HOMELESSNESS, WOMEN AND MENTAL HEALTH:

SERVICE PROVIDER PERSPECTIVES

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF
THE SCHOOL OF PSYCHOLOGY, UNIVERSITY OF EAST LONDON FOR THE
DOCTORATE IN CLINICAL PSYCHOLOGY

SUBMITTED MAY 2022

RESUBMITTED OCTOBER 2022

ACKNOWLEDGEMENTS

I would like to thank all the service providers who made time to take part in interviews and make this study possible. Thank you for your valuable insights and honest contributions. It has been inspirational to hear about your ongoing commitment to supporting and improving services for women experiencing homelessness.

I would also like to thank Dr Lorna Farquharson, my director of studies. Lorna’s time and supervision has been greatly appreciated throughout the completion of this project.

Thanks also to my amazing friends and study partners who have motivated me with words of encouragement and lots of chocolate throughout this process! Finally, thank you to my wonderful family for their support.

ABSTRACT

Aims: People who are homeless disproportionally experience mental health problems compared to the general population, however struggle to get the support they need. There is growing recognition of the gendered nature of homelessness and the need for more research exploring women's experiences. This study sought to explore what helps and hinders women experiencing homelessness when accessing NHS mental health services, and how COVID-19 has impacted service access.

Method: Fifteen semi-structured interviews were conducted with employees working with women in third sector organisations offering a diverse range of services to women experiencing homelessness. Interviews were transcribed and analysed using Thematic Analysis to identify common barriers and facilitators to mental health service access.

Findings: Four themes were identified: 1. *Double Impact of Gendered Abuse and Trauma*, which outlines how gendered trauma can increase the risk of mental health problems but also reduce the likelihood women seek mental health support. 2. *NHS Mental Health Services seen as Stretched Gatekeepers* relates to the NHS being under-resourced, with complex and exclusionary referral pathways and support only available in a crisis. 3. *Generic Mental Health Services are Unforgiving and Retraumatising* outlines how services can be inflexible and punitive, lack awareness of gendered trauma and be discriminatory and coercive. 4*. Ambivalent Interface between Third Sector and NHS Mental Health Services* indicates how service providers offer significant mental health support to women but can feel unsupported by NHS mental health services in doing so. This theme outlines the value of specialist homelessness mental health services.

Conclusion: Mental health services are difficult to access for women experiencing homelessness. Women experience gendered barriers to mental healthcare which services need to consider. Specialist homelessness mental health services can facilitate access to mental healthcare by focusing on outreach, offering more flexible services, and building longer-term trusting relationships with women.

ABBREVIATIONS

A&E	Accident and Emergency Hospital Department
AVA	Against Violence and Abuse Project, UK
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
ID	Identification
ETHOS	European Typology on Homelessness and Housing Exclusion
FEANTSA	European Federation of National Organisations Working with the Homeless.
GP	General Practitioner
NGO	Non-Government Organisation
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
NRPF	No Recourse to Public Funds
PIE	Psychologically Informed Environment
RSI	Rough Sleepers Initiative
SAMHSA	Substance Abuse and Mental Health Services Administration
TA	Thematic Analysis
TIC	Trauma Informed Care
UK	United Kingdom
US	United States

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1. CHAPTER ONE: INTRODUCTION

This chapter will provide an overview of the context of women’s homelessness in the UK including causes and prevalence. Recent relevant legislative and policy developments will be summarised as well as the current homelessness support services available for women. The nature of women’s homelessness will be considered more specifically, as well as women’s experiences of mental health. The mental health services available and barriers to mental healthcare will be discussed. The results of a scoping review exploring women’s homelessness and barriers to mental healthcare will be presented. The research rationale for the current study will then be outlined.

1.1. Definition of Homelessness

Homelessness is defined differently internationally across research, legislation, and policy. The European Typology of Homelessness and Housing Exclusion (ETHOS), developed in 2005 by FEANTSA, differentiates between four forms of homelessness: “Rooflessness” describes people without shelter of any kind, for example those sleeping rough; “Houselessness” describes those with a temporary place to sleep, such as in shelters; “Living in Insecure Housing” describes the situations of those threatened with severe exclusion for example due to insecure tenancies, eviction, domestic violence; “Living in Inadequate Housing” describes those in unfit housing, for example, those in extreme overcrowding or staying in caravans (FEANSTA, 2005).

The definition of homelessness is contested by stakeholders in the UK (Fitzpatrick et al., 2019; Government Statistical Service, 2019). Homelessness is defined differently by the four UK nations, reflecting changes to homelessness legislation following devolution (Government Statistical Service, 2019). In England, the Housing Act 1996 adopts a broad definition of homelessness: a person is homeless if they do not have the legal right to occupy accommodation which is accessible, physically available to them (and their household), and reasonable for them to continue to live in. The Housing Act (1996) also specifies it is not reasonable for a person to continue to occupy accommodation if it is probable this will lead to domestic abuse (Section 177, 1).

As with the FEANTSA definition, under the Housing Act (1996), people do not have to be “Roofless” to be considered homeless (Shelter, 2012) but can be in “Houselessness” situations” such as staying in hostels, hotels, “sofa-surfing” with friends or family, or using other forms of temporary accommodation. The Act’s definition of homelessness also includes people, often women, remaining in an abusive relationship to maintain a home (Groundswell, 2020a).

1.2. Feminist Approaches to Homelessness

Given the circumstances of many women experiencing homelessness, current research and conceptualisations of homelessness have been critiqued by feminist writers. Feminism is founded on the belief that women are oppressed or disadvantaged within society in comparison with men, and patriarchal systems operate in society to confer privilege to men while systematically oppressing women (Hill & Allen, 2021; James, 1998; Tong, 2002). The concept of the patriarchy can be understood as a “system of relationships, beliefs, and values embedded in political, social, and economic systems that structure gender inequality between men and women,” favouring men (Nash, 2020 p 43). Women’s homelessness, when viewed from a feminist perspective, can therefore be defined as a social problem created due to wider structural, cultural and patriarchal forces (Bretherton, 2017).

Feminism highlights structural factors which contribute to gender inequality in the home, and to women and children overwhelmingly being the victims of domestic abuse within this private sphere, which often results in homelessness (Wardhaugh, 2012). From this perspective, experiences of domestic abuse are not seen as part of women’s individual history, but understood within the context of structures which normalise male dominance and female subordination through the physical, sexual, economic, and psychological abuse of power (McPhail et al., 2007). The experiences of women while homeless – including higher rates of sexual abuse – can also be understood within this framework (Christensen et al., 2005; Kushel et al., 2003).

Feminist theory has also been used to understand women’s experiences of the shadow market including sex working while homeless and how women are objectified sexually (Wardhaugh, 2012). There is an extensive feminist discussion on sex work. More

Radical and Marxist forms of feminist theory argue sex work is a form of oppression for women, which depends on structural inequalities between men and women based on male domination (Gerassi, 2015). More liberal forms of feminism argue such views are paternalistic and neglect women's autonomy to choose sex work (Gerassi, 2015). Feminism can be used as a framework to understand the narratives around women experiencing homelessness and its association with sex work and domestic abuse.

Building on early work from feminist theorists in homelessness such as Watson (1988) and Austerberry (1986), scholars such as Reeve and colleagues (2006) and Bretherton and Mayock (2021) have argued the definition and type of homelessness research conducted obscures women's homelessness. They argue that research is focused on male experiences of homelessness due to focussing on streets and emergency shelters. Furthermore, the definitions of homelessness often exclude domestic abuse victims by not including women living in refuges in homelessness research, data, and policy (Bretherton & Maycock, 2021). Such theorists have therefore compared men and women's homelessness and argue that it is important to consider women's homelessness specifically to understand the gender inequality within homelessness and ensure women's experiences are not overlooked in gender neutral research and policy. There is some success in this regard, as research in women's homelessness and the adoption of broader definitions of homelessness have greatly expanded in recent years (Bretherton & Mayock, 2021; Groundswell, 2020a; St Mungo's 2018).

However, feminist approaches to homelessness have also been criticised by some intersectional feminist scholars. Bullock and colleagues (2020), have argued privileging gender inequality as the framework for understanding women's homelessness, means that white, cisgender, heterosexual, middle class women are centred and considered to be normative. Focusing on gender inequality as a single approach to understanding women's homelessness can thus exclude women from different backgrounds and identities and promote reductionist and decontextualised understandings of homelessness (Bullock et al., 2020). For example, the gender binary can exclude those who do not identify within it and see gender as more of a spectrum (Cameron, 2019).

Such thinking draws on the concept of intersectionality (Crenshaw, 1991) which acknowledges the intragroup differences between women and how structural oppression such as racism, sexism, heterosexism, and poverty interact and reinforce one another to contribute to different experiences of marginalisation between women. This research will aim to balance using gender inequality as a lens of analysis, focusing on women and at times comparing women to men, whilst also acknowledging that many people do not identify within this binary and that women may experience other forms of oppression.

1.3. Causes and Prevalence of Homelessness

The causes of homelessness arise from a complex interplay of structural and individual factors (Bramley & Fitzpatrick, 2017; Ministry for Housing Community and Local Government, 2019). Experiences of domestic, interpersonal, and sexual violence are important in the causes of women's homelessness (Baptista, 2010; May et al., 2007; Ministry of Housing, Communities and Local Government, 2019; Vijayaraghavan et al., 2012).

1.3.1. Structural Causes for Homelessness

Common narratives around homelessness which focus on individual irresponsibility to blame people for their circumstances have been criticised by researchers in the field (e.g. Gowan, 2009; Pleace et al., 2018). In the UK, homelessness is often outside the control of the individual and mostly driven by structural factors (Bramley & Fitzpatrick, 2017). Structural factors are societal and economic trends creating a social environment which increases the likelihood of homelessness (Ministry for Housing Community and Local Government, 2019), such as low wage growth and insecure work (Fitzpatrick et al., 2017).

Key factors also include the absence or reduction of low-cost and social housing (Fitzpatrick et al., 2017; Wilson & Barton, 2021), alongside an increase in private sector renting (Watts et al., 2022). Losing a private tenancy is one of the biggest causes of homelessness: the number of people made homeless from the private sector quadrupled between 2009/10 and 2016/2017 (Fitzpatrick et al., 2018; Marmot et al., 2020).

The reduction in spending on social welfare policies by local and central government also contributes to homelessness (Loopstra et al., 2016; Watts et al., 2022; Wilson & Barton, 2021). For example, the benefit cap reduces the amount of housing benefit and universal credit families can receive, increasing the risk of families becoming homeless (Pennington & Kleynhans, 2020). Such policies introduced under “austerity” since 2010 have disproportionally impacted women (Bennett, 2015).

Immigration policies can also contribute to homelessness. Migrant women are often in vulnerable financial positions and at increased risk of homelessness as they may have no recourse to public funds (NRPF) (Barbu et al., 2020). Alongside this, migrant women experiencing domestic abuse may be reliant on their partner for a spousal visa. Fear around the uncertainty of their legal status may prevent them from accessing housing support (Barbu et al., 2020; Boobis et al., 2019a).

The causes of homelessness also differ and intersect across different groups of people with the most marginalised experiencing increased risk of homelessness. Many of the structural factors including immigration status, poverty, insecure work and low wage growth, disproportionally impact people from minoritised backgrounds including people who are racially minoritised, people experiencing disability and people identifying as LGBTQ+ (JRF, 2022; Palmer & Kenyway, 2007; Uhrig, 2014).

As well as experiencing increased structural causes, people from LGBTQ+ communities are also more likely to experience direct discrimination resulting in homelessness. Stonewall (2018) report that one in five LGBT+ people have experienced homelessness at some point in their lives. Research conducted by the Albert Kennedy Trust (2014) indicates a large majority, 77%, describe familial estrangement after coming out as LGBT+ as the primary cause of their homelessness.

People from minoritised ethnic groups are also more likely to experience homelessness. Black people are more than three times as likely to experience homelessness (Shelter, 2020). Alongside social exclusion and unemployment (Shelter, 2020), racial harassment has been identified as a likely cause of homelessness and unsuitable housing with people from racially minoritised groups four times more likely than white people to see racist harassment as a serious problem in their area (Homelessness and Housing Directorate, 2005).

People with a physical disability, learning disability or mental health diagnosis are also more likely to experience homelessness; 40% of people owed a prevention or relief duty in 2021 were diagnosed with one of these conditions (Department of Levelling Up, 2022c). The report of the UN Special Rapporteur on the Right to Adequate Housing identified a vicious circle within homelessness with disability leading to homelessness which "exacerbates impairments and additional barriers linked to stigma and isolation" (United Nations General Assembly, p.8).

Together, these economic structural factors, as well as societal and cultural factors operate to marginalise groups of people, including women with these identities.

1.3.2. Individual Causes of Homelessness

Individual causes of homelessness are specific to the person and may include health, addictions, personal finances, or sudden life circumstances (Ministry for Housing Community and Local Government, 2019). Childhood experiences can contribute to the risk of homelessness, such as experiences of physical, sexual, or domestic abuse; neglect; trauma; or being exposed to parents' substance misuse and mental health problems (Fitzpatrick et al., 2013).

For both single women and mothers heading families, fleeing domestic abuse is central to experiences of homelessness (Duke & Searby, 2019; Tischler et al., 2007; Vijayaraghavan et al., 2012). Domestic abuse is the second most common reason for households needing housing assistance from local authorities (Department for Levelling Up: Housing and Communities, 2022a). Many women cannot find suitable accommodation when leaving a perpetrator. Women can be turned away from refuges multiple times or denied housing by local authorities by being declared intentionally homeless (Bimpson et al., 2021; Solace, 2019). Women can move between sofa-surfing, staying with friends or rough sleeping while seeking housing, with some women remaining in or returning to abusive relationships (Austin, 2021; Mayock et al., 2015; Tutty et al., 2015).

