 4

> *Now I'm just treated like the black sheep of the family, just having the courage to come out, I just get treated like a kid even though I'm a young girl in her 30s.*
>
> Participant 9

> *That's when I felt really different 'cause from what I'm aware there's not a single gay person in my entire family, it's just me.*
>
> Participant 3

Participants also spoke about being made to feel unlovable and temporarily hated as a result of their identity. In some cultures, ideas were posed about LGBTQ+ identity being synonymous with being childless.

> *My parents just can't accept me the way I am, yeah, so I feel like they don't love me anymore.*
>
> Participant 5

> *Especially the mothers expect when they are raising their children, they will give them grandchildren and when you are a member of LGBTQ it becomes a shame to the parents.*
>
> Participant 2

A common consequence of such discriminatory experiences was internalised stigma. For some, a desire to change identity was expressed, and this was particularly felt in the initial stages of disclosing sexual orientation. Wanting to identify as heterosexual perhaps reflects a wish to live without discrimination and all the associated harms and challenges.

> *I think it's hard for a lot of people to admit that something that they were born with is the reason why people don't accept them anymore…I'm sure if you spoke to a lot of LGBT people, they will tell you that like initially it's something that maybe we wish wasn't true.*
>
> Participant 4

> *Everyone want to be straight.*
>
> Participant 6

> *I wish I could turn around the time, I wish I could change who I am, but I can't.*
>
> Participant 7

In response to being stigmatised and excluded, participants spoke of the need for services to improve inclusivity for LGBTQ+ individuals seeking mental health support and acknowledge the perceived differences in treatment based on identity.

> *If you’re not trans the NHS is there for you, even if it is self-caused. But if you are trans and badly, badly need support, the NHS is not there…Give us the same support that cis people get.*
>
> Participant 9

> *Maybe it would be good to add non-binary identities more to the whole NHS especially if we're talking about mental health, it is incredibly important just to know my identity actually exists for those people you know.*
>
> Participant 8

> *[Question about what services could do differently] I think if it's gonna be NHS or a charity that doesn't specifically deal with LGBT people, knowledge and just understanding that not everyone is going to identify as cis or female and just be inclusive, but I think it does come down to knowledge and just open mindedness.*
>
> Participant 3

However, it was identified that any change needs to be meaningful, as tokenism is just as harmful and allows discrimination to continue.

> *What I wouldn't want is for everyone to be sort of given LGBT sensitivity training and then change nothing about the actual procedures of how they give treatment.*

Participant 1

3.1.3 Subtheme Three: Managing the Fear of Sharing Identity

A rejection of identity resulted in a fear of sharing. Although perhaps self-protective to avoid the aforementioned harm from others, this had far-reaching effects for many participants. Fear of sharing was largely centred around LGBTQ+ identity, however there was recognition that there can be a fear around sharing mental health needs, with services being compared to '*a sexual health clinic'* in that '*you don't really know where they are…and you kind of feel like you have to go there alone*' (Participant 4). Some participants spoke about the need to address discrimination in order to reduce the fear of sharing and enable help-seeking.

The extent to which people sought friendships and relationships was impacted by concerns about understanding and judgement.

> *I feared to talk about it… because they are not of the same sexual identity. Sometimes they don't want to associate with other people.*

Participant 2

> *I was scared because of sexual orientation for making fun. Also, their friends. They might talk bad about them.*

Participant 5

With regard to services, sharing was contingent on where someone was in their journey and the impact of prior experiences. Rejection from parents, who are supposed to provide unconditional love and support, impacted the confidence people had in continuing to share their identity with others. It was also acknowledged that the types of questions asked, and the amount of information services gather, can be uncomfortable and may pose a barrier to seeking help.

> *I think for many LGBTQ people, our identities are really tangled up with mental health issues, and so it just means how comfortable you are with your own identity and how comfortable you are in talking about it, because at the end of the day, you need to trust your therapist.*
>
> Participant 8

> *It wasn't something that I really wanted to open up if that makes sense? The idea that people are supposed to love you, unconditionally, especially parents and stuff, and if it's something that they can't accept, it makes you feel really low, in terms of your own self-worth, so to then go and speak to strangers about it and, a lot of the time, the LGBTQ services, like homelessness services that I dealt with, they were lovely but they do and they have to I suppose, ask really intrusive questions, which could be really, really difficult.*
>
> Participant 4

For some, the fear of sharing was heightened and experienced as a risk to safety or danger to life. The latter was described by participants who left countries of origin which continue to criminalise LGBTQ+ identities. This highlighted how the fear and lack of trust associated with traumatic experiences can remain despite moving to the UK, which has different laws.

> *They [family] told me they kill you. It puts fears, you know, because the fact that you are gay, in [country], it’s a crime, so yeah they put fear in you and then they will look down on you, they will treat you like a nobody.*
>
> Participant 6

> *It isn't always going to work living at home. They could potentially be scared to even google these things in case the family had a history or, you know, walked in on them as they were trying to read up about, say, certain information… or they wouldn't want to be seen going into that place either.*
>
> Participant 3

When considering the relationship with the clinician, concerns were shared about how understanding, accepting or homophobic they could be.

> *They are thinking that the psychiatrist or the doctor or the therapist I'm going to speak to might not be gay. How am I going to go and tell him I am gay and all that? So forget about that, I’m not going.*
>
> Participant 6

> *It really depends also what kind of a person your therapist is 'cause we all are just people and it’s a bit of a lottery of how accepting and how educated they are.*
>
> Participant 8

> *It is not easy for me to share with people around me because I don’t know who they are, if they are homophobic or something to lesbianism, and I don’t*

> *know whether they accept me. You don’t know what people might think and who they are and how they react to it.*
>
> Participant 7

For some, this was negated by seeking an LGBTQ+ practitioner, who was deemed to have greater understanding.

> *I actually asked for someone specific to LGBT so it would be good to have therapists part of LGBT to write that on their profile, ‘cause I feel like if you’re gonna be gay then A) they’ve experienced it themselves and B) you know they’re gonna be accepting to it.*
>
> *Participant 3*

The idea of multiple interacting identities was commonly raised, in terms of its impact on sharing identity with family and therapists. Older age was associated with less understanding and greater discomfort, in fear of historical, negative beliefs about LGBTQ+ identity being held.

> *I think the older generation just doesn't understand it. Not all of them of course, but some. So yeah, I feel like maybe it's not natural and they almost feel disappointed when a child comes out as gay.*
>
> Participant 3

> *Both my parents, they're really lovely people but they're just from an older generation and this is not something that they would understand.*
>
> Participant 4

> *I liked that the lady [therapist] was quite young, like I would probably not give her more than 30. And that made me feel a lot more comfortable because I do feel like our generation is more open minded than my parents' generation. So, if I got someone who's like in the 60s, I'd probably feel uncomfortable speaking about certain things.*
>
> Participant 3

Similarly, the role of religion was raised with questions about the level of understanding and ability to share a true self with therapists and family from particular faiths.

> *What about if I go and see a therapist who is a pastor or church father, what are they going to do, how are they going to think about it?*
>
> Participant 6

> *At first, I was given a middle-aged Muslim lady and I know it's awful of me to judge but straight away I'm like oh religion or like you know, is it OK, even though I understand it's their job to be accepting.*
>
> Participant 3

> *Her family are really Christian, they're really nice…they [family] never tried to say anything bad or anything, but you still feel like you cannot be your gay proud self, like I don't know, wave the flag and stuff like this you know.*
>
> Participant 8

As well as fears of sharing LGBTQ+ identity, there were fears of racism, with questions raised about the point of sharing if differences in support exist for racialised LGBTQ+ individuals when working with White therapists.

> *Some therapists might not even give you the right help, they might be racist inside, you never know.*
>
> Participant 6

Many identified a need for discrimination to be addressed on a systemic level with everyone taking responsibility. It is possible that this would reduce the fear of sharing across various aspects of life.

> *By raising an awareness that being lesbian, gay, bisexual is not an odd one out and making them feel that they are also doing what is right. The community at large are not made to feel what they are doing is right, to support all we are.*
>
> Participant 7

> *The government has to publish a good decision or announcement onto everybody because a lot of organisations, a lot of departments, a lot of people think oh why do I have to help these people, because they are not gay, it is not good for me to do that, so they look at people as if they are bad or something…as they say Black Lives Matter, it's all the same for LGBT group matter.*
>
> Participant 6

School, social media and employment were identified as areas that need to be addressed to enable people to feel more confident in sharing and seeking help.

Some participants suggested that organisations need to be receptive to LGBTQ+ training and not discriminate on the basis of identity.

> *Those parties or organisations which will be leading the teaching, they should somehow offer some employment or some chances to ask people you know, because I told you sometimes an employer may fear to employ someone who is gay and lesbian.*
>
> Participant 2

> *I just think they [mental health services] should get the job done especially as it's not something that is taught in schools and stuff*, *so you know, and then using really crazy terms to do with mental health, it can be scary. I just think we need to kind of think about the way we're wording things.*
>
> Participant 4

Mental health services were also considered. Participants highlighted the need for therapists to be accepting and open-minded, and confident in their ability to recognise and challenge any form of implicit and explicit discrimination. This would help to show support for the LGBTQ+ community, negate harmful narratives and place the issue with the system rather than the individual.

> *A lot of people are still hiding, a lot of people are still covering their faces. They are scared to come out and talk about themselves, about what they are, what they are going through, what they need, so I would say that everyone should be recognised with justice and everyone should be treated with respect.*
>
> Participant 6

> *They should be ready to support us as who we are and not judging us their own way. Because a lot of LGBT people, the main reason we are trying to access the support is because of our sexual preference and what is going on around us as well.*

Participant 7

> *You need a therapist who will be educated enough to understand that it is actually a queerphobic experience and not just you being dramatic or whatever, you know.*

Participant 8

3.2 Theme Two: Homelessness Can Strip Away Personhood

The second theme illustrated how homelessness can have a detrimental impact on wellbeing and the sense of self. It appeared to take away physical, social and psychological resources, which impacted the self and societal perception of what LGBTQ+ homeless people deserve and need. Homelessness had the ability to deteriorate wellbeing, such as confidence and self-worth. It exacerbated mental health difficulties, such as low mood, with loneliness and isolation further contributing to this. Practical suggestions were provided regarding how to address loneliness.

3.2.1 Subtheme One: Shame, Hopelessness and Low Self-Worth

For all participants, there was a sense of shame surrounding homelessness, a hopelessness in finding accommodation and low self-worth as a result of these experiences. A loss of confidence and low mood were frequently reported.

There was recognition that whilst some mental health needs pre-exist, these difficulties were exacerbated by homelessness with very low mood being a common, shared experience, that continued to worsen until reaching an '*all time low'* (participant 4).

> *My mental health was really, really, really depressing and I was just in the worst mood most of the time.*
>
> Participant 7

> *I was no longer the same because I couldn't enjoy my life.*
>
> Participant 2

> *Oh, my mental health was declining…It started before but during my homelessness it was worse, it was just getting worse and worse and worse.*
>
> Participant 6

Hopelessness regarding change and the lack of ability to exert autonomy was common, with such experiences further contributing to low mood.

> *I would say a lot of, just like hopelessness... 'cause, also there were so many factors out of my control which were making me actually depressed.*
>
> Participant 8

> *There's no point trying to improve my situation that much because in a few weeks or a few months at most, but really a few weeks, I'm going to have to move somewhere else, and so I felt quite sort of hopeless.*
>
> Participant 1

> *I had like very little hope that I was going to be able to find accommodation.*
>
> Participant 4

Many acknowledged the extreme challenges associated with homelessness and how the context worsened the situation. Participants spoke about noticing a change in their personality and how they might usually act, which occurred as a result of the context and subsequently caused shame.

> *People will mistreat you, people hit you, abuse you because they know your weakness, you know. All these things here trigger me to do things I don't want to do because of my situation. I had to do so many things just because I was in a situation.*
>
> Participant 6

> *I realised my, at the time, girlfriend wasn't very great and did make me very lazy and just changed me a lot as a person.*
>
> Participant 3

Homelessness was described as a degrading experience whereby standards of living were significantly reduced and there was no privacy. A lack of control over the living space was present in experiences of rough sleeping and sofa-surfing.

> *I think, as well, when you're homeless it sounds ungrateful, but some of the accommodation you're offered, you would prefer to be on the street…even though you might be homeless, you still deserve basic human amenities and when you have to share a bathroom and stuff with multiple people, it can be really difficult and really degrading as well. So that was definitely something I experienced, really low self-worth and I just felt like I wasn't important.*
>
> Participant 4

> *Yeah it went much, much worse, because it's not even that you have privacy …you don't have your own space and also you don't really have control over everything, and you feel also really weird 'cause you're kind of a guest here.*
>
> Participant 8

Shame and judgement were prevalent experiences, which raises the question of how people understand homelessness and where responsibility is placed, with misperceptions being attributed to a lack of awareness. This perpetuates the sense that homelessness is something to hide and be embarrassed about.

> *It's really embarrassing especially in this generation… everyone just seems to be living a super, super glamorous life. So especially when you're facing something as big as homelessness at such a young age, I think a lot of people seem to think that it's something that you've caused…It was such a change when I came home because I realised that people were treating me really, really differently than I had been received before, so that was like a*

> *major knock to my confidence. I don't want to make it sound too difficult because it was always something I just kind of got on with.*
>
> Participant 4

> *I had anxiety about buying something for myself 'cause I was like well if you can't afford to rent then why the fuck are you buying new shoes?*
>
> Participant 8

3.2.2 Subtheme Two: Loneliness and Isolation

Homelessness removed and blocked access to support networks, which resulted in overwhelming isolation and loneliness. All participants spoke about having no friends or very few people to talk to during this time, noticing a change in their relationships previously. Being physically alone and living in different areas of the country, away from family and friends, were common experiences. The nature and impact of loneliness was considered, as well as practical suggestions for addressing loneliness.

A significant shift or loss of family relationships was reported. People who previously sought comfort and strength from loved ones were now unable to, due to fears of burdening others, embarrassment regarding the situation or because of location. One participant also spoke about losing her children due to the circumstances.

> *I feel like it wasn’t until I became homeless that it became harder, because when I was homeless, I felt like I didn't really want to go to my sister and be a burden. It was definitely isolating. I didn't feel like I could really speak to anyone about it.*
>
> Participant 4

> *So, it was really a very difficult time for me because of my children, because my boy was quite young…I'm sure he's somebody else's son now [ex-husband's partner], it's really painful. I had nobody, the loneliness, the homelessness, that was really depressing.*

Participant 7

The loss of relationships in general was also widely reported, with a sharp contrast being noticed from life prior to homelessness.

> *If you've lived alone before I think it's easier to cope with, but if you've never lived alone before, like me, for example, coming from a really, really busy loud house…then all of a sudden like I was in a room by myself… it was a pretty sad existence to be honest.*

Participant 4

> *I'm literally always alone. I only really talk to one member of my family.*

Participant 9

Loss of friendships was also apparent, with a sense of being incredibly isolated, both physically and mentally.

> *You know every week when I was sitting in my friend's house I was there alone because he wasn't there. So, at that time I didn't have any friends or any person to talk with. There's no one to talk to.*

Participant 2

> *I did not talk to anyone. I stayed indoors for all those months. I did not talk to others.*
>
> Participant 5

> *I didn't really have any friends. All my friends were on the other side of [area] and just I felt really lonely being so far away from my family and not really feeling like I never necessarily had anyone to speak to.*
>
> Participant 3

Loneliness and isolation were identified as problems in their own right, but they were also recognised as worsening difficulties such as depression, highlighting the interconnectedness.

> *I think the loneliness and isolation because of the instability exacerbated the depression that I was already kind of dealing with by that point.*
>
> Participant 1

The role of social networks protecting against loneliness and isolation was noted, improving people's ability to access support informally and through services. However, as identified, it was recognised that homelessness can reduce these social resources.

> *I was only able to do it because I knew a lot of medical students essentially, and junior doctors [friends to ask advice], but I think that for a lot of young LGBT people they're not going to have that sort of social capital.*

Participant 1

Of course just being able to talk to my girlfriend through this thing, and say 'I think I need therapy' and she's like 'yes you do'.

Participant 8

We have all had to turn towards people in our community for mental health support.

Participant 9

Access to social support influenced life choices and helped to reduce suicidal ideation, by providing hope during the most difficult times.

While I was living in my partner, it would have been good to have that support system because maybe I wouldn't have dropped out of college, maybe I would have gone to university, maybe I would have had a very different life now.

Participant 3

The news that kept me going was the letter I had been left from [family member], which she hasn't said before, that one day my children will look for me and they will find me.

Participant 7

However, such relationships were seen on a spectrum, with acknowledgement that whilst many offered positive support, not all were helpful. For example, socialising with the ‘wrong crowd’ was cited as a contributor to homelessness.

> *No one was born using drugs or smoking or drinking… I just ended up doing it, the area I live in is where I party all the time, so I live with so many people, so many different places.*
>
> Participant 6

> *People getting involved around wrong crowds.*
>
> Participant 3

To counteract loneliness and isolation, many identified the role of services in being able to bring people together. It was assumed this could be achieved through LGBTQ+ meetings and groups to improve community connectedness and lead to subsequent support, positively impacting wellbeing.

> *Organising some meetings would be nice.*
>
> Participant 2

> *Left to me just being in the room all day, not really mixing up, interacting, I might not even be aware of the groups around me. It is due to the people giving me counselling and other LGBT groups that I later on go to, another organisation linked me at the end of it to people that support accommodation.*

> *So, you can see how it takes one person to open a door, then you going through that door opens another.*
>
> Participant 7

There was also agreement on the need for a general space and this varied from somewhere to talk, to problem solve and to be responded to in the moment, using a peer support framework.

> *Someone to talk to me.*
>
> Participant 5

> *Someone to help make the right decisions I guess, to just talk to because it was a very lonely time… I felt like I never got to see anyone.*
>
> Participant 3

> *Creating an organisation that we can access at any time, could be online, it could be a friendship, somebody that we can just talk with.*
>
> Participant 7

3.3 Theme Three: A Lack of Appropriate Support

A lack of appropriate support was identified as a common and multi-faceted problem, understood as the extent to which services helped in terms of supporting health and housing. It was presented as involving long waiting lists and occurred due to limited service choice and flexibility, restricting the ability to meet a variety of needs. As a consequence, support for the LGBTQ+ homeless population has been inappropriate and basic needs have not been met.

3.3.1 Subtheme One: Long and Overwhelming Processes to Access Help

For many, the long and overwhelming processes to access help resulted in people being left without the support they needed. This was particularly apparent in the initial stages of seeking help, such as an awareness of what services existed, and attempts to access and navigate systems, such as waiting lists.

An awareness of what support existed remained unclear for many.

> *You know how you know where your GP is, like they are always down the road, you don't know where there's a mental health service, it’s not commonly known.*
>
> Participant 4

> *Well, if they’re homeless they’re probably going to struggle just to find out information such as where these places are.*
>
> Participant 3

> *Outside [of prison] I couldn't get anything because I wouldn't even know where to go to find help. That was when I realised there are places, there are people that can help you.*
>
> Participant 6

This was perhaps due to limited communication from NHS services, making it unclear as to what help could be offered, with people instead seeking help from charities.

> *Overall, I didn’t feel that the NHS was really reaching out to me in any way…I didn’t have experiences of them being communicated to me just at all. I wouldn’t have known that they are out there.*
>
> Participant 1

> *This is also the thing that if you haven't heard about it, that even if it exists, it wasn't advertised enough, you know?*
>
> Participant 8

> *Well, the only communication that I get with regards to any kind of mental health services and LGBTQ support is through [charity].*
>
> Participant 4

As such, a need for communication to be improved was expressed. Advertising NHS mental health support on social media could normalise difficulties, reduce stigma and improve awareness.

> *Most of the information I see is quite a lot from them [charity], if you just scroll through Instagram, 'cause yes, it doesn't come so much from official pages.*
>
> Participant 8

> *Maybe they could make a TikTok or even an Instagram. I know it sounds stupid but just kind of trivialise it a little bit because it seems so big and daunting at the moment.*
>
> Participant 4

In addition to issues with awareness and communication, some participants with citizenship spoke about feeling excluded from help due to misperceptions about needing to pay.

> *I thought they [mental health services] could charge me.*
>
> Participant 2

> *It wasn't until very late in my teens that I was even aware that there were these kind of services for free.*
>
> Participant 4

Further barriers were faced at the point of referral. Lengthy waiting lists were described by all participants with services as gatekeepers of support.

> *The process seems so long and overwhelming that I always retreat back from it and like leave it for really long, if that makes sense.*
>
> Participant 4

> *The waiting list was two years and before they could call me back the organisation had already given me an opportunity, because I had been on their waiting list, they could see me earlier than NHS mental health.*
>
> Participant 7

The GP process and response further impacted this. Registration was spoken about being incompatible with moving location.

> *I would have had to deregister with my GP and re-register with the new one at which point I would have been bumped to the back of a waiting list. If there was an ability to kind of move that around with you as you moved around the country… then that would be really helpful… I understand your average GP can't do much about a wait list, but the practices not wanting to cooperate together seems like something they could absolutely do better.*
>
> Participant 1

> *It depends on how homeless you are. So, I think if you're rough sleeping it is much harder 'cause also you need to be registered with your GP, like you need to have your address and if you don't have an address you can't get those services which is really hard.*
>
> Participant 8

As a consequence of long waiting lists, distress was found to increase with suicidality being referenced.

> *So many people struggle with mental health and then just get put on waiting lists for 12 months. It's like by the time someone was really, really struggling they might not even be here by then.*
>
> Participant 3

> *Gender identity clinics do not offer mental health support because of the long wait. I've known people who have actually committed suicide. One of them was waiting 5 1/2 years for the first appointment.*
>
> Participant 9

Due to such long and overwhelming processes to access help, participants needed to draw on their own strengths, resources and resiliencies to self-advocate.

> *I speak to people to look for the help, nothing stops me now…I have got the ball in my court, I can make decisions…I really struggle to get to this time I'm speaking to you. I've gone through so much to get by, it's a process, that's what I'm saying, if I can get there, anyone can get there you know?*
>
> Participant 6

> *I was taking initiative because now I'm reliant on nothing.*
>
> Participant 7

It was apparent that without the ability to self-advocate, the impact, frequency and type of homelessness can be exacerbated. There was also recognition that depending on the type of homelessness, self-advocacy may be harder to do.

> *I feel like I have a very strong mentality as a person and you know I can get through quite a lot of things… you know, I could have been fully homeless, I had to go to a centre to get support, that’s not something a normal [age] year old does.*
>
> Participant 3

> *I think if I hadn't pushed through that conversation a bit forcefully…I don't think I would have sat with that conversation because I felt quite sort of overruled by a doctor who knew more than me… I think, depending on the person and the type of homelessness, it can be quite hard to do that kind of self-advocacy, especially if you're on the relatively extreme end of mental illness and homelessness.*
>
> Participant 1

3.3.2 Subtheme Two: Denied Appropriate Help

It was identified that LGBTQ+ homeless people have often been denied the support they felt necessary. This denial might have stemmed from the power imbalance which can lead to professionals making decisions based on their knowledge above the insight people maintain about themselves.

For some participants, there was a sense of needing to prove themselves to health professionals in order to receive the support requested, which was largely determined based on outward functioning.

> *Because they think that ‘oh are we really, really sure of ourselves’ [regarding gender identity]. I was very, very sure from a young age and now I've been*

> *legally living as a woman for over [number] years. How much more do I have to say to them to show I am definitely sure?*
>
> Participant 9

> *The GP also made a comment about they're usually for people with more severe symptoms than you... until I dropped the word thoughts of suicide, the attitude was, 'well, you're getting assignments in on time and you can brush your hair and cook food so I guess you don't really have depression or mental illness'.*
>
> Participant 1

The impact of this resulted in feeling patronised and powerless.

> *It felt a bit condescending that they were trying to push me away from antidepressants, when my attitude wasn't that, 'oh, I feel sad I'll have some pills that will make me less sad', it was 'I have had a chronic condition for many, many years…I've hit a wall and maybe I should try antidepressants'.*
>
> Participant 1

For the transgender participant, access to mental health support was impeded by 'diagnostic overshadowing', where the mental health difficulties reported were assumed to be related to gender. As such, a referral was made to gender-specific services. The failure to separate gender and mental health simultaneously blocked access to generic services and pathologized gender identity.

> *Because I'm trans it took me a lot to get mental health support and them saying 'oh because you're trans that's specialised treatment'… Just give us the support we need because being trans is not a mental disorder.*
>
> Participant 9

Denial of help which participants considered appropriate was also raised in terms of the type of therapy provided. For some, prior experiences led to apprehension to seek further help.

> *I feel like personally I do not like CBT therapy. I don't like the fact that I was given homework and told to write down what I eat, when I sleep…I did not necessarily find it helpful.*
>
> Participant 3

> *Oh, the one other thing I would mention with regards to not really feeling that the NHS was worth even trying was that from what I've heard, they tended to be quite sort of basic entry level support.*
>
> Participant 1

A range of inappropriate support was described, from absent to limited help, which did little to effectively meet needs and fulfil requests in times of crisis.

> *It’s the fear of being caught without help in an emergency you know… the main issues being that it generally arrived not in the crisis period and not in the periods where I needed it most.*
>
> Participant 1

> *So many people just take the mickey out of those hotlines where you can call when you feel suicidal, and they're like ‘have a cup of tea or bath’ and it should be a little bit more than that.*
>
> Participant 3

Some participants spoke about issues related to obtaining British citizenship. Denial of help was prevalent, leaving people feeling alone, punished and confused with no support about how to understand and navigate the system.

> *It is a shame because there was hope when I started, when I made my application, then I end up finding myself in a worse position than when I started…the country that I thought would support me, they imprison me.*
>
> Participant 7

> *England hasn't accepted me yet…so it was kind of like I don't belong anywhere because none of the countries actually acknowledge me and there is no help from this country.*
>
> Participant 8

Additionally, for individuals seeking citizenship, barriers around obtaining a national insurance number denied access to a variety of support and the ability to seek employment.