Poverty during childhood and adulthood has been identified as a cause of homelessness for men and women (Fitzpatrick et al., 2013). Women experiencing homelessness tend to experience high levels of poverty, low levels of education and have few employment skills (Bassuk, 1993; Styron et al., 2000) which may make it harder to prevent and exit homelessness. Women are more likely to be involved in temporary, short-term, and part-time work, which may increase their vulnerability to homelessness, particularly in the context of relationship breakdowns or sudden life events (Bretherton & Mayock, 2021). Life events such as family bereavements, leaving prison, and losing employment (Ministry for Housing, Communities and Local Government, 2019) have been identified as reasons for homelessness.

Health problems are also recognised as important contributor, with physical or mental health and substance misuse problems seen to contribute to difficulties maintaining accommodation (Homeless Link, 2021c). People sleeping rough often cite substance misuse as a reason for becoming homeless (Pleace & Bretherton, 2017). For some people substance misuse and mental health problems can also arise or be exacerbated following long-term or repeated exposure to homelessness (Pleace, 2019).

1.3.3. Prevalence of Women’s Homelessness

It can be difficult to capture the prevalence of women’s homelessness and it is widely considered to be underreported (Bretherton & Pleace, 2018). This is partly due to how such data are understood and recorded (Bretherton & Mayock, 2021). For example, women fleeing their home from domestic abuse are often characterised as victims of abuse rather than experiencing homelessness. Lone mothers with children experiencing homelessness are likely to be supported by social services under child protection teams. In both instances, their homelessness status may not be captured (Bretherton & Mayock 2021).

Furthermore, contrary to the legal definition, homelessness is often narrowly defined as rough sleeping or rooflessness in policy and statistics, which can skew the perception of homelessness towards men (Bretherton & Mayock, 2012; Groundswell, 2020a). In England in 2021, the annual rough sleeper count indicates a marked rise of rough sleeping with 2,440 people estimated to be sleeping rough, a 38% increase since 2010 (Department for Levelling Up, 2022b). Limited demographic information is collected in the count, for example ethnicity is not recorded. Of available data, 86% were aged 26 years or over. Most people sleeping rough are UK nationals (67%), 20 % EU nationals and 5 % of the total were from outside the EU and the UK (Department for Levelling Up, 2022b).

Of these visibly homeless people, only 13% were women (Department for Levelling Up, Housing and Communities, 2022b). This may be as the count focuses on visible rough sleeping (Homeless Link, 2018), whereas women hide themselves in disused buildings, hospitals, airports, buses or in other less visible places (Reeve et al., 2006). Women also disguise themselves as men for fear of their safety (Bachrach, 1992; Bretherton & Pleace, 2010; Spicer, 2017). The figures on women rough sleeping are therefore likely to be an underestimate (Bretherton & Mayock, 2021; Pleace, 2006; Reeve et al., 2006).

Most people who meet the UK legal definition of homelessness are not rough sleeping but are houseless; accommodated in emergency or temporary accommodation. The total number of households in temporary accommodation has increased by 74 percent between 2010 and 2018 (Marmot et al., 2020). On 30 September 2021, 96,060 households were in temporary accommodation (Department for Levelling Up, 2022a). A greater proportion of these people are believed to be women. Estimates in London, indicate 65% of adult occupants in temporary accommodation are women, with many of these households headed by single mothers (London Councils, 2022).

Local councils do not disaggregate the statutory homelessness data, which records those owed a prevention or relief duty, based on gender. However, other demographic information indicates those owed a prevention or relief duty by local authorities are disproportionately young with 55% under the age of 34 and only 9% over the age of 55. Data disaggregated based on ethnicity indicates white and Asian groups are underrepresented and black ethnic groups are overrepresented in the homelessness figures: 70% are white, 10% are black, 6% are Asian and 3% are from mixed ethnic groups (Department for Levelling Up, 2022c; ONS, 2019). For sexuality, a large proportion of people (23%) preferred not to say, with 69% identifying as “heterosexual”, 2.1% “homosexual”, 3% as “Other”. Such a high proportion of people declining to share their sexuality may indicate those with marginalised sexualities are over-represented in the data. People out of work due to unemployment or disability are also more likely to be owed a prevention or relief duty with 39% unemployed and 14% not working due to long term illness or disability. Many of these people are likely to be women experiencing intersecting needs, however as the data is not disaggregated in the statutory homelessness figures, the prevalence and nature of women’s homelessness is difficult to understand.

It can also be difficult to estimate the prevalence of women’s homelessness, as many women are part of the “hidden homeless” who may be sofa-surfing, staying with friends or family or remaining in abusive relationships to maintain housing. In England in 2017, 3.34 million adults were estimated to reside in these “concealed” households (Fitzpatrick et al., 2017; London Assembly Housing, 2017). Women will often exhaust all these informal housing options before seeking help from homelessness services or local authorities (Bretherton & Mayock, 2021; Homeless Link, 2021b; Pleace & Hermans, 2020; Reeve, 2018; Reeve et al., 2006). Women are therefore often not captured in local authority homelessness data (Shelter, 2012). Migrant women and families with NRPF are also likely to seek these informal housing arrangements due to limited housing options (Project 17, 2019).

These more invisible forms of homelessness became more visible during the COVID-19 pandemic. Following the introduction of COVID-19 lockdown measures in March 2020, local authorities saw an increase in people requesting housing support due to relationship breakdown or no longer being able to sofa-surf (Boobis & Albanese, 2021; Homeless Link, 2021a). Homelessness services also reported an increase in women fleeing domestic abuse and requiring housing support; however, many women also reported having nowhere to go during the pandemic and so remaining with the perpetrator (Davidge, 2020).

1.4. Homelessness UK Policy Development

Parties across the political divide have committed to reducing the prevalence of homelessness and improving support and care for those experiencing homelessness (Conservative and Unionist Party, 2019; The Labour Party, 2019). Relevant legislation and policies for the context of women's homelessness are outlined.

1.4.1. Homelessness Reduction Act, 2017

The current Conservative government has pledged to end rough sleeping within 5 years by enforcing the Homelessness Reduction Act 2017; considered to be the largest change in homelessness legislation since 1977 (Homeless Link, 2018). The Act came into effect in April 2018 and created two additional statutory rehousing duties for local authorities: the duty to prevent and duty to relieve homelessness. Public bodies, including NHS settings, have a statutory duty to identify those at risk of homelessness and, with consent, refer them for support. A recent review of the Act indicates some success at meeting its aims (Ministry of Housing, Communities and Local Government, 2020).

1.4.2. Rough Sleepers Initiative, 2018

The government has committed to expanding the Rough Sleepers Initiative (RSI). The RSI, first announced in March 2018, provides funds to local councils to reduce rising levels of rough sleeping. In 2021, £203 million was allocated under the initiative to fund projects in housing, mental health, addiction support and domestic abuse (Ministry of Housing Communities and Local Government, 2021). However, the RSI has been criticised for providing short term funding which makes it difficult for local authorities to offer meaningful services (Homeless Link, 2021e). More recent grants have been allocated for three years with the government encouraging local authorities to bid to use the funding for Housing First initiatives (Homeless Link, 2022).

1.4.3. Policies introduced during the COVID-19 Pandemic, 2020

During the initial months of the pandemic from March 2020, the government suspended evictions from private and social rented sectors which resulted in a drastic drop in the number of people presenting as homeless to local authorities (UK Collaborative Centre for Housing Evidence, 2021).The realignment of the local housing allowance rates to cover the bottom third of private rents and the implementation of the £20 a week universal credit uplift also reduced the number of people presenting as homeless (Homeless Link, 2021d).

The government launched the “Everyone In” initiative on the 26th of March 2020. The programme offered emergency and hotel accommodation to people at risk of rough sleeping or in accommodation unsuitable for self-isolation. Legal barriers for support, such as local connection or immigration status requirements, were removed. The scheme was set up to support an estimated 5,000 people, however, initial research suggests between 33,000- 37,000 people were housed (National Audit Office, 2021; Watts et al., 2022; Whitehead & Rotolo, 2021). Such figures highlight the extent of the “hidden homeless” population.

Third sector organisations have criticised the temporary nature of the COVID-19 measures and the increasing rough sleeping following their discontinuation, arguing the success of these policies indicate it is possible to end homelessness with political impetus (Homeless Link, 2021d).

1.4.4. Domestic Abuse Act, 2021

The recent Domestic Abuse Act 2021 has also shaped the political context for women experiencing homelessness. Following the implementation of the act, all eligible homeless victims of domestic abuse should automatically have priority need for homelessness assistance by local authorities (Home Office, 2022). Crisis (2020b) campaigned for this provision with the aim of reducing the number of women declared “intentionally homeless” and denied housing for leaving their perpetrator (Bimpson et al., 2021). The act also placed duties on local authorities to offer secure lifetime tenancies to women fleeing domestic abuse when offering social housing (Home Office, 2022). The act will be implemented across 2022 and its impact is yet to be evaluated.

1.4.5. The UK Government Drug Strategy, 2021

In December 2021, the government released its new drug strategy which outlines a 10-year plan to reduce illegal drug use (HM Government, 2021a). The government has committed an additional £780 million over three years to rebuild drug services with a focus on integration between substance misuse and mental health services. There is also recognition that trauma and mental health problems can underpin drug addiction, with an aim to make sure “trauma informed care becomes the norm” (p, 37). The strategy has been welcomed by homelessness charities, particularly recognising homelessness can be both a cause and a consequence of substance misuse (St Mungo’s 2021) and the emphasis on treatment over criminalisation (St Mungo’s 2021).

1.4.6. Immigration Policies

Immigration and Asylum Act 1999 states that a person subject to immigration control will have NRPF while subject to immigration control, which removes the entitlement to most welfare benefits – including housing and forms of free healthcare (London Councils, 2018). More recently, policies introduced as part of the “hostile environment” (Griffiths & Yeo, 2021; Worthing et al., 2021), such as the Immigration Acts of 2014 and 2016, have been critiqued for increasing homelessness and discriminating against people based on their race and nationality (Butler, 2018). Such policies have been associated with a reduction in trust in public services including racially minoritised groups accessing healthcare (JCWI, 2021; Worthing et al., 2021). Women experiencing homelessness of different nationalities are likely to be subject to such legislation.

1.4.7. Homelessness Health Policies

Health policy has also moved to address the needs of the homelessness population. The Five Year Forward View (NHS England, 2016) had no mention of homelessness and a cursory mention of the importance of affordable housing for health. In contrast, The NHS Long Term Plan (NHS, 2019a) seeks to address health inequalities and includes a commitment to spend up to £30 million on health services for people sleeping rough, with a particular focus on specialist outreach mental health services. In October 2019, the government announced the first wave of funding worth £12 million (NHS, 2019b) used to create new NHS mental health outreach teams to coordinate with existing outreach, drug and alcohol and other NHS services.

In addition, NICE (2022) have recently released guidance for integrated health and social care for people experiencing homelessness. The guidelines seek to address several barriers to healthcare experienced by the homeless. Recommendations include more flexibility with appointment times and discharge policies as well as using outreach services to ensure healthcare access in convenient locations such as on the street, in hostels or in day centres. These guidelines build on recommendations promoted by third sector organisations, including the Pathways Inclusion Health Standards (2018) which promote good practice standards for health services to support people experiencing homelessness.

1.5. Support Services for Women Experiencing Homelessness

Within the UK, homelessness services are often run by the third sector, although commissioned by local authorities or central government, and offer a range of housing and non-housing-based support (Pleace et al., 2018).

1.5.1. Housing First

Housing First Services give people their own home and intensive, unconditional support to maintain it (Housing First Europe, 2022). Housing First is focused on principles such as service-user choice and control and offering flexible support for as long as people need it, irrespective of behaviour (Housing First Europe, 2022). In the UK, Housing First provision is expanding, although remains regionally inconsistent and predominantly offered by the third sector, with just six female-only services in the UK (Pleace et al., 2018; Housing First England, 2020). Initial research in the US and UK suggest positive outcomes for Housing First for women, with reports of high rates of sustained housing and improvements in mental wellbeing (Bimpson, 2018; Sullivan et al., 2018; Quilgars & Pleace, 2017).

1.5.2. Temporary Homelessness Accommodation

In the UK, most homelessness services operate according to a “stair-case model” (Pleace et al.,2018; Tainio & Fredriksson, 2009). People are offered temporary accommodation, often in third sector hostels, and support to prove they are “housing ready” before being offered their own accommodation (Pleace et al., 2018). Women can be wary of accessing such support when it is mixed sex, particularly those with experiences of sexual violence (Bimpson et al., 2021; Bretherton & Mayock, 2021;

Mayock et al., 2015; Tutty et al., 2013). There is little research on the availability of women's homelessness services (Bretherton & Mayock, 2021); however initial research indicates around 7% of single person temporary homelessness accommodation services are for women only (Homeless Link, 2020), with large regional differences (Agenda & AVA, 2017a).

Domestic Abuse Refuges, often run by the third sector, provide significant temporary accommodation for women (McCarthy et al., 2022). This separation of homelessness and domestic abuse services means women with more complex needs such as mental health problems, substance misuse and domestic abuse, can struggle to access accommodation meeting their needs (Agenda & AVA, 2017a; Baker et al., 2010; Bretherton & Mayock, 2021).

1.5.3. Psychologically Informed Environments and Trauma Informed Care

Recently, homelessness services in the UK have focused on 'Psychologically Informed Environments' (PIEs) (Breedvelt, 2016; Johnson & Haigh, 2011; Pleace et al., 2018) or Trauma Informed Care (TIC) (Bimpson et al., 2021; Homeless Link, 2017). These approaches arise from the homelessness sector's increasing awareness of the impact of complex trauma. Many people experiencing homelessness have experienced violence and abuse across their lives as well as the trauma of losing their home and living in insecure and threatening situations (Goodman et al., 1991) Experiencing multiple traumatic events across childhood and adulthood can impact a person's ability to develop trusting relationships, to self-regulate their emotions, to control impulses, to think and to learn (Gerhardt, 2015; Herman, 2015; Van der Kolk, 2014). Research indicates people can recover from trauma and build the capacity to trust and develop self-regulation, within in the context of safe relationships (Herman, 2015; Van der Kolk, 2014).