> *You don’t have a GP. Who are you going to go to, you are not British citizen, you don't have a National Insurance, you don’t get help…I did not have the support from the beginning.*
>
> Participant 6

> *I couldn't get National Insurance number…I couldn't even get unemployed status because I couldn't show to England any kind of papers that I am unemployed because I haven't worked here.*
>
> Participant 8

3.3.3 Subtheme Three: Basic Needs Not Met

This subtheme highlighted how a lack of appropriate support resulted in basic needs not being met. These referred to the basic needs and rights people had in order to survive and live well, such as access to housing and finance. The subtheme also incorporated access to healthcare, specifically psychological support. Although not directly mentioned by participants, such support enabled other basic needs to be met, reducing the likelihood of repeat homelessness.

For many, housing was considered the most important of the basic needs. A disconnect was highlighted between what services said they offered and how they actually helped, with people feeling let down or failed by the system.

> *I've heard people have this slightly scornful attitude of everyone wants to kind of support us, but no one actually just wants to give me a house, and I actually don't need that much support, I just need to be put in a house… a lot of young people with family issues are relatively responsive in a way to things like being provided housing because they haven't yet accumulated all of those problems that tend to come with long term homelessness.*
>
> Participant 1

> *I just wanted to have somewhere to call my own...I just think that there's a lot of services out there you can obviously call and book to see someone…but ultimately until you are in a house or assisted with getting housing you can't solve any other problem.*
>
> Participant 4

Until shelter, food and water were provided, there was no space to work on mental health needs. There was recognition of whole system failure in addressing social issues, impacting the population in general and the LGBTQ+ homeless. Addressing the social context and fulfilling basic needs was thought to improve wellbeing.

> *I think when you're homeless, especially when you're sleeping rough, your main priorities are obviously finding somewhere to sleep, finding things to eat, and so on and so forth, so it's not necessarily a time where you would go and have a session.*
>
> Participant 4

> *It's just really hard for many people to support their mental health in any way, because if you constantly need to worry about am I able to pay my rent and*

> *am I able to get food, am I able to pay for my travelling, like of course there will be so many mental health problems…but yes, the main system is unfortunately not working at all and not supporting LGBTQ people, and people in general.*
>
> Participant 8

The ability to access healthcare, such as therapy, in a timely manner was impacted by economic and financial resources and whether people could afford alternatives.

> *I just think the only thing that you can do is have a lot of money behind you to access the private care which you know offers a lot more than the NHS.*
>
> Participant 1

> *There is of course private therapy, which is faster but incredibly expensive, so it is again the problem of just not being able to afford that.*
>
> Participant 8

Whilst there was recognition that other basic needs were prioritised above mental health, access to support in this area was still deemed as helpful and as having the ability to improve other areas of life, such as maintaining employment.

> *I would have concentrated with my work and looked for rent…because you can't go to work while stressed.*
>
> Participant 2

> *It would take me away from depression and all this anxiety and all this stress. That treatment always keeps a person onto maintaining, it will be good, so if you got your job right, you got your home, you don't have time to go and party and do other things or move around. You are responsible.*
>
> Participant 6

Access to effective mental health support was thought to prevent or reduce future homelessness. It was assumed that services could identify what basic needs are missing from a person's environment and what further support is necessary, particularly from a social perspective. It was recognised that services also provide a space to process trauma.

> *I think it would also be helpful in preventing being homeless again because I think when you're homeless you're going through mental health issues and then you're suddenly housed, like that doesn't all of a sudden, you know, put a plaster over the issues you're facing… let's just say I became dependent on alcohol, that's something that would have got out of control, I wouldn't have been able to afford my rent and ultimately I would have found myself homeless again, like quite easily.*
>
> Participant 4

> *I would have been able to have shared what I am going through and they would have been able to pick up what is lacking and how I can get support, because that is something that is not really easy to know and how to access. They should look at how can we help, it's not just a matter of medication, they are supposed to pick up that this is what he or she is lacking in their environment.*
>
> Participant 7

> *I definitely think having some form of mental health support after I found accommodation, that would have been valuable just to deal with the process, of actually having been homeless, and the changes that it caused.*
>
> Participant 3

The need for mental health services to maintain an awareness, curiosity and recognition of sexuality was also identified as paramount in providing effective psychological support and preventing homelessness.

> *It was my counsellor's supervisor that picked it up, that I needed support and getting involved in activities more for LGBT…the person I had the initial assessment and counselling with, if they picked up, I might not have been in the position of being homeless, and sorting myself out.*
>
> Participant 7

As a result of basic needs not being met, particularly access to healthcare and housing, participants spoke about the role of self-medication.

> *When I was feeling particularly down I might go the pub.*
>
> Participant 4

> *Because of that I've been using drugs.*
>
> Participant 6

> *I know so many who self-medicate because they cannot afford private healthcare, but I know it can be dangerous.*
>
> Participant 9

3.3.4 Subtheme Four: The Importance of Choice and Flexibility

Services providing limited options or choice have resulted in a lack of appropriate support as LGBTQ+ homeless individuals have been unable to meet requirements. Namely, a historical lack of choice around type of intervention, attendance and general service inflexibility impacted the extent to which people could engage.

During the pandemic, services were forced to adopt new ways of working. Being unable to offer face-to-face appointments resulted in a lack of support for those without access to internet, such as people rough sleeping or living in environments with no privacy or safety to attend a session. It also highlighted how, for some, the only choice to use technology appeared to ostracise individuals and impact the ability to form connections.

> *There are still a lot of people who are completely excluded from this because during the pandemic there were only these choices going online, but if you can't go online there is nowhere you can go… I still think that there are people who would prefer actually talking face-to-face, like if they need to actually see the face of the therapist to connect.*
>
> Participant 8

> *Normally I would have some face-to-face appointments with my GP where I would feel a lot more comfortable to kind of disclose any issues I'm having, especially because we're in that safe space. Whereas if I'm having a*

> *telephone appointment in my house, you’re around people that I don't want to know what's going on, or if they did know what's going on, it's going to severely impact my housing situation.*
>
> Participant 4

However, for others, providing this new option improved access to support, opening up alternatives which were cheaper and more feasible.

> *Now there is nothing blocking me. I've got internet on my phone 24/7.*
>
> Participant 6

> *There are positive things accessing therapists on FaceTime from the comfort of my own bedroom. Yeah that was good, not having to travel and I found someone better and cheaper because they weren't based where I lived.*
>
> Participant 2

As such, it was suggested that both face-to-face and virtual appointments are offered going forward to allow greater support and to meet a wider range of needs.

> *Pre pandemic, the ability to move it to Zoom because I was unstable in my living situation and moving around the country, I think to do it online or on phone call would have been helpful.*
>
> Participant 1

> *I do definitely think though that going forward they should continue having the choice of phone, FaceTime, Skype or basically going face-to-face to see professionals.*
>
> Participant 2

In addition to being able to choose the delivery of intervention, it was identified that the type of support available could be more flexible. For some, this may be brief, one-off support, whereas for others, this may need to be more intensive.

> *Their university offers sort of drop-in one-off counselling sessions, which seems like a good idea and something that I would have benefited from 'cause sometimes you don't need a full sort of excavation of your brain.*
>
> Participant 1

> *Someone has to take a kind of duty of care fully, if they are going to say that you're supporting someone, they have to be available to them, sort of almost 24/7, because when you're dealing with mental health there's no schedule. It's not gonna knock at 9:00 AM you know and leave at three.*
>
> Participant 4

Having LGBTQ+ specific support and therapists available was recognised as important for some.

> *There are a few organisations that are specialists in dealing with LGBT, so they should get more organisations that will be there for these particular people so these people will also feel they are part of it.*
>
> Participant 6

> *It would be nice to have actual services extra for LGBTQ people which are led by LGBTQ therapists. I think that would be a really welcoming space.*
>
> Participant 8

However, the option of mainstream support being available too was deemed as important, due to a mixed consensus about how inclusive or exclusive specialist services feel. This was evident for bisexual individuals who identify with multiple aspects and may therefore feel excluded by distinct categories.

> *I don't think they need to specifically target us in crazy ways, just because that's going to make us feel different…this one is for the straights and this one is for the gays, like no, let's just have it you know for everyone?*
>
> Participant 4

> *Don't make out that because we're trans we need specialised treatment.*
>
> Participant 9

Overall, an attitude of flexibility was identified as most important, with services adopting this in every aspect of the client's journey.

I think it's more about an overall attitude of flexibility.

Participant 2

I think they could be flexible and to be totally indifferent to what we are.

Participant 7

4. CHAPTER FOUR: DISCUSSION

This chapter will seek to answer the research questions and discuss the findings in light of existing literature. A critical appraisal will be provided, whereby reflexivity and the quality of the research will be addressed with strengths and limitations outlined. The implications of findings for clinical practice, service provision, policy and future research will also be considered.

4.1 Research Aims

This study sought to investigate the barriers to mental health services from a LGBTQ+ homeless perspective, which has not been previously researched in the UK. To achieve this, a focus was maintained on understanding the mental health needs of the population, identifying the role of services, the barriers faced and what services could do differently.

4.2 Research Questions and Summary of Findings

4.2.1 What are the mental health needs of LGBTQ+ homeless adults?

The mental health needs of LGBTQ+ homeless adults have been understood through participants' accounts of their wellbeing whilst homeless and the main difficulties faced. It was helpful to understand when psychological distress began and how episodes of homelessness can interact. In general, mental health needs were portrayed as enduring, with 'basic level' support often being inappropriate and crisis periods being common. The theme '*Rejection of identity*' highlights how mental health difficulties were mainly present prior to homelessness, with these circumstances exacerbating distress and level of need, particularly low mood. This supports previous research which suggests that psychological distress increases during homelessness (Martijn & Sharpe, 2006) as opposed to emerging for the first time (Padgett, 2020).

The theme '*Rejection of identity'* provides a wider context for the mental health needs of the population. Specifically, the subthemes '*Lack of family acceptance* *associated with homelessness'* and '*Stigmatised and excluded'* highlight how mental health needs are impacted by discriminatory experiences associated with LGBTQ+ identity, which supports previous literature (The Albert Kennedy Trust, 2021; Ecker et al., 2019). Experiences of LGBTQ+ intolerance, hate and abuse, alongside heteronormativity, were thought to have affected almost every person's mental health. For many, this resulted in a loss of confidence, feeling unlovable, ashamed and 'the odd one out', with a belief that society would prefer to accept the suffering than to challenge it. Experiences of 'double discrimination' were common for participants with multiple marginalised identities. This supports previous research indicating that those who are older and from racialised backgrounds are likely to be at greater risk of discrimination (Mongelli et al., 2019).

For several people, the impact of discrimination resulted in internalised stigma, with the participants wishing that they could change their identity, which is in line with the minority stress theory (Meyer, 2003). For some, the abuse and denial of gender and sexuality from family members led to low mood and suicidal feelings. Suicidality was also referred to in the subtheme '*Long and overwhelming processes to access help'.* Whilst this research is consistent with reports of higher mental health and suicide rates in the LGBTQ+ population (Rhoades et al., 2018), it emphasises how this can be a result of long waiting lists and lack of support. This is different to prior research examining this in the context of minority stress, PTSD and depression (Fulginiti et al., 2021), which perhaps places the 'problem' with the individual, rather than with services.

The theme '*Homelessness can strip away personhood'* highlights the impact of such adversity on wellbeing. A loss of confidence, hopelessness in finding accommodation and shame surrounding homelessness was reported. This was particularly evident for a younger generation who may be more exposed to comparisons of peers' privileged lifestyles on social media. A general lack of understanding in society about what leads to homelessness can result in greater blame and judgement for people facing such circumstances. Participants alluded to a reduction in human rights whilst homeless, finding accommodation unsuitable, unsafe and degrading, leading to feelings of unimportance and a loss of self-worth, highlighting the degradation imposed on the landless. Standard of accommodation has been discussed previously (Abramovich, 2012; Grainger & Cagle, 2016). Where there has been focus on the characteristics which impact safety, such as the level of theft and assault in shelters, the findings of this research focus on how accommodation impacts the sense of self and ideas about what people are deserving of.

The findings indicate that depression is also a common mental health difficulty. A lack of control over changing circumstances and hopelessness in finding accommodation was described as a contributing factor. Low mood can be further exacerbated by the loss of social support, as identified in the subtheme '*Loneliness and isolation'*. The contrast of life prior to homelessness, where some people were surrounded by friends and family, was greatly felt, with many participants being frequently alone with no one to talk to. This provides further support for the association between low mood and loneliness, which has been documented in existing literature (Hawkley & Cacioppo, 2010; Leigh-Hunt et al., 2017).

As a result of basic needs not being met during homelessness, participants spoke about the need to self-medicate. In some literature this may be considered in the context of addiction (Henwood & Padgett, 2007). Whilst the addictive nature of substances was recognised and drugs and alcohol were listed by participants as coping mechanisms, it was unclear the extent to which they were used. This may reinforce prior messages about the need for it to continue to be recognised in services. Where previous literature suggests that services in general do not consider the role of self-medication enough (Vernon, 2008), this was not spoken of as a barrier in the current research, which may be indicative of positive progress. However, this may also be a result of limited contact with services.

Overall, the aforementioned findings add to the research field in highlighting some of the mental health needs of the LGBTQ+ homeless adult population. The small number of existing studies which explore LGBTQ+ homeless mental health suggests increased mental health difficulties for the population, higher levels of suicidality, co-morbid mental health diagnoses and addiction difficulties (Rhoades et al., 2018; Cochran et al., 2011). The current findings suggest that a range of mental health needs exist, including shame, hopelessness, low mood and loss of self-worth as a result of homelessness and the isolation experienced. For some, self-medication can be a coping mechanism and suicidality may occur due to a lack of support from services. Discriminatory experiences appear to lead to a reduction in confidence and a sense of feeling different.