Accommodation, often provided by the third sector, adopting PIE approaches focus on relationships and meeting the emotional, relational and psychological needs of people experiencing homelessness while trying to understand and work flexibly with behaviour (Johnson & Haigh, 2011; Keats et al.,2012). PIE approaches also support staff members through reflective practice to prevent burnout (Breedvelt, 2016; Keats et al., 2012), particularly important as hostel workers often report feeling low in confidence in supporting people with trauma and mental health problems (Burke, 2005; Devine & Bergin, 2020). Initial research in refuges settings indicate PIE approaches improve staff wellbeing and women feel more supported (Ava & Solace Women's Aid, 2018).

Services adopting TIC aim to recognise trauma to promote recovery and avoid retraumatisation (Bimpson et al., 2021; SAMHSA, 2014; Sullivan et al., 2018). Services emphasise person-centred care over predefined protocols or procedures (Wilton & Williams, 2019). More recently, there is a recognition that women experience a different form of trauma to men, often more interpersonal in nature, and so may need services designed to consider the gendered trauma they have experienced rather than gender-neutral services (Agenda & AVA, 2017; Bimpson et al., 2021; Milaney et al., 2020).

1.6. Understanding the Nature of Women's Homelessness

1.6.1. Experiences of Abuse and Trauma among Women

The nature of women's homelessness has been widely reported to differ to men's (Milaney et al., 2020). Women experiencing homelessness report high levels of abuse and victimisation leading up to and during their time as homeless (Huey et al., 2014; Lewinson et al., 2014). The role of domestic abuse in the cause of homelessness has already been elucidated; however, for many women interpersonal violence and coercive controlling relationships remain prevalent during their experiences of homelessness. Women sleeping rough may enter abusive intimate relationships for protection, despite the controlling or exploitative nature of such relationships (Simon on the Street, 2018; Watson, 2011).

Women experiencing homelessness are also more likely than men to experience significant sexual violence. This includes experiences of childhood sexual violence including childhood rape (Weinrich et al., 2016; Duke & Searby, 2019) with it being more likely this abuse was perpetrated by someone they know (Upshur et al., 2017). Sexual violence is also a feature of women's time while homeless. Women sleeping rough can experience high levels of rape, sexual violence, and physical abuse (Christensen et al., 2005; Kushel et al., 2003). Women experiencing sofa-surfing or other forms of houselessness may remain off the streets by engaging in intimate or sexual relationships with men; often described as “survival sex” (Bhui et al., 2006; Watson, 2011). Low or free rent or accommodation in exchange for sex is a growing problem for vulnerable women across the UK (Jones, 2018; Safe Lives, 2018).

1.6.2. Experiences with the Criminal Justice System

Many women who are roofless or accessing homelessness hostel accommodation have experiences of the criminal justice system. Nearly half of the women St Mungo’s (2014) support have an offending history and over a third have been in prison. Many women do not have access to accommodation before prison and over half of women have no permanent home on release (Prison Reform Trust, 2018). Most women are released into temporary accommodation, with over a tenth released to no fixed abode (HM Inspectorate of Probation and HM Inspectorate of Prisons, 2016). As people from racially minoritised backgrounds are overrepresented in prison populations (Ministry of Justice, 2021; Sturge, 2021), release from prison to no fixed abode is likely to disproportionately affect racially minoritised women.

1.6.3. Experiences with the Child Protection Services

Women experiencing homelessness are also more likely to have had contact with social care, or child protection services, both as children and as adults. Young women with experiences of being looked after by social care are at a heightened risk of becoming homeless as a young person (Schwan et al., 2018). A high proportion of women experiencing homelessness are also likely to experience their own children being removed (Bimpson et al., 2021).

While many women are single and homeless, a large proportion of women accessing single homelessness services are mothers who have been forcibly removed from their children; either by the state or due to women placing children with relatives to remain housed (Groundswell, 2020a; Pleace et al., 2016; Safe Lives, 2018). Amongst St Mungo’s female clients, 46% are mothers, 79% of whom have had their children taken into care or adopted (St Mungo’s, 2017b).

Intervention rates among ethnicity form a complex picture in the UK with ‘White British’ children more than ten times more likely and ‘Black Caribbean’ children 20 times more likely to be in care than ‘Asian Indian’ children (Bywaters et al, 2018). The reasons for these different rates of intervention are unclear and exist even when controlling for poverty and social deprivation which are important factors in homelessness and child removal by social care. Women experiencing homelessness from different ethnicities are therefore likely to experience intervention from child protection services differently.

Many women experience significant distress when their children are taken into care and can struggle to be reunited (Groundswell, 2020a, St Mungo’s, 2017b). Women can be expected to cope with this loss with little emotional support and services often do not understand the trauma that develops from separation from children (St Mungo’s 2017). Many women in prison are mothers, and unstable housing conditions can make it more difficult for women to have access to their children, with many children remaining in foster care following their mother’s release (St Mungo’s, 2014).

1.6.4. Experiences of Physical Health Problems

Many women experiencing homelessness can also experience health problems. Speirs and colleagues (2013) review of the literature highlighted health challenges women face, such as poor nutrition, exposure to the elements and low immunity, alongside increased risk of sexually transmitted diseases, respiratory illnesses, gynaecological infections, hypertension, and diabetes. Groundswell’s (2020a) research with women accessing day centres, hostels and drop-in centres in London found over 70% experienced physical health problems including joint and muscle problems, blood conditions and problems with feet. Women described their health being impacted by their living situations, which exacerbated existing conditions.

1.6.5. Experiences of Mental Health Problems

Studies indicate mental health problems are common among women experiencing homelessness and they are disproportionally affected compared to women who are not homeless (Duke & Searby, 2019; Welch-Lazortitz et al., 2015). In Bassuk and colleagues (1998) study, homeless women were 2.5 times more likely than the general female population to meet criteria for major depressive episode and three times more likely to meet criteria for PTSD. Women are also more likely to experience mental health problems compared to men experiencing homelessness (Chondraki et al., 2014; Jainchill et al., 2000; Lee et al., 2010). In Chondraki and colleagues (2014) study, 55.8% of homeless males and 59.1% of females were identified as suffering from DSM-IV conditions. Women experience a range of mental health problems, including suicidal ideation and suicide attempts resulting in hospitalisations (Bassuk et al., 1996; Spicer, 2017). Research suggests women experiencing homelessness are more likely to be diagnosed with mood, affective and personality disorders, whereas men are more likely to be diagnosed with schizophrenia or psychosis (Hamid et al., 2000; Lauber et al., 2006). A study conducted in the US with self-reported measures found high rates of women experiencing homelessness meeting screening criteria for depression (69%), PTSD (45%), bipolar disorder (32%), and psychosis (23%) (Upshur et al., 2017).

Mental health problems are also often experienced alongside substance misuse among women experiencing homelessness (Chambers et al., 2014; Duke & Searby, 2019; Strehlau et al., 2012), often referred to as “dual diagnosis” (NICE, 2016). In Chambers and colleagues’ (2014) sample of women recruited from homelessness shelters, 18% were considered to have concurrent mental health and substance misuse problems. However, research with men and women experiencing homelessness indicates alcohol and drug use is viewed ambivalently, with many seeing it as a coping mechanism to manage mental health problems and the stress of homelessness (Christiani et al., 2008; Patterson et al., 2015). In a Groundswell study (2020a) women reported using drugs and alcohol to cope with children being removed.

Studies have started to connect higher rates of mental health problems and substance misuse in women, to the greater degree of abuse, violence, and trauma women experience (Bimpson et al., 2021; Rayburn et al., 2005; McCarthy et al., 2022). Depression among women experiencing homelessness has been associated with rape within the last year (Arangua et al., 2006), interpersonal violence (Vijayaraghavan et al., 2012), childhood sexual abuse, living in a shelter, experiencing physical violence, childhood physical abuse and the death or injury of a close one (Rayburn et al., 2005). Duke and Searby (2019) in their review of the literature, also highlighted the high prevalence of domestic abuse and subsequent psychological distress women experience. There appears to be a strong relationship between homelessness, trauma, and mental health problems.

1.7. Current Provision of Mental Healthcare for Women Experiencing Homelessness

Mental health provision for women experiencing homelessness is often provided by generic health services, including primary care services such as GPs and secondary mental healthcare services such as CMHTs. There are limited numbers of specialist homelessness GP and primary healthcare services: one mapping exercise noted 123 services, however these are inconsistently spread across England (Crane et al., 2018).

1.7.1. Specialist Homelessness Mental Health Services

The provision of specialist NHS homelessness mental health services is also regionally inconsistent, and teams experience inconsistent budgets (Campbell, 2018). These services often comprise of nurses and social workers rather than psychiatrists or psychologists and are less likely to offer psychotherapy compared to generic mental health teams; although, the services are more likely to offer street outreach or hostel “in reach” (Canavan et al., 2011). Stakeholders have argued these outreach mental health services focus on single people rather than homeless families, often headed by single women; despite research indicating services developed for families can be helpful for parental and child wellbeing (Tischler et al., 2002). Services have also been criticised for offering uniform care to men and women (Agenda & AVA, 2017). The NHS Long Term Plan (NHS, 2019a) places a focus on developing such specialist services. However, services for women experiencing homelessness are not targeted explicitly within the plan and. the impact remains to be evaluated.

1.7.2. Psychology in Hostels

Another form of mental health support available is psychology or counselling services offered within third sector hostels. Some of these services are funded by third sector organisations or the third sector hostels themselves, such as the Lifeworks psychotherapy project offered by St Mungo’s (2011). An increasing number of NHS services are also working with third sector partners on “Psychology in Hostels” programmes, following a successful pilot in Lambeth funded by Guys and St Thomas’ Charity in partnership with South London and Maudsley NHS Trust (Rhodes, 2016). In these projects, psychologists are based in hostels offering clinical interventions, reflective practice as well facilitating the development of PIEs.

1.8. Barriers to Mental Healthcare

Despite the need for mental healthcare, people experiencing homelessness have difficulty accessing the mental health support they need (Hodgson et al., 2014; Homelessness Link, 2014; St Mungo’s, 2016a; Strehlau et al.,2012). In Hodgson and colleagues’ (2014) UK Study, 90 young people experiencing homelessness were interviewed, with nearly 90% meeting the criteria for a mental health diagnosis, while just over 30% had accessed any form of mental health services. Much of the international research exploring barriers and facilitators to mental healthcare among the homeless population has been done with mixed-gender populations which will be discussed below.

1.8.1. Service-Related Barriers and Facilitators

Service-related barriers speak to the structure or design of mental healthcare services. The waiting lists to access mental health support are often cited as a reason it can be difficult to access services quickly when needed (Bhui et al., 2006; Brown et al., 2016; Youn et al., 2019; St Mungo’s, 2016). Devin and Bergin (2020) and St Mungo’s (2016), in their research capturing frontline worker perspectives, suggest people experiencing homelessness often use A&E or emergency services when experiencing mental health problems, rather than accessing preventative support.

The reliance on GPs for accessing services has also been considered a barrier to access for people experiencing homelessness in research in the UK. GPs are often needed to refer to secondary mental health teams, however studies conducted with people experiencing homelessness or frontline service providers, indicate many people are not registered with their GP, so consequently struggle to access mental health support (Bhui et al., 2006; Canavan, 2011; Gunner et al., 2019). Many services request a fixed address or ID which some people experiencing homelessness cannot provide, and are thus excluded from the services (Groundswell, 2020a; St Mungo’s, 2016). People experiencing homelessness can feel GPs are too busy, do not have the time to talk to them about their needs, do not understand health needs of people experiencing homelessness or can gatekeep access to secondary mental healthcare by refusing to refer onwards (Bhui et al., 2006; Gunner et al., 2019). Specialist homelessness GPs are valued (Bhui et al., 2006; Gunner et al., 2019) particularly if offering integrated mental healthcare (Bhui et al., 2006).

In research in countries across the Anglosphere, many people experiencing homelessness are unaware of available mental healthcare or how to go about accessing support (Brown et al., 2016; Hamilton et al, 2012; Martin & Howe, 2016). However, when professionals, for example GPs and homelessness services are aware of such services, they can facilitate access (Gunner et al., 2019; Kerman et al., 2019). It can also enhance access when services are well advertised and assertive in promoting themselves among the homeless population and services (Dixon & Lloyd, 2005).

A further service-related mental healthcare barrier is services excluding people who are homeless. Mental health services can be seen to have very inflexible entry criteria for who is seen within the service, which often excludes people with multiple complex needs (Youn et al., 2019). Studies in the UK conducted with service providers or people experiencing homelessness, indicate mental health services can often exclude those experiencing homelessness due to the complexity of their circumstances, particularly around housing, or when people present with high rates of self-harm or drug use (Canavan et al., 2011; Groundswell., 2020a; Gunner et al., 2019; St Mungo’s 2016; St Mungo’s, 2020). People are often informed they cannot receive support for their mental health until they have a house or are no longer using substances creating a “catch-22” (Groundswell, 2020a; Gunner et al., 2019; St Mungo’s, 2020).

Studies across Europe (including the UK) capturing front line service provider perspectives, also indicate treatment provision is insufficient for this population. People experiencing homelessness often have more limited treatment options from mental health services which often focus on medication use, rather than other forms of preferable support such as psychotherapy (Devine & Bergin, 2020; St Mungo's 2016b). This is further supported by evidence suggesting specialist mental health services do not provide psychotherapy as often as generic mental health services (Canavan et al., 2011).

The location and times of available support also appear to be unsuitable for people experiencing homelessness. Research in the US and Europe, capturing people experiencing homelessness' or frontline service provider's perspectives, indicate services are often hospital or clinic based and operating during working hours which likely excludes people experiencing homelessness who may need more flexible opening times (Canavan et al., 2011; Commander et al., 1997; Hauff et al., 2014; Omerov et al., 2020). People can also have difficulty paying for transport to access mental health services for appointments held in hospitals or clinics (Gunner et al., 2019; Martin & Howe, 2016). Offering transport assistance can facilitate engagement with services (Brown et al., 206; Youn et al., 2019). On the available evidence, flexible services which offer drop-in options rather than appointment times are helpful for facilitating access to mental health support (Brown et al., 2016) as well as outreach services operating in hostels or in community locations (Brown et al., 2016; Canavan et al., 2011).

Previous studies also suggest people experiencing homelessness have a complexity of needs, particularly around trauma, substance misuse, mental health and housing which require specialist teams, of which there are not enough in the UK (Bhui et al., 2006; Reid & Klee, 1999). Alongside this, some studies in Australia and the US respectively have recommended that even within homelessness services, there should be specialist provision for certain demographics such as younger people, and specifically women who may not feel comfortable attending mixed sex spaces (Brown et al., 2016; Hamilton et al., 2012).

Current research in the UK and US, capturing people experiencing homelessness' or service-provider perspectives, also indicate mental health services do not coordinate or communicate sufficiently with other services to meet the varied needs of the clients (Brown et al., 2016; Gunner et al., 2019; Youn et al., 2019; St Mungo's 2016). Canavan and colleagues (2011) study interviewed experts in the homelessness sector in cities across Europe and their research indicated a particular lack of coordination among homelessness mental health and social welfare services. In Ireland, Devine and Bergin (2020) also interviewed frontline homelessness service-providers. Participants in this study felt there was a lack of inter-agency work in supporting people experiencing homelessness with their mental health, often characterised by staff not having the contact details for mental health teams and struggling to contact them to share important information (Devine & Bergin, 2020). Devine and Bergin's (2020) study also indicated the service-providers felt they could not support people adequately with mental health and wanted more communication, training, and support from mental health teams to do so.

Supporting these findings, in studies in Ireland and the US, capturing service-provider or people experiencing homelessness' perspectives, mental health services with good connections to other services involved in a person's care can be useful at facilitating access and providing integrated mental health support (Devine et al., 2020; Hamilton et al., 2012). Third sector providers have advocated for a specialist homelessness case management model among mental health services, with someone to communicate and coordinate different services (Devine & Bergin., 2020). In European research, multidisciplinary specialist homelessness mental health teams have also been promoted to collaborate with other homelessness services (Canavan et al., 2011).

1.8.2. Practical, Personal and Psychosocial Barriers

There are also several practical barriers preventing people experiencing homelessness from accessing mental health services, including poverty. One of the most frequent barriers identified in UK and international research is people prioritising meeting basic needs of food and shelter over mental health services (Bhui et al., 2006; Martin & Howe., 2016; Youn et al., 2019). The focus on other needs can mean people struggle to arrange and stick to appointments (Brown et al., 2016). There can also be difficulties accessing phones to communicate with services (Bhui et a., 2006; Omerov et al., 2020).

People who are homeless also cite personal and psychosocial factors making it difficult to engage with mental health services. In international research, including in the UK, people report high levels of stigma around having mental health problems (Bhui et al., 2006; Brown et al., 2016; Chaturvedi, 2016; Youn et al., 2019; Canavan et al., 2011) which contributes to people finding it difficult to ask for help and feeling ashamed of doing so (Collins & Barker., 2009; Martin & Howe., 2016). Consequently, people experiencing homelessness can deny needing support for mental health problems and can be resistant to opening up about their difficulties (Chaturvedi et a., 2016; Collins & Barker, 2009; Martin & Howe., 2016; Reid & Klee, 1999). People experiencing homelessness have also reported they do not value mental health services, or do not understand what benefit they would provide them (Bhui et al., 2006; Brown et al., 2016; Youn et al., 2019; Martin &Howe, 2016). People experiencing homelessness may instead choose to rely on informal support among those they know (Brown et al., 2016).

A large range of studies, across countries and capturing service provider or people experiencing homelessness perspectives, suggest there are high levels of distrust among people experiencing homeless and mental health professionals (Bhui et al., 2006; Brown et al., 2006; Canavan et al., 2011; Collins & Barker, 2009). This may be in part due to the fear of additional trauma by engaging with mental health services and speaking about difficult experiences (Ponce et al., 2014). It may also be due to people previously having negative past experiences with mental health services and so being unwilling to trust mental health professionals not to harm them in the future (Brown et al., 2016; Chaturvedi., 2016; St Mungo's 2016). In Devine and Begin's study (2020), service-providers spoke about people experiencing homelessness often being discharged rapidly from mental health services and feeling abandoned, contributing to feelings of distrust.

In contrast, relationship-building with service-users by demonstrating respect, consistency, and patience (Canavan et al., 2011; Chaturvedi., 2016) as well as normalising the use of psychological therapy (Chaturvedi, 2016) have been highlighted as facilitators for accessing mental health support.

1.8.3. Impact of COVID on barriers

The COVID-19 pandemic resulted in a dramatic shift in mental healthcare service provision. Many mental health services moved to offering online support; however, people experiencing homelessness can have difficulties accessing digital healthcare due to poor literacy skills, privacy problems and limited access to technology (Dorney-Smith & Gill, 2021; FEANTSA, 2021; Groundswell, 2020b).

Initial research in the UK indicates the COVID-19 pandemic resulted in increased difficulties for people experiencing homelessness in accessing mental health support (Groundswell, 2020c; Lenhard et al., 2021). Digital provision may have reduced engagement with services as mental health professionals have struggled to connect with people experiencing homelessness over phone or video calls (Lenhard et al., 2021). Virtual groupwork has also been viewed negatively by people experiencing homelessness (Lenhard et al., 2021).

Adams and colleagues (2022) explored the experiences of access to community based mental health and substance use support for people experiencing homelessness during the COVID-19 pandemic Qualitative telephone interviews were conducted with 10 women and 16 men (ages 25 to 71) who self-identified as experiencing homelessness in North East England between February and May 2021. Findings indicated COVID was a barrier to access due to increasing digital exclusion, increasing feelings of uncertainty, and reducing choice. Facilitators recommended by the research included peer support, opportunities for choice and empowerment and trauma informed care.

Other UK studies suggest the pandemic has resulted in cancelled appointments and even longer waiting lists (Groundswell, 2020c). However, further research is needed to consider how the pandemic has impacted mental healthcare access for people experiencing homelessness.

1.9. Scoping Review

The previous research identified has focused on people experiencing homelessness more generally rather than women specifically. However, as has been discussed, the causes and experience of homelessness differs for women and men (Bretherton & Mayock, 2021). Women experience more “invisible” forms of homelessness, more interpersonal violence and different forms of mental health problems compared to men experiencing homelessness (Bretherton & Mayock, 2021; Chondraki et al., 2014; Jainchill et al., 2000; Lee et al., 2010). Given the increasing interest in women’s homelessness and arguments women's homelessness should be studied in its own right (Bretherton & Mayock, 2021), a scoping review of the literature (Arksey & O'Malley, 2007) was conducted to understand the barriers and facilitators women experiencing homelessness face when accessing mental health services (Appendix A). A scoping review aims to offer a methodological approach to reviewing the literature to identify types of evidence within a field and to identify gaps in knowledge (Munn et al., 2018).

International databases SCOPUS, PsycInfo, Academic Search Complete and CINAHL were searched with the terms "mental health" AND "homelessness" AND "women" AND "barriers" OR "facilitators." A total of 178 articles were identified across the databases. The titles were reviewed and excluded if they were not relevant to identifying the barriers or facilitators to mental healthcare access among the homeless population, not in English, not focused on an adult population, not published within the last 15 years, not focused on mental healthcare and not a published research study. Key third sector websites were reviewed such as Crisis, St Mungo's, Shelter, Homeless Link, Groundswell and Women's Aid and a further study was identified. Twenty articles were reviewed, and five articles were identified as relevant for the scoping review. Three were conducted in the US, one in Sweden and one in the UK. The studies have been presented in publication date order.

1.9.1. Huey, Broll, Hryniewicz and Fthenos (2014)

As part of a wider US-based study exploring the barriers criminally victimised women experiencing homelessness face in accessing services post-victimisation, the study's focus was to understand whether being asked about violence facilitates access to services, including counselling services, and whether not being asked hinders access to services and how this impacts homeless women. The study explored wider barriers and facilitators to service access.

Huey and colleagues conducted 42 exploratory interviews with women experiencing homelessness in Chicago and Detroit. Of the 42 women most were African American (n= 37), followed by white (n = 3). The most frequently occurring age group were those in the 18–30 years category (n =17). Most frequently, women in the sample had been homeless for a period of 1 month to 1 year (n=18). Data were analysed using Braun & Clarke's (2006) thematic analysis.

Findings indicated women experienced significant interpersonal violence including most women reporting physical assault by partner, physical assaults in childhood and childhood sexual abuse. A large proportion of the sample also experienced sexual assault in adulthood.

The study also indicated many barriers to services for women including a lack of financial means such as not having health insurance or being able to access transportation. Some shelters did provide women with transport to access services, but not all. Women also described not having the flexibility to schedule appointments and having work demands to prioritise. A further barrier identified was the lack of knowledge about available services, particularly around the counselling services available to women. Some women also described childcare was an issue and many described the US department of Child and Family Services involvement meant that they were unable to attend other appointments due to needing to prioritise the children's service appointments. Women also described it as a barrier having male workers, as they wanted to have people they could speak to about traumas and emotional problems which they felt they could not do with men. The study also identified it as a barrier that shelter staff did not ask about women's experiences of victimisation so could not refer them on to appropriate mental and physical healthcare.

Huey and colleagues study explored women who have experienced victimisation and focused on mental and physical healthcare needed because of this. It therefore may exclude wider mental health care needs of women experiencing homelessness beyond victimisation. The study also explored access to physical and mental healthcare, so barriers specific to mental healthcare may be overlooked.

Huey's and colleagues research is also based in the US which has a different healthcare system funded by private insurance, compared to the publicly funded NHS in the UK. Barriers identified, particularly around funding and geography, are therefore likely to be different. Furthermore, this study was conducted in 2014, before the COVID-19 pandemic, which has resulted in significant changes in service-provision.

1.9.2. David, Rowe, Staeheli and Ponce (2015)

In this US based study, David and colleagues reviewed a five year federally funded project, The Community Living Room, to determine how to facilitate mental health service delivery for women who are homelessness with mental health problems. The project employed eight peer mentors at several drop-in centres to provide outreach, engagement, and interpersonal support. Over 300 adult women who were homeless or at risk of homelessness and were diagnosed with substance use or comorbid substance use, and mental illness were supported. The project used mixed methods to evaluate the programme with clients, staff and peer mentors including collecting quantitative outcome data and qualitative interview and focus group data.

Findings indicated four principles which facilitated access to mental health care for women: *1. Peer support* was valued as having someone who has "been there" and through similar experiences to the women. Peer mentors were also valued for spending time with women in less traditional activities, such as attending hearings with children's services, joining family reunions or going shopping or socialising. Staff members engaging in open and honest dialogues were seen as better able to build trust with women and engage women in the services they offered. *2. Flexible Services and Resources* described as assertive mental health outreach was seen as a facilitator for connecting with women. Outreach and meeting women in shelters, or on the streets with meetings seen to focus on develop trust and highlighting strengths to then engage women gradually in other forms of treatment. Services able to work flexibly with women's diverse backgrounds including culture, experience, diagnosis, substance abuse, trauma, and education were also valued. Flexibility in scheduling was also important and not discharging women when they had missed appointments. Flexible therapy was also important, with less structured approaches and not enforcing time dependent options. The drop in centre aspect of the programme was valued as and when the service was needed.

The third subtheme indicates that *Supportive program leadership* was valued through fostering a partnership among community agencies and organisations including homeless shelters, mental health services and community organisations through regular meetings and dialogue. David and colleagues also noted that it was useful to provide staff members working with women to have a voice in shaping service provision to improve service delivery. 4*. Gender-sensitive services provided by women* indicated that experiences of sexual trauma impact how women engage with mental health services. Women reported that being surrounded by all women was important to be able to feel safe enough to address their needs.

A strength of David and colleague's study is that it proposes what can facilitate women accessing mental healthcare. The study also captured the views of women experiencing homelessness as well as service-providers.

However, the study does not clearly outline the method for how its principles for working with women were elucidated and how the interviews were analysed. The study is also an evaluation of a pilot programme in the US and so does not outline the barriers women experience when attempting to access wider mental health support. It is also a US based study and was conducted prior to the COVID-19 pandemic.

1.9.3 Groundswell (2020a).

Groundswell 's (2020a) study aimed to find out more about the health conditions women experiencing homelessness face. A mix methodology was used including 77 survey-based interviews and three focus groups with women experiencing, or with a history of, homelessness. Women were recruited from a range of services across London including day centres, drop-in centres and hostels. Peer researchers, with an experience of homelessness, ran the project.

Findings indicated women experienced mental health and physical health problems and struggled to access appropriate healthcare. Many women accessed support via emergency services, with participants using an ambulance for physical health issues (53%), mental health problems (33%) and self-harm/attempted suicide (27%). While most women were registered with a GP (81%) 17% of participants had been refused registration by a GP.

Participants described personal reasons as barriers to healthcare with a lack of motivation, exhaustion, poor health, stress and a lack of self-worth as barriers to engaging with healthcare services. The study also identified that there were structural and practical barriers to accessing healthcare; not having money to get to appointments, inflexible appointments, being refused registration and a lack of support to get to appointments. Participants also described “catch 22s” in accessing mental healthcare, particularly being denied support due to having a lack of housing or substance misuse problems.

A key strength of this research is the focus on participatory methods, with peer researchers leading the project. The research also draws across mental health and physical healthcare and is not focused on mental healthcare specifically – so barriers to mental healthcare may neglected. Furthermore, by focussing on London, the experiences of barriers and facilitators outside of the capital may be missed. The research was collected in 2019, prior to the COVID-19 pandemic.

1.9.4. La Mar, Mizock, Veazey and Nelson (2021)

In the US based study, La Mar and Colleagues study explore the mental healthcare barriers and facilitators experienced by women experiencing homelessness with serious mental health problems.