4.2.2 What do LGBTQ+ homeless adults view as the role for mental health services?

Participants shared that mental health services should work across multiple aspects of the system, such as with families, schools and employment. The subtheme '*Lack of family acceptance associated with homelessness'* outlines how services could work with families to address conflict and rejection. Educating families on LGBTQ+ matters and rights through direct work and in group settings was raised as a suggestion to help understand and normalise identity, which may subsequently improve relations. The desire to educate families was most commonly expressed by individuals who left countries of origin which criminalise LGBTQ+ identity. Whilst existing literature focuses on the importance of addressing family conflict and rejection with youth, the current findings highlight the need to support some adults too, such as 18 to 25-year-olds who may have recently left home.

It was suggested that services should also work more broadly to target societal perception and stigma. Such a movement needs to be conducted on a large scale and addressed collectively, with much support required to attend to the level of discrimination that exists. It was suggested that services work with organisations, such as schools, housing associations and employers to reduce discrimination as identified in the subtheme '*Stigmatised and excluded'*. In doing so, it is possible that some inequality will be addressed. This is essential given existing research documenting the inequalities in housing and employment for the LGBTQ+ population, often as a result of fear and discrimination (Romero et al., 2020; Agocs, 2016).

Participants also outlined how services can directly address homelessness and reduce the loneliness and isolation experienced, through increased community connectedness. Ways to achieve this will be explored in service implications. The subtheme '*Loneliness and isolation'* highlights the need for people to have access to

LGBTQ+ groups, opportunities to meet other people and to talk to someone, either in an informal or formal capacity; all of which are areas mental health services can support in terms of signposting or offering this directly. Such support aimed at building and increasing social identities through meaningful interaction is thought to improve wellbeing (Haslam et al., 2022).

Services may have a role in preventing repeat homelessness, as identified in the subtheme *'Basic needs not met'*. Participants spoke of finding food and shelter, all of which are referred to in Maslow's hierarchy of needs (Maslow, 1943). Whilst psychological support was not specifically referred to in this way, participants described how it enabled other basic needs to be met. Moreover, some literature understands access to healthcare to be a basic need and also part of the Human Rights Act (Kennedy, 2009). Access to psychological support was reported to help people process the events that occurred whilst homeless, including any changes and trauma as a result. It was also thought to improve management of stress and anxiety, allowing people to feel more able to seek and maintain employment. For other participants, mental health support was described as providing an opportunity to identify coping strategies and reduce the likelihood of using substances, which can impact day-to-day functioning, such as the ability to pay rent. Some identified it as a way to give purpose and a sense of responsibility, and to allow services to identify what is missing from a person's environment. Such findings indicate the importance of systemic formulations which better understand social issues and may support preventative practice.

In summary, the main roles identified for mental health services include family interventions to address rejection, work with organisations to reduce discrimination, and prevention of repeat homelessness through the provision of psychological support following an episode of homelessness.

4.2.3 What do LGBTQ+ homeless adults think are the barriers to accessing mental health services?

Given the context of high levels of discrimination, it is unsurprising that many participants were worried about seeking support from mental health services. This provides support for existing considerations about whether excessive discrimination impacts access to health services (McCann & Brown, 2019). Where distrust of service providers has previously been cited as a barrier (Prock & Kennedy, 2020), the current research supports this and identifies specific aspects of what encapsulates 'distrust' (as highlighted in a '*Managing the fear of sharing identity')*. Firstly, the ability to share is contingent on what stage in their journey the person is at and how comfortable they feel. This is due to identity often being 'tangled up with mental health' as described by one participant, with a second sharing that for many, the main reason support is sought is because of sexuality and the surrounding context. Many participants reported abuse, hate and threats to safety, which can lead to concerns about such harmful experiences occurring again. The fear of sharing can be compounded by the complexity of such adverse reactions often being from parents. This contrasts with the expectation of unconditional acceptance and support, and may act as an internal working model for future relationships.

Secondly, the discrimination felt in society was also described in mental health services. Where this has previously been identified in social services, with reference to cisgender discriminatory policies (Shelton, 2015), and in physical health settings, with hospital documents failing to account for transgender identities (Spicer, 2010), mental health services can also be critiqued for similar failings which still exist today. Similar experiences of mental health services have been reported, which is thought to reinforce stigma (Rees et al., 2021). Participants spoke about a lack of inclusive forms and heteronormative assumptions being made in therapy sessions. Whilst one individual did not describe this being an issue, others questioned how much the service or therapist would understand about LGBTQ+ identity. Questions were raised about whether therapists could be homophobic and how this would engender a reluctance to seek help. It was also suggested that a therapist's age and religion might impact how much participants share which could limit the help provided. One participant spoke about the added effects of racism and wondered how a White therapist might respond following the disclosure of identity from someone from a racialised background.

Other barriers to mental health services were reported under the theme '*A lack of appropriate support'.* This was multi-faceted and identified many areas in which adequate support can be lacking, resulting in blocks to effective care. A common barrier encountered was the awareness of what services exist, partly due to a lack of communication from NHS services. Long waiting lists were also identified, which appear to contribute to increased risk and suicidality*.* This supports existing research in the general homeless population outlining the same uncertainty about where to seek support and concerns about the time it takes for help to be offered (Reeve et al., 2018). At the point of services being identified, further barriers can be experienced. These were summarised as difficulties in re-registering at GP practices and losing spaces in a waiting list following a move, as well as services being uncooperative when working together.

Participants also shared experiences of actively seeking help and not being provided with the support they felt was necessary, as identified in the subtheme '*Denied appropriate help'.* For individuals seeking citizenship, access to mental health support was impacted by a lack of guidance in making an application, leading to no recourse to public funds and therefore no access to most mental health services. Where this has been recognised as a barrier by researchers (Powell et al., 2018), the current findings provide confirmation from a LGBTQ+ homeless perspective. Denial of appropriate help was further expanded on through examples of participants needing to prove difficulties to services. GPs were described as making judgements about the severity of mental health needs on the basis of outward functioning (such as the ability to get dressed), rather than the person's account of how they were feeling. This may suggest that their needs were being seen as unsuitable by professionals for the course of action being requested, which follows existing literature (Reeve et al., 2018) highlighting similar participant accounts.

For the transgender participant, the cited failure of GPs to recognise mental health difficulties and instead assume this to be related to gender, resulted in a referral to a gender identity clinic (GIC) and no mainstream mental health support being provided. This raises considerations around how often services refer to GICs on that basis, rather than referring to generic adult mental health services if a difficulty is present which could be effectively supported by them. Secondly, the need to provide enough 'evidence' of wanting to transition was felt to be a barrier to support by GICs. This participant's active seeking of support from services was more explicit than in some literature. Existing research with transgender homeless adolescents highlights some apprehension due to worries about family knowing and hopes that the difficulty would go away (Ferguson et al., 2021). This may reflect the difference in an adult and youth population; it is possible that older age may be associated with an increased confidence in seeking help and a reduced dependence on family.

Previous experiences of mental health support also served as barriers for some participants. The type of intervention offered, specifically Cognitive Behavioural Therapy (CBT), was felt to be ‘entry level’ and unsuitable for some, due to a high level of mental health need being present at the first point of active contact. This follows previous literature which highlights how support can often be variable (Reeve et al., 2018), as a mismatch is apparent between the intensity of the intervention provided and the presenting need. Some people were deterred from accessing further help in anticipation that the same therapy would be offered, which simultaneously highlights the lack of autonomy people can feel in therapy and the limits and rigidity of services. This was further expanded on in the subtheme ‘*The Importance of Choice and Flexibility’* which highlights how a lack of options around where and when to meet for a session can result in people being unable to reach service requirements.

Finally, participants highlighted how the need to prioritise finding shelter and food during homelessness can be a barrier to accessing mental health services, as identified in the subtheme ‘*Basic needs not met’*. It was acknowledged that in the midst of homelessness, people may not have the time or space to attend a psychology session as there can be more important elements to focus on.
This offers support for existing literature which highlights how LGBTQ+ homeless individuals are more likely to seek support which meets other basic needs rather than mental health (Prock & Kennedy, 2020). Where Prock and Kennedy (2020) refer to seeking of community involvement and recreation, the current findings highlight participants’ focus on finding food and shelter. The emphasis on finding accommodation as a priority supports Pathways Housing First model (Tsemberis, 2011). This model seeks to support individuals by improving the living situation, providing contact with outreach teams, visits to shelters, through to the final stage of providing permanent accommodation (Tsemberis, 2011). However, the model has

been critiqued for being a 'Housing Only' solution (Tsemberis, 2011). In line with this, the current findings highlight the importance of addressing other needs too and demonstrate how interconnected the relationship is. For example, some participants spoke about how access to mental health support may impact the ability to seek and maintain employment. This highlights the need to provide longer-term holistic care which continues after the point of accommodation being obtained, rather than housing being seen as the final step.

Overall, a number of barriers to accessing mental health services were suggested by the participants. These included a lack of awareness of the help available and long waiting lists. For some, previous experiences of being denied appropriate support or unhelpful input impacted their willingness to seek further help. Discrimination was also generally listed as a barrier, in terms of its existence in services and due to past experiences. Sharing with services, in order to seek help, was also thought to impact access and may be influenced by intersectionality, such as a therapist's religion and age. The need to prioritise basic needs whilst homeless was also considered a barrier to help.

4.2.4 What do LGBTQ+ homeless adults think that mental health services could do differently?

The subtheme '*The Importance of Choice and Flexibility'* highlights how beneficial it would be for remote and face-to-face psychology appointments to be offered based on individual circumstance. Participants thought that this would improve accessibility as it reduces concerns around travel costs, inaccessible locations and a fear of being in a new, unfamiliar space. In contrast, in person appointments meet the needs of people who do not have access to somewhere confidential and may prefer seeing a therapist in person to better connect and build rapport.

Participants also highlighted the need to improve the variety of support offered more generally, with one-off sessions being available. In addition, more intensive intervention is required, as it was recognised that mental health difficulties do not stop outside of nine to five hours. This was also the case for crisis support, as it was felt that suggestions offered by phonelines are more suited to mild distress (as identified in the subtheme ‘*Denied appropriate support’).* Improving the availability of crisis care has previously been identified by the general homeless population (Reeve et al., 2018), suggesting it is a universal need.

It was also recommended that services have LGBTQ+ specific support available in addition to what is routinely provided. This provides some support for existing literature rating LGBQ spaces as favourable, due to being safe, supportive and tailored to individual needs (Martin & Howe, 2015). However, the mixed consensus in the current research regarding offering ‘exclusive’ services highlights the need to take an integrated approach. While providing sole LGTBQ+ spaces may be beneficial for some, for others it can increase the risk of being made to feel different. Offering the option to meet with an LGBTQ+ practitioner within generic services was suggested.

The need for services to better hold in mind sexuality was deemed important, as failure to do so can result in limited understanding of a person’s presentation. For one person, this had significant consequences in the form of potentially contributing to homelessness. The participant wondered whether they would have become homeless if the clinician had known that they were a lesbian; such knowledge was thought to lead to better support and involvement with the community, helping to reduce isolation and wellbeing. Such a finding provides tentative support for previous research citing service failure to ask about sexuality as an example of insensitivity to LGBT needs (Vernon, 2008). In this case, sexuality was asked about but at a much later point of contact than necessary. It is therefore important to address this in initial assessments, formulations and interventions, whilst being mindful that people may be at different points in their journey and in making sense of their sexuality.

Participants identified that mental health services need to examine their policies and procedures, which were described as gender-normative and heteronormative. This supports research outlining the responsibility of services to challenge heteronormativity and promote acceptance (Rees et al., 2021) to better meet LGBTQ needs. The findings suggest that services should provide more inclusive forms accounting for non-binary and transgender identities, and for therapists to actively name discrimination when witnessing it. The need for services to undergo LGBTQ+

sensitivity training was also identified with an emphasis on how this should be meaningful and evident in intervention (as explored in the subtheme '*Stigmatised and excluded').* This suggests that there is a current gap in service knowledge, which is comparable to existing research suggesting that staff (providing mental health support) in transitional living programmes were inadequately trained to meet LGBQ needs (Prock & Kennedy, 2020). As such, this supports the consensus that all clinicians need to increase their understanding to better advocate for the population (Rice et al., 2013). 'Advocate' in this context may perhaps be better understood as empowering the population and actively working to address discrimination.

The aforementioned suggestions focus on what change can be made within services when clients are at the point of accessing support, however, some suggestions were made about how to better reach those who are not yet in contact. Participants highlighted how advertisement of support needs improvement. Specifically, it was reported that the wording surrounding mental health should be normalised to appear less daunting. Furthermore, this should be evident in schools, which highlights the importance of early intervention. To reach more LGBTQ+ homeless people, it was suggested that services could be advertised online, through charities and at events run by third party organisations. Finally, suggestions were made in terms of existing positions in waiting lists being accounted for when transitioning to another service in a new borough, as highlighted in the subtheme '*Long and overwhelming processes to access help'.*

In general, the findings highlight the need for flexibility to be applied to services in general, with a continued development of the culture of open-mindedness. It is possible that a lack of open-mindedness may refer to a combination of issues which need to be addressed, such as medicalisation, eugenic philosophies, inadequate training and underfunding. Such issues will be addressed in clinical and service implications. The main aspects services can change include increased flexibility regarding the type of intervention and mode of delivery. It was felt that the variety and intensity of support could be better with specific LGBTQ+ help being made available. Discrimination and inclusivity were also cited as areas which services could work on, with greater advertising of support being a prerequisite to reaching more people.