Qualitative interviews were conducted with thirteen women experiencing homelessness recruited from a homelessness shelter. Women identified across a range of racial backgrounds including three black, four white, four women of mixed race, and two Latino/Hispanic women all identifying as having “serious mental illness”. A grounded theory methodology was used to analyse the interviews.

The study identified eight themes. *Needing VIP status* captured women’s views that they were seen as less worthy of healthcare by practitioners due to not being able to access resources such as money and insurance to access support. *Feeling Broken* describes the internal obstacles to receiving mental healthcare and how the reason for needing mental healthcare can act as a barrier to support including negative emotions about the self. *Long road to care* describes women feeling they need to engage with mental healthcare for a long period of time to be able to receive any benefits from it. *Soaring above rock bottom* captured how participants felt a sense of happiness after they had received mental healthcare and how love and trust in oneself resulted in increased ability to utilise mental health services. *Whole Package of Care* identified how participants valued having services that meet multiple needs within one place within an integrated service setting. *Care that feels like home* identified how it was important for women to feel that the mental healthcare facility was welcoming and comfortable.

While this study explored both barriers and facilitators specially to mental healthcare access, this study is based in the US and also does not explore the influence of COVID-19 on barriers and facilitators to mental healthcare.

1.9.5. Kneck, Mattssona, Salzmann-Eriksonc and Klararea (2021)

Kneck and colleagues conducted their study as they argued more evidence was needed in Europe to understand the accessibility of healthcare services among women experiencing homelessness. The study aimed to gain women's perspectives on experiences of seeking healthcare and included experiences of women seeking mental health support such as medication or counselling.

Data collection took place in a primary healthcare centre in Stockholm, Sweden and 26 women with experience of homelessness were interviewed. Their median age was 46 years (range 42) and 70% were roofless/houseless.

The study prioritised co-production with the use of a Women's Advisory Board for Inclusion Health of women with lived experience who were involved in study design and data analysis. Data were analysed using content analysis.

Findings resulted in one overall theme: *Visiting healthcare from the outskirts of society* comprising three sub-themes:

Demand for a life in order -Exclusion in Action detailed how women described healthcare services coming with conditions and how women needed to adapt to and conform to policies and structures within healthcare services, rather than services adapting to their needs. These included requirements such as ID cards, a fixed address, the use of a telephone. The fixed office hours were seen as a problem, especially for women who were sex working so may struggle with morning appointments. Women described they were dismissed and denied care if they did not meet such conditions.

Women discussed wanting drop-in clinics in the evenings and outreach services specifically targeted at women experiencing homelessness. the women described that healthcare services contributed to making unreasonable demands on the women seeking care.

Unwell, unsafe and a woman - Multifaceted needs challenge healthcare detailed how women felt their multiple complex needs were invisible to healthcare services which were serving the average citizen needs, not theirs. Women described healthcare not being a priority due to needing to survive homelessness. Women also described healthcare needs needing to be addressed differently to men, for example due to the result of male violence. There was a sense of being seen as an outsider in health services and judged and then denied services, for example being denied mental health support due to substance misuse. Women also described the lack of continuity of care as a problem as they needed to repeat their history, often to healthcare professionals who were ignorant about the realities of homelessness.

Abuse versus humanity – power of healthcare encounters to reduce or elevate, the third subtheme, captures women's avoidance of healthcare services due to feelings of shame, stigma and being treated with a lack of respect and experiencing abuse from healthcare professionals. Women described strong patient-professional relationships in healthcare as important for good quality care. Women described being denied care due to healthcare professionals perceiving they had substance misuse disorders. Women described healthcare professionals as uncaring and abusive. Services specially designed of homeless people were valued and seen as more compassionate spaces, where women were listened to and felt there were people who cared. When good care was provided, women described services providing respite from the harsh realities of homelessness.

Kneck and colleagues' study was conducted looking at broader health services, including mental health services, and so barriers more specific to mental health services may have been obscured within the analysis.

The study is also conducted within Sweden which has a different healthcare system compared to the UK's NHS service, which may result in different barriers and facilitators to care. The interviews were also conducted before the COVID-19 pandemic and so the circumstances and barriers facing women are likely to be different following the change in lifestyles and service provision post-pandemic.

1.10. Research Rationale

Apart from the Groundswell (2020) study, the previous studies identified in the scoping review have been conducted internationally, suggesting a gap to explore the barriers and facilitators women experiencing homelessness face when accessing mental health care in the UK. Healthcare is devolved in the UK, and NHS England operates differently to other parts of the UK indicating a study focussing on England would be appropriate. The Groundswell (2020a) study was conducted within London, however women experiencing homelessness in other parts of England may experience different barriers to mental healthcare. This study will therefore seek to explore barriers and facilitators to healthcare for women experiencing homelessness from across different parts of England.

All of the studies identified within the scoping review were conducted prior to the COVID-19 pandemic. The pandemic has influenced the context of women's homelessness (Davidge, 2020) and the provision of mental healthcare (Groundswell, 2020b). This study therefore seeks to explore the barriers to women's mental healthcare considering the changes initiated by the COVID-19 pandemic.

The studies identified in the scoping review, apart from David and colleagues (2015), have also been from the perspective of women experiencing homelessness, which is an important area of research. However, previous mixed-gendered literature has sought to explore barriers and facilitators from the perspective of service-providers, often third sector organisations or experts in the field (Black et al., 2018; Canavan et al., 2011; Devine & Bergin, 2020; Hauff et al., 2014; St Mungo's 2016). In this mixed-gender research, service providers have offered a helpful perspective due to the frontline nature of the service-provider work, and the relationships built with people experiencing homelessness. Service-providers have been able to identify both personal barriers to healthcare and more systemic and structural barriers and facilitators to healthcare due to partnership working with healthcare services.

Within England, national and local third sector organisations offer significant support to people experiencing homelessness. Many women may be accessing third sector support, but not NHS support. These organisations refer to GPs and specialist homelessness NHS services as well as working alongside NHS mental health services. Third sector service providers are therefore in a position to understand the barriers, and to notice what works well and facilitates, women accessing NHS mental healthcare. This study will therefore gain the perspective of third sector service providers on the barriers and facilitators facing women.

1.11. Research Questions

This study seeks to understand what helps and hinders women experiencing homelessness from accessing the NHS mental health support they need from a feminist perspective. This study will focus on England due to the devolved nature of UK health policy and explore third sector service-provider perspectives.

This research seeks to address the following questions:

- What are the barriers and facilitators to accessing mental healthcare for women experiencing homelessness?
- How has COVID-19 impacted women experiencing homelessness accessing mental healthcare?

CHAPTER TWO: METHODOLOGY

This chapter will discuss the methodology of the study including the ontological and epistemological position, the methods of data collection and data analysis. Ethical and quality considerations will be discussed. The relationship to the research will also be addressed.

2.1. Ontology and Epistemology

There should be consistency between the ontology, epistemology, and methodology of the research (Levitt et al., 2017) and such positions should be named explicitly (Madill et al., 2000). The researcher approached this thesis project from a critical realist perspective (Archer et al., 2016). Ontologically, critical realism adopts a realist perspective: an authentic, knowable reality exists independent of the researcher (Braun & Clarke, 2013). Epistemologically, critical realism adopts a relativist position in recognising the researcher and study participants make judgements influenced by and located within their social milieu (Archer et al., 2016; Pilgrim, 2014). Thus, while there is one reality, there can be different perspectives of it (Maxwell, 2012; Willig, 2009). Service-providers' perspectives are likely to have been influenced by their own experiences, the social context and methodological process and may not reflect the "true" barriers and facilitators women experiencing homelessness face in accessing mental healthcare.

From a critical realist perspective, the researcher is engaged in knowledge creation, rather than holding a neutral position (Robson, 2002). The researcher's own understanding will influence the research process, analysis, and overall findings of the research. The researcher therefore engaged in personal reflexivity (Wilkinson, 1988) – using a research journal - throughout the research process to consider how her own assumptions, thoughts and background have shaped the research (Nowell et al., 2017).

Critical Realism goes beyond "naive" realism by seeking to look for explanations within underlying psychological and social structures to further understand the focus of research (Willig, 2019). This study recognises the phenomenon studied – homelessness and barriers and facilitators to mental healthcare – exist within the present historical, cultural, political, and economic context. Government policies, for example are important to consider when understanding this phenomenon. The critical lens of critical realism means the researcher drew on these wider contextual factors to understand the barriers and facilitators to mental healthcare access.

2.2. Rationale for Thematic Analysis

The researcher adopted a qualitative approach for this initial research (Flick, 2009) into the barriers and facilitators to mental healthcare for women experiencing homelessness. An experiential qualitative approach prioritised the service-provider perspectives and therefore the researcher's prior understanding did not limit data collection (Braun & Clarke, 2013).

The researcher analysed data using Reflexive Thematic Analysis (TA) as it is theoretically flexible (Braun & Clarke, 2021a) and compatible with a critical realist epistemology. Through TA, patterns of meaning can be linked with broader social and psychological phenomenon allowing for data analysis beyond the level of qualitative description (Braun & Clarke, 2006; Braun & Clarke, 2013). TA within an experiential framework is accessible to the public (Braun & Clarke, 2022) and is considered appropriate when there is a need for the research to have implications for practice (Braun & Clarke, 2021a; Sandelowski & Leeman, 2012).

TA is suitable for interview data (Braun & Clarke, 2006; Braun & Clarke, 2013; Willig, 2019) and appropriate for heterogeneous and relatively large samples (Braun & Clarke 2021a). TA can also be useful to identify similarities and differences across datasets (Braun & Clarke, 2022) which is helpful given the diversity of homelessness services.

2.3. Data Collection

2.3.1. Participants

The study had broad inclusion criteria; employees or volunteers with experience of working directly with women experiencing homelessness in organisations offering women support. A broad definition of homelessness was taken when identifying service-providers, including organisations offering support to women sleeping rough as well as organisations supporting more "invisible" forms of homelessness including women staying in refuges, temporary accommodation or hostels, sofa-surfing with friends or family or staying in unwanted relationships to access accommodation (Groundswell, 2020a).

Fifteen participants were recruited. Demographic data were collected by asking participants to identify their gender and ethnicity in their own words. Age categories were provided. The sample included one man and fourteen women between the ages of 25 and 54. The sample was predominantly white. Participants worked in third sector organisations including hostels, Housing First services, temporary accommodation and services offering outreach support. Half of the participants were based in London and the South East with participants also recruited from across England. Participants occupied varying roles from support workers to service managers (Table 1).

Table 2.1

Participant	Gender	Ethnicity	Age	Service	Region	Role
P1	Female	Black British	25-34	Women's only homelessness hostel	London and South East	Support Worker
P2	Female	White British	35-44	Outreach for rough sleepers and women's only housing provision	South West	Support Worker
P3	Female	Black African	35-44	Women's only homelessness hostel	London and South East	Support Worker
P4	Female	White British	35-44	Domestic abuse charity	London and South East	Project Manager
P5	Female	White British	25-34	Women's only Housing First service	London and South East	Service Manager
P6	Female	White Other	35-44	Healthcare service offering women only drop-in service	London and South East	Women's and Children's Project Lead
P7	Female	White British	35-44	Mixed gender homelessness hostel and services for sex workers	East Midlands	Project Lead/ Healthcare Assistant.
P8	Female	White British	25-34	Women's only homeless hostel	London and South East	Support Worker
P9	Female	White British	45-54	Mixed gender outreach and hostel for young people	Yorkshire and the Humber	Support Worker
P10	Female	White British	24-34	Mixed gender COVID hotel experience in 2020. Current role in Housing First service	London and South East	Case Worker
P11	Female	White Other	25-34	Mixed gender COVID hotel experience in 2020. Currently case management support for people identified as homeless	London and South East	Case Worker
P12	Female	White British	45-54	Homelessness outreach and mixed and women only hostels	East of England	Service Manager.

P13	Female	White British	45-54	Mixed gender day centre, outreach service and Housing First accommodation	London and South East	Service Manager
P14	Female	White British	35-44	Women only self-contained accommodation and support services	East of England	Service Manager
P15	Male	White British	25-34	Temporary housing provider	Yorkshire and the Humber	Case Worker

2.3.2. Recruitment

The researcher used purposive sampling to identify service-providers who worked in a diverse range of services supporting women experiencing homelessness across England to provide rich data (Patton, 2002) and the necessary information for the research question (Sandelowki, 1995). Snowball sampling was also used to increase the number of participants (Flick, 2009), with five participants recruited in this manner.

Databases of domestic abuse refuges and homelessness charities were used as well as a search engine, to identify service-providers. An information sheet (Appendix B) was distributed via email to domestic abuse charities, medical charities as well as homelessness organisations offering hostel, day services and outreach support or COVID-10 hotels. Follow up telephone calls were conducted to increase participation in the study.

An initial screening telephone call was arranged prior to the interview, to ensure the participants had read the Participant Invitation Letter (Appendix B) and understood the purpose and involvement of the study. Participants were asked to complete a Consent Form via email (Appendix C). A video interview was then arranged at a time convenient for the participant.

2.3.3. Interviews

Semi-structured interviews were selected as the method of data collection: the most common qualitative data collection method (Braun & Clark, 2013) and effective in previous research exploring service-provider perspectives (Black et al., 2018; Devine & Bergin., 2020). With semi structured interviews it is possible to explore the perceptions of participants when they have a high level of knowledge in the topic (Braun & Clarke, 2013), as is the case with service-providers.

The interview schedule (Appendix E) was developed from previous literature and in consultation with a service-provider working with women experiencing homelessness. The guide addressed practical, service-related, and personal influences on access to healthcare, which have previously been identified as important (Bhui et al., 2006; Brown et al., 2016; Canavan et al., 2011). In line with semi-structured interviewing, questions in the guide did not follow on specifically (Kvale, 1996); the order depended on points raised previously. The open-ended nature of the questions allowed the participants to pursue topics they felt were relevant, meaning participants could focus on their own perspectives rather than those of the interviewer (Bryman, 2008).