4.3 Critical Review

4.3.1 Reflexivity

Reflexivity considers the relationship between the researcher and research (Willig, 2013). Whilst this has been explored in the method chapter, with reference to the initial interest in the topic and beliefs about homelessness, it can be helpful to document subsequent stages from conceptualisation to finalisation (Willig, 2013). It is also important to recognise epistemological reflexivity and appreciate that the position taken assumed that multiple perspectives existed. The data collected might not be an accurate representation of a single reality; instead, it was understood through the structures that exist in society and through personal understandings of homelessness.

During data collection, some participants completed the interview in public as this was felt to be the safest and most accessible place for them. At times, due to noise levels, it was difficult to hear a response and greater follow up questions were needed which impacted the flow and rapport. I was also aware of the nature of the discussion and therefore checked in with participants about what they felt comfortable sharing more often. It is possible that sharing was influenced by the mode of device chosen. For example, some participants requested to speak over the phone and being unable to see appearance may have allowed people to discuss more freely, perhaps due to an increased sense of confidentiality. Equally, as a researcher, this made it more difficult to identify cues of how the interview was being experienced and could therefore have inhibited sharing.

An area which I found difficult to navigate whilst documenting the findings was how to capture the strength of character of participants when the research was problem focused. Although apparent in the themes, the research questions did not allow as much space for consideration of participants' strengths and capabilities. I attempted to manage this by considering how the knowledge and skills of people with lived experience could be utilised within services, which is later explored in greater detail. Some of the findings which required more work were the framing of multiple barriers to services. Aspects such as long waiting lists provoked a shared personal frustration, highlighting my position as both a researcher and a clinician. Framing the types of discrimination also felt difficult as the term itself sometimes felt too weak for what was being described. I was acutely aware that I was defining what constitutes heteronormativity, discrimination and violence and grappled with how best to communicate these findings and implications in the write up. I attempted to manage this by continuing to use participant terms where provided.

A finding which caused some surprise was the extent to which discrimination infiltrates all areas of life, which likely reflects the privilege I hold in not having experienced this. Hearing these accounts provided a clear reminder to hold in mind the experiences people may have had when first coming to services. It also highlighted the responsibility as a clinician to make clear the zero-tolerance policy regarding LGBTQ+ discrimination through a number of formats. The interviews prompted reflection of past clinical experiences where inclusion could have been better, for example, asking about someone's preferred pronouns.

It must be noted that there was a great level of variability in participants' experiences of homelessness, including the length and type. Suggestions made may have differed based on experiences of rough sleeping or sofa surfing, and whether the experience was over weeks or years. This was partly accounted for in the results by stating any similarities or differences, such as the reduced standard of living and lack of control being present for both people sofa surfing and rough sleeping.

4.3.2 Evaluating the Quality of the Research

The quality of the research was assessed using common criteria (Guba & Lincoln, 1994). Some of the guiding principles as outlined by Spencer and Richie (2011) list contribution, credibility, transferability, and rigour. Confirmability and dependability have also been included, and together these areas have been reviewed to appraise the trustworthiness of the research (Stenfors et al., 2020).

Credibility focuses on how well the theory, research question, data collection and analysis align (Stenfors et al., 2020) and whether the data represent participant views (Tobin & Begley, 2004). In order to achieve this, the methodology has been explained in attempt to justify reasoning. An emphasis was placed on the process of familiarisation of data, with the analytic process being described in detail. Potential themes were shared in peer supervision to achieve ‘analytic triangulation’ (Grafsky et al., 2018) and with the overseeing supervisor. This helped to gain outsider input before themes were finalised, helping to improve confirmability through validation that the proposed findings reflected the data set. Contrasting opinions have been indicated and a summary for each quote provided to increase transparency of the claim made (Yardley, 2003). Additionally, an extract of a coded transcript has been provided (Appendix H).

Transferability considers how well the findings can be applied to another context. As such, it is deemed important to include a specific account of the context in which the research was conducted. This helps to understand how it took place and shaped the outcome. As such, the specific steps taken were documented in the methodology, including details regarding data collection and analysis (Hadi & Closs, 2015).

Rigour considers the overall conduct of research, such as the methodological validity which has been addressed in the research strengths and limitations, and the dependability of findings (Spencer & Ritchie, 2011). To achieve dependability, as defined by consistency and stability of findings over time (Guest et al., 2012), a clear rationale for the decisions made has been included, which continued to be discussed with the supervisor throughout. To improve the methodological validity, the researcher consulted with the supervisor and LGBTQ+ homeless charities. A reflexive approach was maintained through the reflective log. The study’s contribution to the research field, policy and practice will be explored under implications.

4.3.3 Limitations

The nature of recruitment and virtual engagement may be critiqued. To improve infection control as a result of coronavirus, the study was advertised and conducted online and required participants to have access to a remote device. Whilst this allowed participants to take part from different areas across the country, some views will have been excluded, for example, individuals without access to a device, data or the internet. As such, future research may seek to advertise and conduct interviews in person.

In consideration of views missed, it must be noted that only one transgender participant took part. Whilst their input was invaluable and the research was not seeking generalisability to wider groups akin to quantitative research (Willig, 2013), the number limits the extent to which claims can be exerted and suggests caution is needed in drawing similarities to the transgender homeless population more broadly. Although the research was open to people who were either formerly or currently homeless, the majority of participants were living in more permanent accommodation and reflecting on past experiences. It is possible that different data would have emerged from people reflecting on their current needs.

The sample size was small and the participants that took part had varied experiences of homelessness and gender/sexual diversity, therefore it is hard to draw conclusions as to how representative their views and experiences are and reach firm conclusions. Additionally, some of the opening questions, as well as those focused on what could be done differently by services, focused on third person data which did not always relate to participants' personal experiences.

Information regarding disability was not collected, therefore it is unclear how this may have impacted participants. One participant disclosed that they experienced a mild brain injury when they were younger. Whilst they did not disclose how this may impact service access, it highlights the important of services considering disability and any additional barriers posed, such as the person's level and ability to advocate and navigate complicated referral processes.

4.3.4 Strengths

The research focused on the hidden homeless population, a group which have received less attention and often been labelled as 'hard to reach'. Such focus has helped to make their needs more visible and known. Using a qualitative approach enabled exploration of LGBTQ+ homeless experiences of mental health services, and the gathering of rich data allowed a more nuanced understanding of some of the barriers. As such, findings and recommendations can be disseminated with services to help improve inclusivity.

Speaking with a number of charities in the initial planning stage helped to identify a significant gap in LGBTQ+ voices, which was reiterated in the literature. Consulting and co-designing the interview schedule with individuals with lived experience helped to increase sensitivity in a way that would have been more difficult to achieve without this experience. A strength of the wide range of participants that took part (different age groups and cultural backgrounds, and with varied types and lengths of homelessness) is that it addresses recommendations highlighting the need to recruit participants with a range of homeless experiences (Semborski et al., 2021). Additionally, the participants who took part lived in different areas of the UK, which helped to understand the barriers to mental health services in rural and urban areas.

4.4 Implications of Research

4.4.1 Clinical Implications

The fear of sharing with services and high levels of discrimination experienced highlight just how important it is for clinicians to remain non-judgemental and sensitive, as in line with NICE guidelines recommending a person-centred approach (NICE, 2022). Such consideration should be present in the histories asked, and in pacing of questions, in order to build trust and develop a sustained relationship. Aspects such as increased time with the individual, an informal setting and regular contact have been identified as important (NICE, 2022). Clinical psychologists may seek to identify interventions which support mental health needs by adopting an affirmative stance (The British Psychological Society, 2019). Such a stance may be achieved through narrative interventions, which seek to emphasise strengths, normalise concerns and externalise emotions, such as shame, which as noted can be highly prevalent. Furthermore, it allows people to separate themselves from stigmatising discourse (Nylund & Temple, 2017).

Clinical training programmes may support this work by increasing the amount of teaching dedicated to working with LGBTQ+ clients. There may be a focus on understanding the effects of discrimination, as well as providing specific guidance around supporting individuals. An example of this may be signalling that the space is safe and supportive of LGBTQ+ people through implicit and explicit cues. Explicitly stating that all identities are recognised and the therapeutic space can be used to explore this, should clients wish to, along with visual representations (waiting room literature, service and website information, lanyards, forms) (The British Psychological Society, 2019) aims to illustrate to clients that sexuality is being considered. It simultaneously remains tentative enough for individuals who do not wish to or feel ready to disclose identity, meeting people at different stages of their journey, which was raised as important in the findings. Improved training may also seek to develop an increased culture of open-mindedness as raised by one participant.

Increased knowledge gained during training will also better equip psychologists to address heteronormative policies and procedures and enable more meaningful service change to occur, as identified by participants. Supervision and reflective practice can further support this by allowing clinicians to consider their own bias, prejudice and assumptions (Rees et al., 2021) and recognise their level and limits of competence (The British Psychological Society, 2019). It also provides an opportunity to consider and formulate intersectionality and explore similarities and differences. This may be acknowledged with clients to bring an awareness and understanding of how it feels, bringing any barriers in the therapeutic relationship to the forefront. This is particularly important for psychologists whose identities are not commonly questioned (The British Psychological Society, 2019). Critical reflective practice is thought to help increase praxis (awareness and action) in recognising and addressing discrimination (Thompson & Pascal, 2012), including racism and gay hate, which are two areas apparent in the results.

Clinicians have a role in supporting teams to formulate the adversities, trauma, effects and history of social stigmatisation and oppression, and how this can impact attachment and the relationship to help (The British Psychological Society, 2019). Understanding how eugenic philosophies have harmed the LGBTQ+ community and continued through practices such as conversion therapy, can help better recognise the fear that exists. An emphasis on formulations which identify how inequality can lead to and perpetuate homelessness is required, as well as the impact on mental health. This is important given that healthcare professionals report insufficient knowledge of social causes of health and homelessness (NICE, 2022). It also follows findings which highlight how a lack of understanding of the causes can result in greater blame and judgement, negatively impacting wellbeing. Where assessments should account for health inequalities and address diversity and inclusion, formulations should consider the intersections of identity and the unique mental health challenges specific to the LGBTQ+ population (Rees et al., 2021). An increased understanding may allow services to better identify absences in a client's environment, and improve experiences of care (NHS England, 2019).

4.4.2 Service Implications

Family rejection was deemed to be the main cause of homelessness, supporting other literature (The Albert Kennedy Trust, 2021; Ecker et al., 2019). Therefore, services may work preventatively to help people stay housed if the environment can be improved to an extent that feels safe. However, the complexity and nuance of family conflict may mean that this is not always appropriate (Semborski et al., 2021). Additionally, any parenting education and intervention that does occur should be customised to the culture, values and histories of the population (Mills-Koonce et al., 2018).

In order to address the gaps in the environment, community-based approaches may be adopted. Bringing communities together and the creation of safe places, such as youth centres, may strengthen support networks and increase social support. This would better address loneliness, and associated low mood, and is thought to lead to better outcomes (Semborski et al., 2021), such as reduced suicidality and substance use (Fish, 2020). Co-developing the spaces with the LGBTQ+ homeless population may also allow further opportunities to engage in collective action against discrimination, similar to a social action model (Holland, 1991). There is a need for community psychology (which provides an alternative to previously tried therapies, such as CBT) as individual-level approaches and pharmacological treatments remain the majority intervention for LGBTQ+ individuals seeking mental health support (Fish, 2020). However, there are barriers to increasing community connectedness such as services being structured to largely provide assessment and medication, remaining part of a system of medical research and traditionally functioning to incarcerate people. In order to address these barriers and increase community approaches, more volunteers are required in services, as well as a wider range of professionals (such as peer support workers) being employed. Moving away from diagnosis and assessment would help to increase the likelihood of implementing community-based approaches. Such a shift may also help to further develop the aforementioned culture of open-mindedness in services.

Aside from possible advertisement of support on social media and continued online and in-person appointments, services may consider their waiting list criteria to improve service accessibility. This follows on from findings suggesting that a person’s place should be accounted for when moving borough and supports recent updates to NICE guidelines. The guidelines state that people may be moved up a waiting list for health appointments if their circumstances result in higher risk of deterioration or death (NICE, 2022). Such recommendations were also made on the basis that feeling unsafe and excluded, which is commonplace for many LGBTQ+ homeless people, perpetuates disengagement which is subsequently harder for services to address. As identified, some LGBTQ+ people face increased risk of repeat homelessness and experience greater suicidality whilst waiting, which based on the above, may be a reason for being prioritised. In conjunction with special considerations being made, the resources available whilst waiting may be increased to reduce the absence of support reported by participants. This may include greater signposting and linking in with charities, and/or check in calls.

Services also have a role in providing training to a number of organisations in a multilevel and multicontext way to account for interacting environments, which have previously been addressed in a singular manner (Fish, 2020). An example of how training may help to reduce discriminatory barriers would be working with GP practices. Services could support practices to better understand transgender needs (for example, providing an alternative understanding to ‘gender dysphoria’ to reduce the likelihood of gender and mental health difficulties being seen as synonymous) and enabling referrals to be made to appropriate services. Additionally, training regarding the rights of asylum seekers and refugees in accessing health services could be provided. Although there has been work aimed at increasing GP access for people who are homeless without a permanent address (Healthwatch, 2018a), the findings suggest that this is still an issue, highlighting the need for greater investment in aforementioned projects. Such information should also be shared with individuals and other services, such as social care. This would seek to reduce the barriers noted by participants in the research whilst improving understanding of how multiple intersectional marginalised identities can result in greater inequalities and barriers, resulting in poorer outcomes.

Finally, the findings highlight a fear of sharing with services (including concerns about the therapist's level of understanding) and the need for improvement in inclusivity. One way this may be supported is to develop services with people with lived experience, as doing so is thought to lead to safer, more inclusive spaces (Blunden & Calder, 2020). It is also thought to improve relationships between health services and marginalised groups and redistribute power (Watson, 2014). Working with peer support workers may help clients to feel more confident that there is a greater understanding of LGBTQ+ needs, an aspect which is currently a barrier to support. This may increase engagement and help people to form more trusting relationships and improve communication (NICE, 2022).

It must be acknowledged that some of these recommendations have previously been indicated for the LGBTQ+ population in general, when considering mental health care (The British Psychological Society, 2019), but they have not been widely implemented. It is likely that the reasons for this are based on systemic factors which impact services overall, such as government policies regarding austerity and lack of funding. Such factors have resulted in services becoming over-stretched with less capacity, more demand and increased 'burn out' in staff teams. Austerity policies have put increased pressure on services to respond within the context of significantly reduced budgets and can be reflected in the increased pressure on inpatient beds, out of area placements, increased use of the Mental Health Act and the position of the Criminal Justice System as a default provider of mental health care (Cummins, 2018). This may also be exacerbated by the lack of time and the need to meet service targets which can result in teams focusing and prioritising certain aspects above others, such as the number of people seen rather than experience of healthcare. Additionally, a lack of conceptual clarity in recommendations can also make it difficult for services to implement change (Cummins, 2018). Furthermore, it has been cited that the lack of efficacy (resulting in many mental health treatments for LGBTQ+ groups remaining unknown) has worsened the delay of important research findings into community practice (Perry & Elwy, 2021).

As such, a proposed ‘theory of change’ to implement the aforementioned recommendations has been included based on guiding frameworks. Theory of change refers to evaluation of community initiatives and clear implementation to achieve outcomes, with the recommendations being feasible (resources available), plausible (evidence supporting recommendations) and testable (specific to track progress) (Connell & Kubisch, 1998). Implementation science is one way change may occur. It has been cited as a way to reduce the mental health disparities experienced by the LGBTQ+ population by ensuring that knowledge is translated into practice (Perry & Elwy, 2021).

A Quality Enhancement Research Initiative Implementation Roadmap, inclusive of three stages (pre-implementation, implementation and evaluation) can help to guide the overall process (Kilbourne et al., 2019). An implementation science theory such as the Integrated Promoting Action on Research Implementation in Health Services model (i-PARIHS) should also be selected (Harvey & Kitson, 2015). This model provides a framework for considering the process of implementation and recognises the complexities involved. It considers the nature of the innovation, the recipients, the context and facilitation (all of which will be referred to as each stage of the roadmap is outlined). These areas have informed the recommendations by considering the motivation and beliefs of stakeholders and networks, and the wider context in terms of structures, systems and external levels. As part of innovation, a starting point must be decided upon which can be achieved by identifying a goal. One example goal to create change may be to improve access to community interventions for LGBTQ+ populations.

Within the first stage of the roadmap (pre-implementation) the range of recipients involved must be considered. It is recommended that all key stakeholders and advisory board of key decision makers meet repeatedly (and continue to meet at all stages of the process) to understand how implementation and delivery can occur. This is a critical tool in implementation science (Perry & Elwry, 2021). This may include administrators, policy makers, organisational leads as well as those providing and accessing the service. Qualitative interviews may be conducted to understand the perceptions of LGBTQ+ specific support from service providers and clients and to identify any unexpected barriers to implementation. Additionally, qualitative feedback may be collected from local populations to understand perceptions of how LGBTQ+ people are supported. It is possible that some resistance may be faced if colleagues do not recognise this as a priority or feel sufficiently involved. Such interviews would allow information to be comprised from clinical, client and local experience, and aligning this with local priorities can increase compatibility of a proposed change (Harvey & Kitson, 2015).

If achieved, this would allow the voices of the community to be heard and taken into account. Whilst a challenge of this may be practical aspects of arranging a consultation, advertising and disseminating findings of such research findings at conferences may help to garner interest and increase motivation to meet. Through partnership working and collective action, there may be greater influence over strategic planning and commissioning decisions; a proposal may be written to request greater funding and resources to allow services to implement the relevant changes. However, greater investment in services will likely be inhibited by government agenda and aims. Therefore, it is important to provide evidence from research to build the case and highlight the long-term benefits in increasing service funding (reduced demand, targeting root systemic cause) to better meet the needs of LGBTQ+ homeless clients, whilst recognising that this may be one of the largest obstacles faced. It may also be highlighted how certain services and aspects are prioritised, such as the investment in technology, as opposed to services providing personal care.

With greater funding, the implementation phase may begin. This may involve teams expanding and a creation of new roles, such as greater numbers of experts by experience to reduce the level of medicalisation that exists in services and increase the likelihood of community-based interventions. This would also help to move towards a structural change within services to better address discrimination by addressing the societal and systemic causes rather than individualising distress through a biomedical model. Finally, contracts may be agreed with third party organisations to provide mandatory training for all professionals working with the LGBTQ+ population to ensure adequate knowledge, skills and understanding. This may be focused on addressing heteronormative policies and ensuring affirmative practice. As per the i-PARIHS model, the context must be considered. It is possible that re-organisational change more widely with the NHS may pose a barrier to keeping local level change on the agenda, therefore facilitation will be crucial. Facilitation helps to contribute to sustained progress, by describing the ongoing support needed to change attitudes, skills and ways of working (Kitson et al., 1998); such facilitation is the responsibility of a key individual and is focused on enabling and empowering others to create change. Having specified roles will help to ensure change continues despite wider service alterations.

Evaluation of implementation outcomes (as listed as the final step in the i-PARIHS model) is important and may be achieved using Proctor’s framework (Proctor et al., 2011) which focuses on the following: acceptability (level of knowledge and attitudes towards implementation from providers), appropriateness (level of resources available to make changes, as well as time and skills), monitoring (who will continue to implement changes and what are they key elements for it to be successful) (Perry & Elwy, 2021). Qualitative data may be collected through interviews and focus groups based on the aforementioned areas. Evaluation of implementation may also include developing specific CCG targets regarding collection of demographic information including sexuality, homelessness and disability routinely to monitor how many LGBTQ+ people are accessing community-based interventions to determine whether this has improved. Training programmes may be evaluated in terms of impact and implementation, and questionnaires may be developed to measure the awareness in the community regarding factors that contribute to poorer or better health for LGBTQ+ homeless individuals (Birmingham, LGBT). Further qualitative data may be collected from service providers and clients to determine how acceptable the implementation has been in general.

4.4.3 Policy Implications

Health promotion for the LGBTQ+ homeless population should be driven by the voices of the community, with society gaining a better awareness of the issues faced (Rees et al., 2021). Clinical psychologists have the ability to contribute to this and macro-level policy change. This may be achieved by promoting an understanding of psychological and social issues which marginalised groups experience and contributing to policies which are committed to reducing social inequality and tackling social injustice. Psychologists may support policy change by contributing to green papers and highlighting the impact of proposed implications and any harms before they transition to white papers, where editing is no longer possible. Doing this will aim to better protect marginalised groups and reduce discrimination, contributing to improved societal attitudes. For example, the government's recent partial conversion therapy ban, which excludes transgender people, fails to acknowledge the harms caused and allows discrimination within society to continue. Therefore, it is important to highlight the consequence of such policies, and for change to occur at these higher levels, remaining the responsibility of all, as it is evident that societal discrimination in itself is a barrier to mental health services.

A range of homelessness prevention typologies exist, including five categories listing universal, targeted, crisis, immediate and recovery prevention (Fitzpatrick et al., 2019). The findings of this research point towards greater emphasis on targeted and recovery prevention for the LGBTQ+ homeless population. Targeted prevention identifies at risk groups at a local level and emphasises early intervention to improve the awareness of and links to homelessness, which is thought to be more effective than a universal approach (Semborski et al., 2021). One way this might be achieved is the NHS joining with LGBTQ+ homeless charities to jointly deliver talks in schools. Terms such as 'wellbeing' and 'distress' may be used to reduce pathology and normalise difficulties. Such training would seek to increase the awareness of support on a larger scale and improve navigation of services, particularly as many of the population experience homelessness during teenage and early adult years. Additionally, for some, improving family relationships can support both suicide and homeless prevention (Frey & Cerel, 2013). However, it must also be recognised that for others, leaving home may be more protective than remaining housed.

Although at the opposite end of the spectrum, recovery prevention was also identified as important. This argues for greater investment to prevent the recurrence of homelessness which may be achieved through intensive ‘wrap around’ support. Such support, which includes access to substance misuse, mental health and social services, is provided by specialist homeless multidisciplinary teams, such as Pathway (Khan et al., 2018). These teams can support people in crisis, offer flexible ‘out of hours’ support and ensure psychological support is available, such as after an episode of homelessness. Specialist teams may expand further by developing LGBTQ+ specific support which may be achieved through training, employment of LGBTQ+ practitioners, people with lived experience, and increased working with charities in this area.

4.4.4 Future Research Implications

Due to the study limitations, future research could focus on collecting more data from the transgender homeless population regarding the barriers to mental health care to further contribute to the findings identified.

Other areas of focus may include accounts of workplace discrimination to better identify intersections of identity and whether certain groups are more at risk. This would help to build on the findings which reference discrimination in employment and the interconnected relationship between such experiences, mental health and homelessness. Information could be collected on people’s past and present employment to help contextualise the data. This may contribute to increased development of targeted prevention policies.

It may also be helpful to interview mental health service providers working with LGBTQ+ homeless clients to understand the barriers to mental health care from their perspective. This would help to comprehend decision making regarding the level of support offered in the first instance, why it may be variable, and to draw any similarities and differences to the general homeless population.

4.5 Conclusion

The research was undertaken as no previous studies in the UK had specifically investigated the barriers to mental health services for the LGBTQ+ homeless population. In previous literature, there was a significant absence of LGBTQ+ homeless service user perspectives with regard to their health needs and requirements. This was particularly evident for adults. Furthermore, homelessness and health had often been researched independently.

Where homelessness can cause low mood, shame and loss of self-worth, harmful reactions to sharing identity can result in feeling different and internalised stigma. The role for services was identified and revealed a need to work systemically with families, address wider discrimination, and prevent repeat homelessness. The barriers to services outlined how discrimination in society, health services and past experiences can lead to a fear of sharing when help-seeking. A lack of support from services in the form of denial of help or inappropriate intervention can also impact access, along with long waiting lists and limited awareness of help. It was suggested that people are more likely to prioritise basic needs above psychological support when homeless, therefore it may be beneficial to invest in both targeted and recovery prevention policies. Moving forward, it was suggested that services improve flexibility in the type and delivery of intervention offered, clearly demonstrate inclusivity and integrate LGBTQ+ specific support with generic services.

Implications of these findings highlight the importance of building trust with clients and developing assessments, formulations and interventions which address social issues. Reflection on intersectionality and bias is essential to the therapeutic relationship. For services, increasing community psychology approaches, embedding coproduction and conducting LGBTQ+ sensitivity training is deemed beneficial. The need to address heteronormativity within practice, and work with organisations such as schools and GP practices regarding discrimination was highlighted. Future research may focus on collecting more data from the transgender homeless population, exploring workplace discrimination, and interviews with service providers.

Overall, the research allowed an understanding of the barriers to mental health services from a diverse, adult, LGBTQ+ homeless perspective. The research enabled mental health needs to be identified and highlighted a number of aforementioned barriers. As a result, suggestions have been made to improve service accessibility and engage with positive practice, which should reduce the likelihood of repeat homelessness and directly improve wellbeing.

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APPENDIX A: Interview Schedule

Preferred pronouns: He/Him ☐ She/Her☐ They/Them☐ Own description☐ (please state):

Which of the following best describes your gender: Male ☐ Female ☐ Non-Binary ☐ Own description☐ (please state):

Do you identify as Trans? Yes ☐ No ☐ Questioning ☐ Own description ☐ (please state):

Sexual orientation: Bi-sexual ☐ Gay ☐ Lesbian ☐ Heterosexual/straight ☐ Queer ☐ Questioning ☐ Pan sexual ☐ Own description☐ (please state):

Age:

Ethnicity: White ☐ Black/African/Caribbean/Black British☐ Asian/Asian British ☐ Multiple/Mixed ethnic groups ☐ Other ethnic group ☐(please state):

Longest period of time homeless:

Type of homelessness experienced: Rough sleeping/street homeless ☐ Sofa Surfing ☐ Hostels ☐ Staying at a friend/family member ☐ Staying at a partner/casual partner's house ☐ Other (e.g. B&B, bedsit, refuge)☐ (please specify):

Mental health difficulty experienced (e.g. feeling low/anxious/stressed):

Mental health diagnosis: Yes☐– diagnosis given: No☐

Opening questions

1. What age were you when you first became homeless?
2. What do you think are the main causes of homelessness for LGBTQ+ people?