Initial consultation with a service-provider indicated it would be viable to recruit for one-to-one video call interviews of around an hour. Interviews took place during the summer of 2021. Video calls minimised the risk of COVID-19 transmission and have also been recognised as a useful alternative to face-to-face interviews (Krouwel & Greenfield, 2019). Interviews lasted between 53 minutes and 2 hours 4 minutes.

2.3.4. Completing Interviews

The researcher considered saturation and disregarded it as an ending point for interviews. There are several definitions of saturation; however, is widely recognised as the point at which new data or interviews are considered redundant as they do not reveal new information (Saunders et al., 2017). Saturation is often recognised at twelve interviews (Ando et al., 2014; Francis et al., 2010; Guest et al., 2006). It has been argued saturation adopts a naïve realist ontology, with the assumption codes pre-exist in the data independent of the researcher (Sim et al., 2018); is used to appease positivist requirements in determining an appropriate sample size (Varpio et al., 2017); and is a meaningless “rhetorical device” (Braun & Clarke, 2021b p.4).

In line with a critical realist approach, saturation was discounted in favour of information power (Malterud et al., 2016) alongside pragmatism (Braun & Clarke, 2019). Information power is regarded as a sample big enough to meet the aim of the study (Malterud et al., 2016; Patton, 2015). A larger sample was considered necessary for this study given the broad nature of the study aim, the variety of service-providers in the sample and the cross-case nature of the analysis. The research project was also shaped by the time and resources available (O’Reilly & Parker 2012). Following four months, fifteen interviews had been conducted, considered appropriate for moderate sized research projects seeking patterns across the dataset in TA (Braun & Clarke, 2013). After transcribing the fifteenth interview, the researcher considered the data rich enough to address the research question (Sim et al. 2018).

2.4. Ethical Considerations

This research sought to adhere to the BPS Code of Human Research Ethics (Oates, 2021) and its principles of respect, scientific integrity, social responsibility, maximising benefit and minimising harm.

2.4.1. Ethical Approval

Ethical Approval was obtained from the University of East London School of Psychology Ethics Committee (Appendix F).

2.4.2. Choice and Informed Consent

The Participation Information Letter (Appendix B) informed participants of the purpose and scope of the study and benefits and risks of participating. Participants gave informed consent and signed a Consent Form (Appendix C). Participants were aware they could withdraw from the study up to 3 weeks following the interview.

At the end of the interview participants were asked if they had questions and were also sent a debrief form (Appendix D) with information about the study and the researcher’s contact details.

2.4.3. Confidentiality and Anonymity

Participants were aware the interview would be recorded and transcribed. A data management plan was created and followed carefully to ensure the participant information and data were secured and remained confidential.

2.5. Analysis

2.5.1 Transcription

Interviews were video recorded on Microsoft Teams and manually transcribed to gain familiarity with the data. Recordings were transcribed verbatim focusing on transcribing the words and content of interviews so nonlinguistic features were not transcribed (Willig, 2013). Transcripts were then checked against the original tapes for accuracy (Braun & Clarke, 2006).

Identifying information was removed to maintain confidentiality and anonymity. Data were anonymised upon transcription so the participants could not be identified while retaining key information (Guenther, 2009). A notion system (Appendix G) was created for consistent transcription across interviews (Braun & Clarke, 2013).

2.5.2. Process of Thematic Analysis

Braun and Clarke’s (2006) six phase procedure was followed, although in a recursive rather than linear format (Braun & Clarke, 2013).

1) Familiarisation with the Data: The researcher transcribed the data and checked all transcriptions against the recording for accuracy. The researcher noted initial observations and ideas in a reflective log to inform later codes.

2) Generating Initial Codes: The researcher coded each transcript inductively (Braun & Clarke, 2022). Codes identified features of the data of interest to the research question (Braun & Clarke, 2013). Some segments of the data were uncoded, and others coded multiple times when reflecting different meanings (Braun & Clarke, 2022). The transcripts were coded twice and in different orders, accounting for codes adapting across the process. NVivo, a data management software, was used to code each interview and organise codes, while allowing the researcher to remain in control of the process of analysis (Zamawe, 2015).

*3) Generating Initial Themes: (*Braun & Clarke, 2022*)*: Following collation of the codes, the researcher looked for patterns and similarities which contributed usefully to the research questions. Mind mapping and visual diagrams (Appendix H) were used to help identify these patterns and the relationships between the codes to start to develop themes. In line with a critical realist perspective, the researcher acknowledges the active role taken in generating these candidate themes, rather than assuming they were inherently within the data (Braun & Clarke, 2021b; Braun & Clarke, 2022).

4) Reviewing Themes: During this stage, themes were reviewed and considered in relation to the research questions. Initial candidate themes were discussed in peer supervision and with the research supervisor to consider their usefulness in relation to the research project and the wider literature. Themes were checked for a central organising concept to ensure the analysis had appropriate depth (Braun & Clarke, 2022). The researcher then returned to the codes and refined the themes to ensure the themes were faithful to the data (Braun & Clarke, 2013).

5) Defining and Naming Themes: The themes were then defined and named to reflect the analysis. Theme names were selected to elucidate the distinction between but coherence within themes (Braun & Clarke, 2006).

6) Producing the Report: Extracts were selected to illustrate the themes and were altered only if needed for clarity (Willig, 2013). Longer extracts were shortened to remove unnecessary detail (Braun & Clarke, 2022) (Appendix, F). In qualitative research, the frequency of occurrence across the dataset does not indicate the value of the perspective (Pyett, 2003) so frequency descriptions are not reported. The researcher considered writing the report in the first person, due to the importance of researcher reflexivity in reflexive TA (Braun & Clarke, 2022). Due to academic precedent the researcher adopted the third person; however, reflexivity and the role of the researcher are discussed throughout, with reflections written in the first person.

2.6. Reviewing the Quality of the Study

Many of the general quality principles for qualitative research, such as secondary coders and coding frameworks, are not compatible with a critical realist epistemology and reflexive TA (Braun & Clarke, 2022). Throughout the research process, the researcher considered Braun and Clarke's (2022) Version 2022 15-point checklist for good reflexive TA which outlines standards from the transcription process through to the write up stage. While the necessity of quality criteria measures for TA are debated (Braun & Clarke, 2022), this study also considered Lincoln and Guba's (1985) criteria of credibility, transferability, dependability, and confirmability while holding in mind the critical realist epistemology adopted. The quality of the study will be further considered in the *Discussion*.

2.7. Relationship to Research

Adopting a critical realist position, I acknowledge, as the researcher, I have an active role in producing knowledge (Pezalla et al., 2012; Willig, 2013) and therefore need to reflect on how my own position influences the research and production of knowledge (Braun & Clarke, 2022). This process of reflexivity is essential in producing high-quality qualitative research and an essential process in reflexive TA (Braun & Clarke, 2006; Braun & Clarke, 2013; Braun & Clarke, 2022).

When selecting a topic for the thesis, I was drawn to homelessness due working in mental health services and recognising the important intersection between housing and mental health and how people experiencing homelessness are left with inadequate housing and mental health support.

I therefore could be positioned as both an insider and outsider in this research; sharing both similarities and differences with the service-providers interviewed (Dwyer & Buckle, 2009). An "insider," as a professional having worked with women experiencing homelessness, but also an "outsider" positioned as a psychologist within statutory mental health services. At times, participants did position me as an "outsider" and a mental health expert, asking for clarification about medical diagnosis. On other occasions I was an "insider," identified as another professional.

I have not experienced homelessness myself and am producing a piece of research about women experiencing homelessness. Ethically, it is important to think about how I represent the women who occupy a different position to me (Wilkinson & Kitzinger, 1996). I am a white, middle-class, professional woman raised in rural England. These aspects of my identity – and how others position me – shape how I experience the world (Cerezo et al., 2019), and will have influenced my reasoning and motivation for conducting this research. For example, my identity as a woman likely attracted me to the literature regarding women experiencing homelessness (Groundswell, 2020a) and shaped the research questions. Throughout the process, I have utilised a reflective journal to note reflections on how my identity, values and experience have shaped the research.

The way I understand and construct mental health services and homelessness have also been important to reflect on. In line with a biopsychosocial model of mental health (Álvarez et al., 2012; Engel, 1977) and my clinical training at UEL, I value the social determinants of mental health problems. From my perspective, biological, individualising, medical models of mental distress can be prioritised within mental health services. When conceptualising homelessness, I view it as a preventable phenomenon, which is maintained by an unequal society (Shelter, 2016) but again often individualised. Alongside these perspectives, I also believe mental health services should be available to all and, as psychologists, we have a duty to ensure healthcare is accessible. Such positions, assumptions and views are important to consider when conducting research and particularly reflexive TA.

By reflecting on my own identity, my professional experience and my beliefs around mental health and homelessness, I have sought to notice and understand my active part in the research process. From a critical realist position, I acknowledge it is not possible to be a neutral party within qualitative research and I hope to be transparent about how I have influenced the research process.

CHAPTER THREE: FINDINGS

3.1. Overview

Findings comprised of four overarching themes constructed from the data. These are presented in Table 3.1.

Table 3.1

Theme	Subthemes
Double Impact of Gendered Abuse and Trauma	Experience of Gendered Abuse Contributes to Mental Health Problems
	Experience of Gendered Abuse Reduces Likelihood to Seek Mental Health Support
NHS Mental Health Services seen as Stretched Gatekeepers	Under-resourced
	Complex and Exclusionary Referral Pathways
	Only Available in a Crisis
Generic NHS Mental Health Services are Unforgiving and Retraumatising	Inflexible and Punitive
	Lack of Awareness of Impact of Gendered Trauma
	Discriminatory and Coercive
Ambivalent Interface between Third Sector and NHS Mental Health Services	Service Providers offer Significant Mental Health Support
	Service Providers Feel Unsupported by NHS Mental Health Services
	Value of Specialist Homelessness Mental Health Services

3.2. Double Impact of Gendered Abuse and Trauma

Throughout the interviews, all service-providers spoke about the gendered abuse and trauma within women's lives. This theme comprises two subthemes which capture two dimensions of the impact of this abuse. First, the abuse women had experienced was understood to increase mental health problems. Secondly, while the abuse increased the need for women to seek support, the experience of abuse meant women were less likely to do so. Thus, gendered abuse can have a double impact on women's mental health.

3.2.1. Experience of Gendered Abuse Contributes to Mental Health Problems

Every participant spoke about the women they support experiencing forms of gendered abuse and trauma; abuse seen to have a greater impact on women. There was a sense while women were individuals who had their own histories, there were often many similarities between women's stories and experiences. Participants described parents or adults in women's lives when they were growing up being physically abusive, exposing the women to substance misuse, domestic abuse, or sexual abuse, resulting in women being exposed to the social care system. Multiple participants spoke about abuse resulting in "layers" or "cycles" of trauma which have impacted women across their lifetimes.

> *"All of the women experiencing homelessness that I have ever worked with[…]have struggled with their mental health for quite a long time. I suppose a lot of them have experienced some kind of abuse in childhood, or been in the care system or have experienced, it is quite common to have experienced sexual abuse in childhood. And from there, erm, they quite understandably have really struggled and that trauma erm just compounds really"*
>
> *(Participant 4)*

These "cycles" of trauma could be understood within the context of the patriarchy which creates systems which disempower women and girls from a young age and provide a context for such abuse to continue to occur across women's lives. The high rates of "common" sexual abuse among women experiencing homelessness, indicates that society normalises this abuse within this population. Women experiencing homelessness appear to be objectified and sexualised by society in order for this “cycle” of abuse to be created and sustained.

Participants also spoke about women experiencing abuse and trauma from services. The majority of participants spoke about women having children removed by social care, often multiple children over a lifetime. Child removal was seen as compounding the women’s experiences of trauma and severely impacting the mental health of the mothers, particularly for women who had experienced social care themselves when young and were worried about what this may mean for their children.

> *“I think there's definitely a relationship between[…]women who are homeless and child removal and mental health. Yeah, it's shockingly common that the women that we work with have had children removed”.*
>
> *(Participant 11)*

> *“That wasn't her first child that was removed, so it is all layers of trauma that they have experienced which, you know it comes out with them self-harming. It comes out with them[…] [moving from] being really, really high to really really low. I mean yeah, threatening suicide and carrying, carrying stuff out”*
>
> *(Participant 13)*

The removal of children by social care, when many women have themselves experienced social care as children, indicates how power is asserted over women from public services as well as abusers. Some participants indicated women were not provided enough support by the state to keep their children, for example highlighting the lack of mother and baby units in the UK or lack of support for domestic abuse victims. The lack of support to maintain children, and the state then asserting its power over mothers to remove children, could be understood as negative assertion of patriarchal power.

The majority of participants also spoke about the experience of homelessness exacerbating women’s mental health problems. Participants described women not being able to meet their basic needs of food and shelter, sleeping on the streets, sofa-surfing or in unpredictable hostels contributed to a decline in mental health among the women. This decline in mental health was often connected to further interpersonal abuse as a result of being exploited due to being homeless. Participants spoke of women operating within a context of constrained choice in exchanging sex for accommodation, being forced into sex work, or entering coercively controlling relationships to seek a sense of safety. The constrained choices available to women in negotiating housing indicates the lack of available alternatives – participants frequently mentioned the lack of social housing provided by the state – indicating how such choices operate within patriarchal political and social systems. Exchanging sex or engaging in coercively controlling relationships exposed women to more abuse and trauma and further impacted on mental health:

> *"Homelessness is in itself a trauma. A lot of women I've worked with who are homeless have experienced sexual violence whilst being homeless and you know, physical violence in the community. But yeah, I mean gender-based violence, just all of the types, all the types of gender-based violence"*
>
> *(Participant 11)*

The gendered abuse experienced when on the streets and in the context of coercively controlling relationships, indicates how women negotiate male power within both the public and private spheres and the assertion of power can result in gendered trauma.