What are the mental health needs of LGBTQ+ homeless adults?

3. How would you describe your mental health whilst homeless? What were the main difficulties you faced?
4. When did these difficulties start?

What do LGBTQ+ homeless adults view as the role for mental health services?

5. Have you ever received or tried to receive support from NHS mental health services?
6. What was your experience of these mental health services?
7. Do you think having support for your mental health (at all/earlier than provided) could have prevented homelessness or impacted the length of time spent homeless?

Follow up question: What type of support would have been helpful?

Barriers to mental health services?

8. What made it easier/more difficult to access support?
(Prompt: Is there anything about mental health services that makes you feel uncomfortable?)
9. What do you think are the main things which make it difficult for other homeless LGBTQ+ people to get support?
10. In what ways do you think access to mental health support has been impacted by COVID-19?

What could services do differently?

11. What do you think mental health services could do differently to better support LGBTQ+ homeless people?
12. How are mental health services communicated to LGBTQ+ homeless people? In what ways could they be more inclusive?
13. Is there anything else you would like to change?

Closing questions

14. Would you like to add anything else?
15. Are there any questions that you would like to ask me?
Thank you very much for your participation.

APPENDIX B: Research Advert

Understanding the barriers to mental health services from a Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) homeless perspective

University of
East London

Would you like to take part in this research to tell us about being homeless and the challenges in seeking mental health support?

I would like to talk to LGBTQ+ people (18 years or older) who view themselves as having mental health needs (you do not need to have a diagnosis to participate) and have experience of being homeless (e.g. sofa surfing, hostels, staying with a friend, street homeless etc.), whether that is at present or in the past.

This research is being carried out to understand the mental health needs of LGBTQ+ people who have experienced homelessness and to find out what things make it difficult to get support for mental health.

At the moment, very little is known. We are hoping that this research will allow more understanding of the challenges and improve access to mental health support.

Taking part in the study will involve an informal chat over the phone or online. The questions I ask will generally be about homelessness and mental health, help from services and how COVID-19 might affect this.

To thank you for your time in participating, we will offer you a £10 voucher. If you are interested in taking part, please email Olivia on u1945508@uel.ac.uk where you can receive more information.

APPENDIX C: Participant Information Sheet

University of East London

PARTICIPANT INFORMATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

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

What is the research?

This research is being carried out to understand the mental health needs of LGBTQ+ people who have experienced homelessness and find out what things make it difficult to get support for mental health. The 'things' that make it difficult are known as barriers. An example barrier might be long waiting lists to be seen.

There is little research that has been done to understand the barriers to mental health care when homeless, and even less is known about the challenges the LGBTQ+ homeless population may face. Therefore, I would like to find out more about this from your point of view. It is hoped that this information can be shared with services to help support become easier to access.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking to speak to people who identify as LGBTQ+ and have experience of being homeless (such as sofa surfing, staying at a friend's house, hostels etc.), whether that is at present or in the past.

You need to be 18 years or older and view yourself as having mental health needs. You may or may not have a diagnosis from professionals. You can participate in this research either way. You may have tried to seek support from mental health services for this problem, but you can still participate if this is not the case.

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

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

What will your participation involve?

If you agree to participate you will be asked to:

- Have an informal chat with me where I will ask you some questions. This is referred to as an interview and is expected to last around 45 minutes. There are no right or wrong answers.
- The questions I ask will generally be about homelessness, mental health, help from services and any barriers, and how the pandemic might have affected getting support.
- The interview will take place over phone or video, depending on what is easier for you and it will be recorded so that I can listen to it afterwards. I will be the only person listening to the interview.
- It is recorded so that I can type it up into a transcript. This will be read by my supervisor Dr Lorna Farquharson at the University of East London. The examiners who will be marking my research will read extracts. Your name, and anyone else you mention will be changed so that you are anonymous.
- Anonymised extracts of the interview will also be included in the write up and may also be used in presentations, reports and publications.
- After I have typed the interview up into a transcript, the recording will be deleted.
- A £10 voucher will be offered to you to thank you for your participation. Your participation is really valuable in helping to understand more and work towards making help easier to access.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

- Whilst some broad demographic information may appear in the write up (such as age, ethnicity, gender) you will not be identified. You will not be identified in the data collected or in any written material resulting from the research.
- You do not have to answer a question if you do not wish to and you can stop the interview at any time. You will still be provided with a voucher to thank you for your time.
- A list of numbers and charities have been included in the debrief form should you wish to speak to someone after the interview has finished.
- If there are serious concerns about your safety during or after the interview, I will need to discuss this with my supervisor. I will try to let you know if I need to do this, but this is not always possible.

What will happen to the information that you provide?

- I will store the information collected from the interview, including the recording, on a file within a computer which are both password protected.
- The recording will be encrypted, and it will be locked in a secure cupboard.
- After the recording has been typed into a transcript, the recording will be deleted.
- The transcript will be kept on a password protected computer for up to five years due to examination purposes. After this point, it will be deleted.
- The write up will be read by my supervisor, the examiner, and it may also be published in an academic journal. The write up will also be publicly accessible on the university website which is called the ‘UEL repository’.

What if you want to withdraw?

You are free to withdraw from the research study at any time during the interview without explanation, disadvantage or consequence. You will still be provided with a voucher. You may also request to withdraw your data after you have participated, provided that this request is made within 3 weeks of the data being collected. After 3 weeks following the interview, the data analysis will have started and withdrawal will not be possible.

Contact Details

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

My name is: Olivia Milburn
My university email address is: u1945508@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: L.Farquharson@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Trishna Patel,
School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

APPENDIX D: Consent Form

CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

“Understanding the barriers to mental health services from a Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) homeless perspective”

I confirm that I have read the information sheet dated 12/03/21 for the above study and that I have been given a copy to keep. (**NB**: all consent forms should show the date on which they were agreed and have a version number in order to keep track of any changes that might occur over the course of the study). ☐

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation in the study is voluntary and that I may withdraw at any time, without providing a reason for doing so. ☐

I understand that if I withdraw from the study (up to 3 weeks after the interview) my data will not be used. ☐

I understand that I have 3 weeks from the date of the interview to withdraw my data from the study. ☐

☐

I understand that the interview will be recorded using Microsoft Teams.

I understand that my interview data will be transcribed from the recording and anonymised to protect my identity. ☐

I understand that my personal information and data, including audio recordings from the research will be securely stored and remain strictly confidential. Only the research team will have access to this information, to which I give my permission. ☐

It has been explained to me what will happen to the data once the research has been completed. ☐

I understand that short, anonymised quotes from my interview may be used in the thesis and that these will not personally identify me. ☐

I understand that the thesis will be publicly accessible in the University of East London's (UEL) Institutional Repository (ROAR). ☐

I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in professional and academic journals resulting from the study and that these will not personally identify me. ☐

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. ☐

I will offer you an Amazon/Love2Shop voucher as a token of appreciation for your participation. However, HMRC regulations require that recipients must provide details of their name, address and National Insurance Number. If you wish to receive a voucher you should tick to indicate that you have been informed of this requirement. ☐

I agree to take part in the above study. ☐

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Researcher’s Name

OLIVIA MILBURN………………………………………………………………………..

Researcher’s Signature

…………………………………………………………………………………………

Date: ……………………..…….

APPENDIX E: Debrief Letter

DEBRIEF FORM

University of East London

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on homelessness and the barriers to mental health services. This letter offers information that may be relevant now you have taken part.

What will happen to the information that you have provided?

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

- I will store all of the information collected from the interview, including the recording, in a folder on a computer which are both password protected to stop anyone else from seeing or hearing it.
- After I have typed up the interview into a transcript the recording will be deleted.
- I will be the only person listening to the recording. My supervisor, Dr Lorna Farquharson and I will read the transcript. The examiner will be able to read extracts of this.
- The transcript will be kept on a password protected computer folder for up to five years for examination and publication purposes. After this point, it will be deleted.
- The transcript will be used to help me describe the main points from the interview and these will be included in the write up.
- Some quotes from the interview will be included in the write up. All identifiable information will be removed or replaced with pseudonyms to help keep you and anyone you mention anonymous.
- The write up will be read by my supervisor, the examiner, and it may be published in an academic journal for the public to access.

- You can withdraw from the research up to 3 weeks after the interview has taken place. After which, you will not be able to withdraw as the data analysis will have started.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support.

Please click on the name of the charity to access their webpage:

- [Name] (LGBTQ+ homelessness support) [number], [email] and [address]
- [Name] (mental health support): [number]
- [Name] (mental health support): Call on [number] / Text on [number], [website]
- [Name] (LGBTQ+ shelter in London)
- [Name] (housing support and accommodation in London)
- [Name] (housing and homelessness support)
- [Name] (homelessness or risk of support)
- [Name] (homelessness support)
- [Name] (homelessness support)
- [Name] (homelessness support)

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. My details are attached below:

Name: Olivia Milburn
University email address: u1945508@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London, E15 4LZ, Email: L.Farquharson@uel.ac.uk or

Chair of the School of Psychology Research Ethics Sub-committee: Trishna Patel,
School of Psychology, University of East London, Water Lane, London, E15 4LZ.
(Email: t.patel@uel.ac.uk)

APPENDIX F: Ethical Application and Approval

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: ☒

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed.

- The participant information letter ☒
- The participant consent form ☒

- The participant debrief letter ☒

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

  Included ☒ or

  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).

  Included ☐ or

  Not required (because the research takes place solely on campus or online) ☒

To be included after proposal submission deadline.

- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☒

- A Disclosure and Barring Service (DBS) certificate (see section 7).

  Included ☐ or

  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☒

- Ethical clearance or permission from an external organisation (see section 8).

  Included ☐ or

  Not required (because no external organisations are involved in the research) ☒

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

  Included ☐ or

  Not required (because you are not using pre-existing questionnaires or tests) ☒

- Interview questions for qualitative studies.

  Included ☒ or

  Not required (because you are not conducting qualitative interviews) ☐

- Visual material(s) you intend showing participants.

  Included ☐ or

  Not required (because you are not using any visual materials) ☒

2. Your details

2.1 Your name: Olivia Milburn

2.2 Your supervisor's name: Dr Lorna Farquharson

2.3 Title of your programme: Professional Doctorate in Clinical Psychology (ClinPsyD)

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2022

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: "Understanding the barriers to mental health services from a Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) homeless perspective".

3.2 Your research question:

- What are the mental health needs of LGBTQ+ homeless adults?
- What do people with lived experience view as the role for mental health services?
- What are the barriers to accessing mental health services?
- What do people with lived experience think mental health services could do differently?

3.3 Design of the research:

- This will be a qualitative study using purposive sampling.

- Semi-structured interviews will be conducted with approximately 8 service users to gain their perspective on homelessness and the barriers to mental health services.
- Interviews will be conducted via phone or video-conferencing and are anticipated to last approximately 45 minutes.
- An interview schedule has been attached which has been shaped through consultation with the Research Officer, the Head of Service and the Youth Ambassador at [name] (a charity that supports young homeless people who identify as LGBTQ+) .

3.4 Participants:

- Participants will be either formerly or currently homeless and identify as LGBTQ+.
- This study is focusing on the adult population, so participants will be 18+ years and will self-identity as having mental health needs and/or experience with mental health services.

3.5 Recruitment:

- Participants will be recruited via an LGBTQ+ specific homeless organisation [name] and through their links to other possible organisations (e.g. name).
- An advert will be included in the [name] newsletter which will include my university email address. If participants are interested in taking part in the research, the advert will advise them to email me to let me know. I will then send the information sheet and consent form to be read through before participating in the interview. At the start of the interview, some of the main points will be re-capped, such as the ability to stop the interview at any time and the fact that it is recorded.
- Both verbal and written consent will be obtained and the right to withdraw will be reiterated.

3.6 Measures, materials or equipment:

- The interviews will be conducted using MS Teams, or a phone conferencing system depending on individual accessibility.
- Interviews will be audio-recorded either through Microsoft Teams or an encrypted device to enable transcription onto a password-protected computer.
- A draft interview schedule has been included in Appendix E.

3.7 Data collection:

- Data will be collected via semi-structured interviews which will be conducted via telephone or video conferencing.
- It is thought that data collection will take place between April and September 2021 following ethical approval.

- Personal data will be collected on consent forms (names) and demographic information will be asked at the beginning of the interview (age, ethnicity, sexuality).

3.8 Data analysis:
- Data will be analysed using Thematic Analysis.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?
- No

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?
- Pseudonyms/numbers will be given.
- All data will be kept in a secure, locked environment.
- Recordings will be deleted after transcription.
- No identifiable information will be included in the transcripts.

4.3 How will you ensure participants details will be kept confidential?
- All identifiable information will be removed.
- Pseudonyms will be given to ensure anonymity.
- All details will be stored in a secure, password protected folder and not shared with anyone else.
- Data will be kept in a locked environment and will be destroyed after academic purposes have been achieved.
- Interviews will be deleted off Microsoft Teams or the recording device if over the phone after transcription has taken place.

4.4 How will the data be securely stored?
- Data will be stored on the UEL one drive which is deemed a password protected file, on a password protected computer.
- Consent forms will be uploaded directly onto the one drive after the interview. Email versions will then be destroyed.
- Each file will be saved in separate folders and will be named by initials and date of interview. Each participant will be attributed a number in chronological order.

- Microsoft Teams recordings will be deleted after transcription due to the large file size and to protect confidentiality. Recordings made via Teams will be stored automatically in Microsoft Stream. If downloaded to my laptop they will then be uploaded directly to OneDrive for Business. Once I have uploaded the files to OneDrive for Business any local copies created will be deleted.
- The same process will apply if recordings are completed via dictaphone.
- All data will be backed up on the researcher's personal space on the UEL H drive or One drive.
- Any list of codes will be stored in a separate folder from the other data to avoid re-identification of participants.
- All identifiable information will be removed from the transcript. The transcript will be read by the researcher, supervisor and examiner only.
- Audio recordings will be stored on UEL storage e.g. OneDrive for Business and will be deleted from the device used during the interview. Files will be kept in separate folders and named as the participant's initials and date of interview.

4.5 Who will have access to the data?

- The interview will be typed into an anonymised transcript. This will be read by my supervisor at the University of East London, which will be sent via UEL email, and the examiners who will be marking the research. The participant's name, and anyone else mentioned will be changed to ensure anonymity. The data will be shared by emailing links via the UEL OneDrive.
- Quotes and extracts of transcripts will be included in the write up and if published, in an academic journal. Identifiable information will not be included in the extracts.
- The transcript will not be deposited via the UEL repository due to the anonymised data being too sensitive to share.

4.6 How long will data be retained for?

- Audio recordings will be deleted once the interview has been transcribed. Consent forms will be kept until the thesis has been examined and passed. After this point they will be deleted from the UEL one drive.
- Transcripts will be erased from the laptop up to five years after the interview due to examination and publication processes.
- The transcript will be kept on a password protected computer for up to five years at which point it will be deleted. The folder in which the transcript is stored will be encrypted to improve security.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: ☒

5.2 Your research question: ☒

5.3 The purpose of the research: ☒

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ☒

5.5 That participation is strictly voluntary: ☒

5.6 What are the potential risks to taking part: ☒

5.7 What are the potential advantages to taking part: ☒

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ☒

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): ☒

5.10 How long their data will be retained for: ☒

5.11 How their information will be kept confidential: ☒

5.12 How their data will be securely stored: ☒

5.13 What will happen to the results/analysis: ☒

5.14 Your UEL contact details: ☒

5.15 The UEL contact details of your supervisor: ☒

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature. NO

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

- Pseudonyms will be given to participants by the researcher.
- All information will be stored on a password protected computer and not shared with other people.

- Pseudonyms will replace any given name, and this will be made clear to the participant before taking part in the research.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

- Participants will be given £10 vouchers as advised by the charity to be able to recruit participants and to thank them for their time.

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

- A named contact from a charity will be identified to offer support after the interview and a list of resources identifying sources of support have been included in the debrief form for the participant to refer to.
- The participant will also be reminded of their right to withdraw at any point during the interview and up to 3 weeks after.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised? YES

The nature of the topic being researched presents some psychological risk to the researcher. The experiences being shared may be difficult to hear. The risks of any emotional toll experienced as a result of conducting the interviews can be minimised by discussing this with my DoS, who will provide adequate support should it be needed.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant? YES.

- Names and numbers of charities which offer support if people are feeling low, anxious or suicidal have been provided.
- These have been provided in case the participant feels distressed.
- Names and numbers of homeless charities have also been provided.

6.4 Does the research take place outside the UEL campus? If so, where? YES. Interviews will be conducted remotely via MS Teams or phone conferencing.

If so, a ‘general risk assessment form’ must be completed. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed: ☐

6.5 Does the research take place outside the UK? If so, where? NO

If so, in addition to the ‘general risk assessment form’, a ‘country-specific risk assessment form’ must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a ‘country-specific risk assessment form’ *is* needed, please tick to confirm that this has been included: ☐

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

NO If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

NO

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

NO

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

- LGBTQ+ homeless charity named [name]

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☒

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation,’ or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Olivia Milburn

Student's number: U1945508 Date: 12.03.21

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Icram Serroukh

SUPERVISOR: Lorna Farquharson

STUDENT: Olivia Milburn

Course: Prof Doc Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

3.3 – Minor spelling error – LBGTQ+ needs to be amended to LGBTQ+

5.17 – It may be better to select the pseudonyms yourself, rather than asking the participant to do so as you may have several participants choosing the same pseudonym.

6.2 – The nature of the topic being researched presents some psychological risk to the researcher. The experiences being shared may be difficult for the researcher to hear. The risks of any emotional toll experienced as a result of conducting the interviews can be minimised by discussing this with the DoS, who should provide adequate support for the student.
The response to this question should be amended from ‘No’ to ‘Yes’, with a statement included to reflect the above point. A risk assessment form does not need to be completed.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student’s name *(Typed name to act as signature):* Olivia Milburn
Student number: u1945508

Date: 28.04.21

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / **NO**

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

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

I am aware that as per the ethics form, a risk assessment is not required for online research. Therefore, a risk assessment will not need to be submitted. I note that whilst this is the case, the researcher should be cognisant of the potential risk to their own mental wellbeing as they may be exposed to information that is difficult to hear, due to the nature of what is being researched.

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

Date: 27/04/2021

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

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

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Trishna Patel (Deputy Research Director/Chair of School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Trishna Patel at t.patel@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

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

Name of applicant:	Olivia Milburn
Programme of study:	Professional Doctorate in Clinical Psychology
Title of research:	"Understanding the barriers to mental health services from a Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) homeless perspective".
Name of supervisor:	Dr Lorna Farquharson

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

Proposed amendment	**Rationale**
To recruit via social media (e.g. Twitter, Instagram) and other platforms such as LGBTQ+ forums (online, university). • Proposed wording: 'Do you identify as LGBTQ+? Have you experienced homelessness (sofa surfing, staying with a partner etc)? Have you ever struggled with your mental health? To tell me more, please read the attachment, email u1945508@uel.ac.uk and receive a £10 Amazon voucher for taking part.' (Ethically approved advert listed at the end of my application will be included as an attachment).	To improve recruitment by reaching out to a larger number of people as there have been few responses so far through accessing charities.

Please tick	**YES**	**NO**
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student’s signature (please type your name): Olivia Milburn

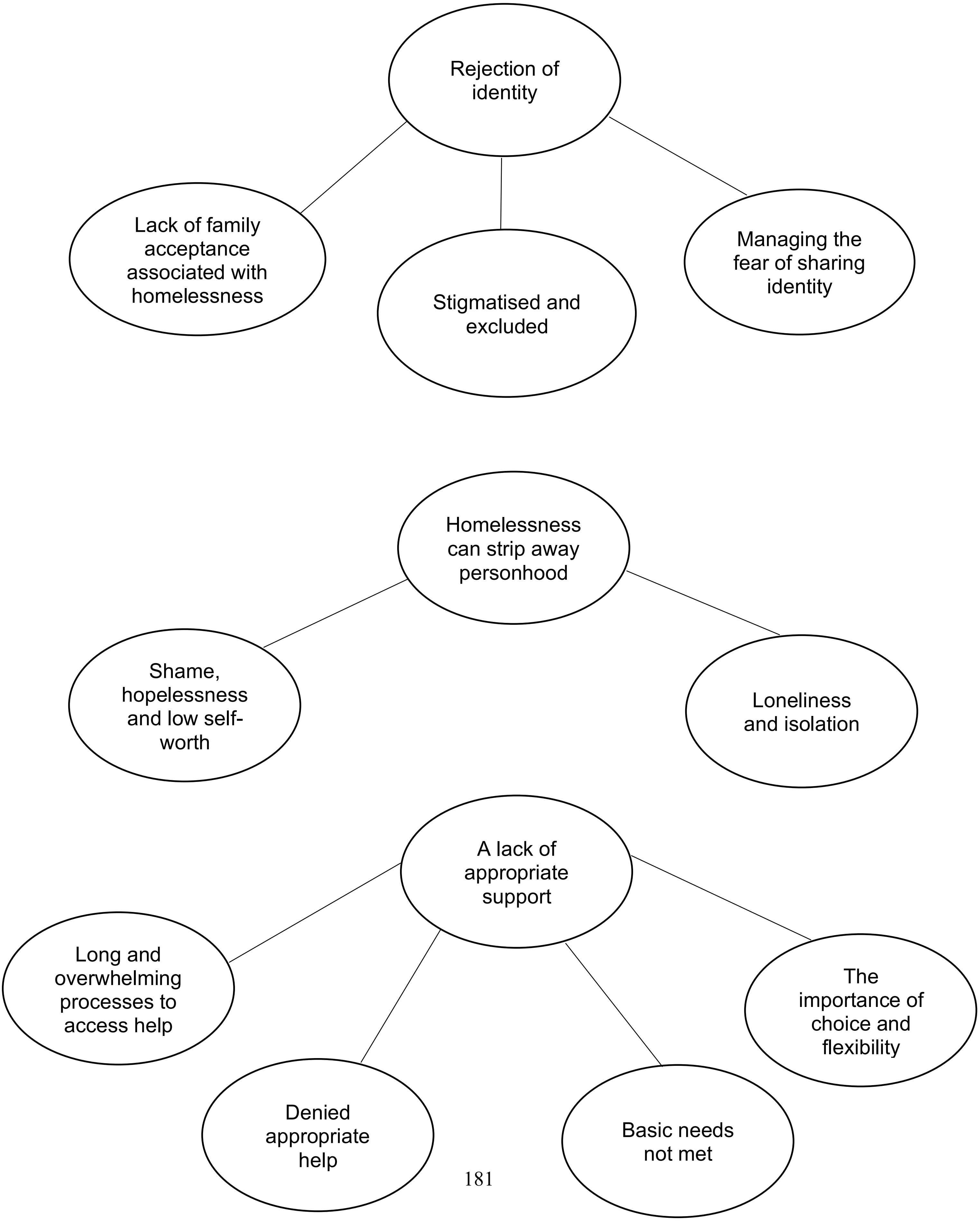
Date: 05/08/21

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

Reviewer: Trishna Patel

Date: 06/08/2021

APPENDIX G: Thematic Map



APPENDIX H: Extract Coded Transcript

Participant: Pre pandemic, the ability to move it to Zoom because I was unstable in my living situation and moving around the country, I think to do it online or on phone call would have been helpful. And during the pandemic when I was living with my partner, I think if I'd been able to access really any kind of support. I was looking at, and I had no money, and I was looking at NHS wait lists and not knowing or expecting to end up spending six months in the place that I did, it didn't seem worth even getting on the wait list. So that's an area where I had no support for quite a long time, and it really would have been helpful to have had something.

Interviewer: Yeah, that’s understandable. So, something about being able to work online and via Zoom would have been helpful, and the waiting list it sounds like a barrier to accessing any kind of support because you weren’t sure where you'd be in six months?

Participant: Yeah, it was huge, and another thing is like because I had the previous experience of even just moving between university and home GP practices, GP practices really do not seem to want to cooperate with each other at all. Like, the, you know it just, it's quite distressing at times because it feels like in theory they're all there for patient wellbeing and then in practice they actively are trying to sort of avoid giving you any help if you're not legally registered with them. So the thing that was an issue for me was I was living in [area] and I didn't know when I was going to come to [area] or if, when I was with my partner, and there were several times when I did try to move and then had to not move, so umm, like, then I would have had to deregister with my GP and re-register with the new one at which point I would have been bumped to the back of a waiting list was my understanding.

Codes

Unstable living situation

Benefits of virtual therapy

No support in COVID-19
Social context interacting

Unknown living situation
Not worth it

No support in needed times
Role of psychology

Moving GPs

Lack of service co-operation

Distress
Contrast in help (offered vs. help provided)
Legal barriers

Unpredictable visits

Multiple attempted moves

De-registering and re-registering
Loss of space in waiting list

If there was an ability to kind of move that around with you as you moved around the country in some way, or receive some support from your original GP, then that would be really helpful. But obviously I knew from prior experience that GPs do not work together, umm different services and practices. Yeah, so that was the thing that kept making me go, aside from the waiting list, there's like, there is just no point in me even waiting because I don't know where I'll be.	Priority waiting lists Continuity of care Lack of GP co-operation No point waiting Unpredictable living situation
Interviewer: Yeah, I think that's a really good point that when you do move the wait isn't necessarily counted for and then it's back to another long waiting list. Very difficult. And yeah, it's really hard when practices or healthcare professionals don't work as coherently as they could 'cause I think it makes things harder than they already are.	
Participant: Yeah, it's just one of the things that makes less sense to me because I understand that your average GP can't do much about a wait list, but the practices not wanting to cooperate together seems like something they could absolutely do better. The one other thing I would mention with regards to not really feeling that the NHS was worth even trying was they tended to be quite sort of basic entry level support, often with a 'well if that doesn't work you go on another waiting list for more intensive support so I'll refer you to like an online thing' and then a phone conversation and then you get kind of bumped up the list, and each time you're waiting and you're waiting.	Level of understanding GP improvements Entry level support Multiple wait lists Hierarchical interventions Online therapy Multiple stages Endless process