3.2.2. Experience of Gendered Abuse Reduces Likelihood to Seek Mental Health Support

Participants described gendered abuse and trauma preventing women from accessing mental health support. A large majority of participants described women being prevented from accessing mental health services due to domestic abuse and coercively controlling partners. Participants described it being advantageous for men if women continued to experience mental health problems. Participants also described men seeking to isolate women from services to prevent service-providers identifying the abuse. One participant described men using children in a controlling way to limit women accessing support. Multiple participants described men encouraging women into sex work which itself created barriers to support.

> *“A lot of women will be in an abusive relationship and that will something that will not be allowed, or you wouldn't even think about trying to get mental health support if you're in a relationship where there is that coercive control or domestic violence. Often in this context of women, rough sleeping, that would be unthinkable.”*
>
> *(Participant 10)*

> *“ The ex-partner is quite controlling, and she doesn’t always know when she is going to get the children, that can be a barrier for her, so she is within the mental health team, the drug and alcohol service, and if the partner suddenly says next week you can have the kids on this day and she has already got appointments booked in, she is going you have to change them at the last minute”.*
>
> *(Participant 2)*

Coercively controlling relationships therefore act as a barrier to women accessing mental health services, with men using all resources at their disposal to exert power over women, including children.

Participants described domestic and sexual abuse, or other forms of interpersonal violence, as damaging the future formation of trusting relationships with mental health professionals. Previous relationships were marked by abuse and so women are suspicious of building trusting relationships. A few participants with experience of working with both men and women, shared it can take longer to build a trusting relationship with women due to women being more guarded. Participants attributed this to women being more vulnerable to exploitation than men. Many participants shared that as a result, women were seen as “harder to engage” with services or “more complex” than men.

> *“I understand trauma in quite a gendered way, so in that if you are a woman or a girl you are more likely to experience violence and abuse from somebody very close to you, like a partner or a family member. Whereas, I think men and boys, it seems to be friends of acquaintances”*
>
> *(Participant 4)*

> *“My kind of reflection is that women's mental health is such a gendered issue, and it's also incredibly broad, but in my understanding is that women's experience of homelessness […] people who have experienced such intense trauma and their presentation will often be […] just a lot more hidden, it's a lot more kind of hard to reach.”*
>
> *(Participant 5)*

> *“They have been let down by so many different people and everybody that erm they've come into contact with expects something in return, so they're very fearful of that.”*
>
> *(Participant 13)*

Women experiencing more abuse than men, would support the notion of a patriarchal society which privileges men over women. Women appear to be adapting to survive in this world by being wary of who they engage with. Participants were able to identify that it was not just abuse from individual abusers which made women wary, but also the abuse women have experienced from services – particularly children’s social care or immigration services– which also exacerbated women’s distrust of professionals who were seeking to build a relationship. Participants shared women associate professionals with *“something bad”* happening *(Participant 2)*.

However, it was evident that this mistrust was not ill placed as the majority of participants described the traumatic experience of social care removing women’s children. Participants described this experience exacerbating mental health problems and was a key reason women did not want to seek mental health support. As well as associating professionals with trauma, women were fearful of disclosing mental health problems in case it reduced access to children or led to future children being removed from their care.

> *“We've seen quite a few women who have been reluctant to address mental health issues because they're scared they're going to have their children taken away or they're going to have access to their children reduced”.*
>
> *(Participant 14)*

Participants also identified fear of being deported or healthcare services passing information to immigration services as a reason women did not trust mental health services. This mistrust can be framed as an individual problem in how each woman, shaped by her psychological and social history approaches the relationship with mental heath and public services. However, some participants identified many women being “quite rightly” concerned about the power of the state in women’s lives in regard to their children or immigration status. There was a sense that women understood this patriarchal power and mental health professionals should not simply expect women to engage with them. The mistrust of other people and professionals was seen as particularly difficult for mental health services which require trust for women to talk about vulnerable and difficult life circumstances.

This view of professionals as people with power over women’s lives is highlighted in participants perception that women’s mistrust was reinforced by professional markers of power such as formal dress codes, lanyards and identity badges which created a divide between mental health professionals and women.

> *“I think sometimes some of the women get put off when someone comes in with a badge and a suit, it makes them feel quite uncomfortable”*
>
> *(Participant 1)*

Finally, a large majority of participants spoke about this abuse and trauma leading women to manage their mental health through alcohol and drug abuse rather than by accessing mental health support. Many participants spoke of “self-medicating” to manage mental distress such as flashbacks, anxiety, or psychotic experiences by using substances. Substance misuse was considered inseparable from the trauma.

> *” [Women] find ways of coping that probably “make the problem worse” in many people's eyes, like using substances to manage that way, but that is their coping mechanism that is “working” for them in some sense, and it's probably easier than trying to get the right mental health support realistically”*
>
> *(Participant 10)*

This narrative could mean women are considered socially deviant in not responding to their trauma in a socially accepted manner of seeking mental health support, but rather by using alcohol and substances.

3.3. NHS Mental Health Services Seen as Stretched Gatekeepers

The second theme captured participant descriptions of NHS mental health services struggling to cope. Even when women did want to access support, NHS mental health services often prevented women accessing a service. Underpinning this theme were three subthemes. The NHS was characterised as under-resourced. There was also a sense that women had to negotiate complex and exclusionary referral pathways which made it difficult to access the service. Participants conveyed these barriers meant support for women was often delayed and only available in a crisis.

3.3.1. Under-resourced

All participants described NHS Mental Health Services as under-resourced. Some participants placed this in the political context of austerity and financial "cuts" to mental health services, whereas others described services as always having been underfunded. Underfunding was often used to explain why it was so difficult to access mental health support for women experiencing homelessness.

> *"Obviously mental health services are being cut massively, so they are under, they have got no choice but to say, and to give every single excuse to be like "no we can't take you on"*
>
> *(Participant 5)*

Overworked mental health professionals were seen as unable to accept referrals due to struggling with their workloads. One participant described noticing high sick leave within the local community mental health service due to staff struggling with their own mental health, which impacted on the service's ability to support the women effectively. High workloads were also seen to impact mental health professionals' ability to offer time to support the women's mental health appropriately and liaise with service-providers as needed.

> *"As soon as you get someone who is mental health involved. You have to pin them down and then make sure they stay [laughs] before they fly off again, probably because they probably have massive caseloads, and they can't stay."*

(Participant 5)

Only one participant, working with young women who have recently become homeless, spoke positively of mental health services. She attributed service expansion as the reason the women she supported were able to get the support needed. The difference in narratives may be related to improved funding of mental health services or the lower level of need experienced by women who are recently homeless, compared to women experiencing more entrenched forms of homelessness.

Many participants spoke about the negative impact of COVID on access to mental health services. Participants described a perceived increase in need for mental health services which was not reflected in increased provision or funding. Participants described local mental health services struggling to cope with the extra demands of the pandemic, for example struggling to manage staff absences due to sickness, fear of the virus or shielding, due to how stretched the services were before.

> *“There has been more people requiring the service. So, an already underfunded, under-resourced service has had to cope with even more. Not having enough to manage these people. There has been a lot of their staff who have had to shield.”*

(Participant 2)

3.3.2. Complex and Exclusionary Referral Pathways

Participants also described mental health services gatekeeping through complex referral pathways with tight exclusion criteria, meaning women and service providers need to *"jump through hoops"* to access support.

The majority of service-providers shared they tried to access support for their clients via the GP who would then refer on to other services. However, participants expressed dissatisfaction at reliance on GPs. It was often challenging to get an appointment due to women having difficulty registering with a GP. Many participants described GPs requesting forms of identification or proof of address, which women could not provide. Without the GP, onward referrals to mental health services were unattainable. However, even when a mental health appointment was offered, it was a convoluted process to reach support.

> *"Getting an appointment with a GP here in [large town] is near on impossible. And then if you do, if you are lucky to be able to pre book an appointment, you could be looking at three or four weeks down the line. Then there's the referral process. The doctor has to do the referral that has to be picked up at the other end. Contact made; another appointment has to be made".*
>
> *(Participant 13)*

Most participants expressed it was difficult and confusing for them to know what mental health services were available for the women and a good knowledge of how mental health services operated was needed to navigate the system.

> *"I don't think I know enough about how they are structured. Erm. I suppose my general opinion is that they are really hard to access. They are a bit of a maze"*
>
> *(Participant 4)*

A few participants shared they had used professional contacts within community mental health services to help them. Several participants spoke of their services hiring in-house mental health professionals to navigate mental health services. However, some participants also expressed frustration at needing an inhouse mental health worker to advocate for service access.

> *"It is about who you know, not what you know. And, having [in-house mental health worker] come from that background with all of those contacts [has helped]."*
>
> *(Participant 2)*

> *"It should not take a whole separate paid role [in-house psychologist] […]to support referrals into the local mental health service"*
>
> *(Participant 4)*

Participants described traditional referral processes to mental health services– via the GP – had become more difficult during the pandemic. Women were confused about how to access GP appointments with a lack of face-to-face appointments and increasing waiting lists. However, one participant with experience of a COVID hotel described the complexity of the referral process had been removed due to mental health professionals working on site, making it easier for women to access support.

> *"You know, they might have like all these things going on, but if they're there in accommodation and you know where you can find them, you know how to contact them and having staff on site [at a COVID hotel] obviously, like definitely made accessing services much easier"*
>
> *(Participant 11)*

All participants shared mental health services were exclusionary for women experiencing homelessness due to service provision working in "silos" which do not acknowledge the *"multiple disadvantage"* or "*complexity of needs"* women experience. Additional needs included mental health problems, domestic abuse, NRPF, substance misuse problems, learning disabilities and higher risk of self-injury. Participants shared mental health services focus only on mental health and deny women with more complex needs support meaning they are often stuck or *"pushed"* between different services not receiving appropriate support. Participants described services needing to work with women “holistically”, particularly around domestic abuse, substance misuse and mental health.

> *“Everything seems to operate in kind of silos. Like which team just deals with this situation? Is it mental health, or physical health or is it up to housing? In fact, it's all of those things compounding each other[…]it’s the same with people who have substance use[…]but when they try and get mental health support and they're told “well we can't support you with your mental health until you sort out your substance use”. And then you go to a substance use service and they say, “well we can't support you with your substance until you stabilise mentally”*
>
> *(Participant 11)*

> *“We went to the GP with her, and they said, you know the kind of IAPT service, that she was too high needs for that, and they couldn't do it, but when we've tried to get her assessed for secondary services, they said no, she's too low needs”*
>
> *(Participant 14)*

The exclusionary nature of services appeared to impact some women more than others. For example, one participant working with younger women in supported housing identified local mental health services were able to meet their needs; whereas participants supporting women who may have been homeless for longer periods of time, who had children removed, had NRPF or were experiencing domestic abuse identified services did not.

In comparison, many participants spoke about it being positive when services were able to work together in a more inclusive and integrated manner, supporting women with a range of their needs. One participant cited recent policy changes in her area around health and social care integration which meant women’s needs could be assessed together.

> *“Another positive thing is the social worker is part of the mental health team and having the social care assessments with them is a relatively new thing. If you’re not in the mental health team you still have to go the adult social route, but if you are, you can have a social care assessment done through the mental health team and I think that is amazing.”*

(Participant 2)

Two participants with COVID hotel experience noted it was helpful having staff trained in mental health interventions integrated and able to work alongside the wider team.

> *“[Worker trained in counselling] would just see people in the COVID hotels where they were. So, she would meet on the steps and have a chat and check in and then would kind of feed that back to the team about how we best work with this person because they're experiencing this. I genuinely think that probably worked quite well, but she was embedded, really embedded in our team in our organization*

(Participant 10)

Such experiences appeared to be rare with most participants describing silos. A few participants connected the silos and the exclusion criteria to services implementing commissioning criteria. Women were described as not fitting within the criteria services were funded to support. Participants attributed this due to the changeable nature of women’s circumstances meaning they moved in and out of eligibility. The transitory nature of commissioning services was also highlighted, perhaps indicating a lack of consistency in service-provision and funding for this population.

> *“We had another mental health worker who is doing mental health on the streets, like outreach […] but I think she closed a case pretty quickly as well after the client moved in[…]I don’t know if that’s because some are only commissioned to work with some on the streets”*

(Participant 5)

> *"There was a big thing a few years ago about this dual diagnosis, about people having substance misuse and about people having mental health issues. They go hand in hand and a big old pot of money, and a big load of stuff was put in for this dual diagnosis stuff, but actually when you're trying to access that now it's like it never existed"*
>
> (Participant 12)

Commissioning structures and silos highlight the power of public services to define women's experiences and control what women are eligible to access. There is a sense of hierarchical decision-making which women and participants are unable to influence but are affected by.

3.3.3. Only Available in a Crisis

Participants described it as difficult for women to access preventative mental health support. Services were seen as only available when the women were experiencing mental health crises, for example self-harm, suicide attempts or anti-social behaviour involving the police.

All participants described high waiting lists across a range of mental health services including GPs, CMHTs, IAPT, Crisis Teams and A&E. Participants spoke about waiting lists being inappropriate for the women they support due to women's circumstances constantly changing, and the delay in access meaning their mental health needs can change dramatically during this period of waiting. Due to "chaotic" aspects of women's lives, participants described mental health support needed to provide women with support quickly during "windows of opportunity" to engage women with mental health services. Services needed to make the most of the motivation and momentum women have in accessing support at the time. There was a focus on it needing to be easily and quickly accessible to be effective; however, the delays meant preventative support was difficult to access, and women's circumstances had often changed by the time women reached the tops of waiting lists.

> *“There's a process that has to be followed. It's long and lengthy, and by the time that they could get an appointment that ship sailed - it's too, it's too, too late. You just have to wait for that moment. You know you have to seize the moment with them sometimes because they are that chaotic. And there isn't really services out there that allow that immediate access”*
>
> *(Participant 13)*

Many participants described women who had been unable to access community or preventative mental health support subsequently needing to access emergency support.

> *“Everywhere she goes she was being told “you’re not causing a danger to yourself or others, therefore you are not really a high risk”. And in the end that is what happened, she did try to commit suicide and the only option available was to take her to Accident and Emergency on the day”*
>
> *(Participant 3)*

As a result, participants explained women would often enter mental health services, via emergency routes such as A&E or via the police when they were at risk of hurting themselves or concerns around anti-social behaviour. Participants described needing to have something to “get attention” of services or to be “taken seriously” by mental health services to gain access.

> *“This one client used to make all of these calls to the police[…]so because of that, we were able to use that as a reason why she really needed the support of mental health professionals, so that kind of thing actually allowed us to get our foot in the door, to actually get someone to come out and assess her[…]but prior to that, we were just left in limbo and not knowing what to do”*
>
> *(Participant 1)*

This reliance on crisis services may have a gendered impact on service access. One participant who worked with both men and women, wondered if women’s mental health was neglected due to mental health crises presenting differently across the genders. The participant highlighted the externalising nature of men’s mental health crises, whereas women may be experiencing mental distress out of the public domain, perhaps inside the home. Services may be designed to support those expressing distress, or being socially deviant, within the public sphere whereas what happens in the private sphere is regarded as outside of the state control. This perspective of women’s mental health not being “taken seriously” until presenting in an emergency was prevalent across many interviews.

> *“The boys that I'm working with often end up in trouble with the police, whereas the young women don't necessarily end up in trouble with the police. If they are having a mental health crisis it's more, maybe in some ways it's probably less likely that they're going to get the help they need, because they are probably not going to end up getting sectioned and probably not going to end up getting arrested, and they're going to have to rely on the like the GP, the single point of access, the NHS services, the voluntary sector, and that means you'll be on a waiting list, yeah, basically to, to get like immediate support you need to, maybe not commit a criminal act, but you need to do something where it’s like, highlights the seriousness of the situation"*
>
> (Participant 15)

Not being “taken seriously” by public health services indicates there is an expectation within services or from those who fund them, that women’s pain and distress is not a priority. This gendered expression of emotion, internalising distress and being expected to wait their turn, may draw on societal ideas of compliance and women needing to place other’s needs above their own. This may fit within narratives of women needing to cope with pain, or with ideas about who is deserving of support and those not interfering with public life are not.

At crisis moments, participants described support would often be accessed via A&E or the police. However, participants spoke about this reliance on emergency and crisis services being inappropriate for meeting the needs of the women they work with. Many participants spoke about spending a long time waiting in A&E and women often leaving before being seen. Some participants spoke about women's mental health not being supported in the long-term, with women often discharged prematurely or discharged back onto the streets or unstable housing incompatible with improving their mental health and services not offering a longer-term plan of how to support the women's mental health.

> *"My experience has just been sat waiting in hospital for a very very very very very long time, to be seen by a psych liaison who generally says: "oh, erm, you know, they are fine to go home". And I think "she is clearly not fine" and there is no follow up or after care in fact for the woman"*
>
> *(Participant 4)*

Dissatisfaction with the reliance on A&E as an option for women's mental health crises was more evident when speaking to more rural service providers. Here, a few participants shared women did not have the resources or time to access A&E and the lack of public transport making this more difficult if service providers were unable to support the women to get there.

> *"A lot of advice is "can you get to the hospital". We are in [small town] and the nearest hospital is [hospital] which is 13 miles. And for a homeless person with no money, no means of transport, in a crisis, to get to a hospital, it won't happen. It just will not happen, unless we physically put them in our cars and take them over there, it will not happen."*
>
> (Participant 7)

Since the pandemic, participants described they had noticed it was more difficult to access preventative community mental health support, with an increase in waiting times across all services – particularly GPs.

> *"It is a lot more difficult not being able to see the GP, and not being able to get through to the GP. As I said you, even if they do give an appointment. it won't be for a month, two months, sometimes […] and I think it is because of the COVID"*
>
> *Participant 3*

3.4. Generic NHS Mental Health Services are Unforgiving and Retraumatising

The third theme highlighted when women do eventually receive care, generic mental health services are experienced as authoritarian and retraumatising. This was underpinned by three subthemes. Firstly, generic mental health services – such as IAPT, CMHTs and crisis services – were seen as inflexible and punitive in responding to the needs of women experiencing homelessness. Secondly, generic services do not account for the specific needs of women and the high level of trauma they have experienced. Thirdly, participants talked about the active discriminatory and coercive practices women experience when interacting with mental health services.

3.4.1. Inflexible and Punitive

Generic NHS services were seen to set unrealistically high and rigid expectations for those who engaged with them, which resulted in barriers to access and disproportionately negative impacts for women experiencing homelessness. These rigid expectations included how women communicate, their access to resources, engagement, and behaviour as well as their ability and willingness to meet on professional's terms around time and location. Participants described women often being discharged from services as a result of women not meeting these expectations. These expectations were seen as unrealistic by participants when considering the context of the women including their current homelessness status and their trauma histories.

> *"It was almost kind of like you expect a level of engagement for people that can't, that struggle to kind of engage in a normal way anyway"*
>
> *(Participant 8)*

These unrealistic expectations can be linked to patriarchal expectations for women to behave in a compliant, controlled and socially expected manner when in distress, for example by ensuring they fit into a professional's schedule and meet the professional at a time and location dictated to them.

Participants spoke about communication between professionals and women as a barrier. Participants described services requiring a high level of education, literacy, English language fluency or cultural code for women to understand and interact with professionals. Participants described services often did not provide additional support when women's needs did not align in this expected way, for example women being unable to access interpreters. Other participants described miscommunication due to women not being familiar with the health services or not understanding professional language.

> *"Often like young people can find it difficult to communicate with certain, you know, people who may be a higher class or, it's just because they speak in a certain way. Yeah, so those sort of like a speech code, can be difficult."*
>
> *(Participant 15)*
>
> *"I know NHS does have that [interpreting services] but it is very difficult to access that service and appointments are often cancelled because the translating person is no longer available or they forgot to book it, or lots of issues, so there is a big problem there".*
>
> *(Participant 3)*

The intersecting needs of different women therefore does not appear to be met by services, with women with different or additional needs experiencing more barriers. Women who are able to communicate in English and interact with mental health professionals, a generally middle-class profession, experience fewer barriers. Women who are foreign nationals, more likely to be from racially minoritised backgrounds, in need of an interpreter, experience further barriers to access. The influence of institutional classism and racism, intersecting with gender, can therefore be seen within participant accounts of barriers to access.

Participants also described mental health services as inflexible in the form of support they offered women. Remote working – using phones or video platforms – during the COVID-19 pandemic was seen to be inappropriate for the women by most participants, but alternatives were often not available. Many participants spoke about women preferring face-to-face contract to aid communication through lip reading and body language, particularly if English was a second language. Multiple participants shared women who had experienced abuse did not feel comfortable building relationships over the phone or on digital platforms, which participants viewed as an important part of interventions being successful. Participants also highlighted women can be suspicious of, or reluctant to use, telephones or computers.

> . *“We're still going back to normal, but services still aren't really coming out. Yeah, and they really need that face, the face-to-face contact, especially for a lot of women who've been through trauma and stuff like, you can't, they can’t build relationships over a computer. They need to be able to deal with their support needs.”*
>
> *(Participant 8)*

> *“He was doing ward rounds on a screen. And a couple of the women[…]who I know experiences psychosis, really struggled with that because it's like weird. And it feels, feels like there's something going on that isn't right, you know?”*
>
> *(Participant 14)*

Participants also spoke about the practicalities of remote working during the pandemic, with services expecting women to have access to phones, laptops, internet, mobile data, or credit to be able to access remote services such as therapy. Given many women’s unstable housing, participants also spoke about women not having access to a private space where they could hold meetings with mental health workers and feeling uncomfortable about where they were having phone or video calls.

> *“Or if it is a video call, then some women don’t have the internet, so, it is probably better for our women in general to have the option of seeing someone face to face”*
>
> (Participant 5)

The use of technology demonstrates different barriers for different women, with it representing a financial barrier for those who cannot afford it or do not have private space, which may influence women of different socio-economic backgrounds to differing degrees, with those women unable to afford technology more likely to experience barriers to access. However, technology also represents a cultural barrier or language barrier for women – impacting foreign nationals or those who have not had access to be able to learn English. Many of these women are also likely to have experienced trauma and abuse alongside these financial and cultural barriers, indicating how technology can create numerous barriers which compound and intersect. However even if women were unable to access services remotely, most participants shared women were discharged with no available support, a policy which is likely to impact these more marginalised women to a greater degree.

> *"So, it was mandatory for someone to do an emotional skills workshop, which is like 12 weeks on zoom in a group. OK, so my client refuses to do anything on Zoom, so they discharged her"*
>
> *(Participant 8)*

When face to face appointments were offered to women, participants spoke about mental health services expecting women to attend appointments in clinics or at hospital and being inflexible and discharging when women were unable to attend. Which can be understood within the context of patriarchal state service dictating to women the conditions under which they can receive care and punishing those women who are deemed to be socially deviant or uncompliant, through discharge.

Participants described practical reasons women were unable to attend, such as not having the funds for public transport or access to a car, particularly in more rural areas where there was limited public transport. Here, participants shared they were key facilitators in supporting women to reach appointments by accompanying women for moral support, organising taxis, or driving women in their own cars. Participants described COVID had made it more difficult for service-providers to accompany their clients to appointments due to social distancing measures. Women living in different areas therefore appear to experience different barriers in accessing care with more urban areas benefitting from the use of public transport and lower costs of travel compared to women in rural areas requiring the use of cars – indicating how geography and the available public resources are important in access.

Participants also described women being “chaotic” and needing to prioritise other aspects of care such as housing and food. Women could therefore forget appointments, lose phones or struggle to charge phones to accept calls. Participants explained women were often involved with multiple services, such as physical health, housing, or child social care, which were often not communicating with each other and may result in conflicts making it harder to attend mental health appointments.

> *“A significant number of them are going through the social services route, maybe haven’t got children with them, are fighting for custody, fighting for contact and undergoing real robust and in-depth assessed parenting assessments to try and get their children back. And you know having to juggle all of those appointments with the appointments for their personal mental health, you know it can be a real task”*
>
> *(Participant 2)*

How women use their time is therefore dictated by the state and public organisations with significant power over these women, particularly over their right to see their children. The unrealistic expectations imposed on these women appears to set up a catch-22 with women needing to balance a large number of appointments and high expectations, but then being heavily punished if they fail to do so, through discharge or by impacting their parenting assessment.

Participants also outlined the psychological reasons making it challenging for women to attend appointments elsewhere. Some participants described women experiencing low mood and struggling to motivate themselves to leave their temporary accommodation. Participants also described hospitals and clinics as being “triggering” for women, due to being associated with memories of trauma.

> *“They will sometimes miss appointments, forget appointments, not feel like going on the day and with the mental health team, we have so many clients threatened, and that’s what it is, that’s what it feels like being threatened that the service will close to them, as they have not been meeting these appointments.*
>
> *(Participant 2)*

Hospitals and public services therefore may be associated with abuse and negative assertions of power and yet women are expected to visit them for help to heal which places women in a dilemma.

Many participants promoted the alternative or mental health professionals offering outreach to the women, by attending hostels, street outreach or visiting day centres – describing it as being in the women’s “territory” or “comfort zone” and giving the women a greater sense of control while reducing anxiety about the unfamiliar places. A few participants described it as difficult for the women to reach services, so it being service responsibility to go out and reach them. However, participants described outreach as rare and often it depended on who was offering the appointment as to whether flexibility would be given, or the women would be treated punitively.

> *“I think they could come out in the community a bit more. I think that would definitely help, rather than getting the clients to travel to them. I suppose it would make the women feel like[…]they are important, that their mental wellbeing is being taken seriously. Rather than, “oh you have to come to us and if you don’t attend then you are being discharged”.*
>
> *(Participant 7)*

This punitive response to women not engaging with mental health services, again demonstrates that the services hold power over the women. Not attending appointments may be due to “chaotic” aspects of the women’s lives, but also may be a form of resistance in choosing not to engage with a service that dictates terms to the women and is associated with previous trauma.

There was also seen to be a lack of flexibility in terms of the availability of times to see women and offer them mental health support. Participants spoke about most mental health services, apart from the crisis services and A&E, operating between 9am-5pm, which did not suit the women's needs. Participants explained women would often be sleeping during these hours as it was safer, or they may have been sex-working at night and resting during the day.

> *"They get discharged from mental health services for non-engagement but, and this does apply to a lot of the women, the hours that they function are not the hours that professionals function[…]they wake up 10:00 o'clock at night and are awake all night[…]and the services aren't available to them at those times"*
>
> *(Participant 13)*

Services are thus arranged at times considered to be socially appropriate and women who are living life in a "socially deviant" way through sex working or living by different body clocks to professionals, are denied services.

Alongside non-engagement or missing appointments, participants spoke about women's behaviour and how they interacted with professionals within mental health teams as not meeting service expectations. Participants described the women could be aggressive, defensive, ungrateful, or angry and may swear at staff or abuse staff members. Participants understood this behaviour as trauma responses but indicated mental health professionals would discharge women for inappropriate behaviour.

> *"Our women are warriors and survivors, but they do get angry[…]but scratch the surface and you have an amazing woman who is just in a lot of pain and I think you know, it is professionals, particularly from the mental health service, sort of looking beyond that a little bit[…] there is a way of dealing with it without going "no, you are gone"*
>
> *(Participant 2)*

Women who are angry or aggressive are also treated punitively despite the trauma they have experienced. This notion that mental health services expect women to comply with their demands, behave in a polite manner and to be grateful for receiving support, can also be understood within patriarchal ideas of compliance and control. Many women have experienced abuse and injustice and may respond through justifiable anger as a form of resistance; however, such emotion is not tolerated within services which expect women to passively meet their demands.

3.4.2. Lack of Awareness of Impact of Gendered Trauma

Participants also portrayed mental health services as lacking an awareness of gendered trauma. The support available from mental health services starting at the time of assessment through to treatment and discharge was often depicted as unhelpful or retraumatising in the context of women's previous trauma. Most participants shared such knowledge was important to support women as it explained why women behaved as they did.

> *"If you are going to work with women experiencing homelessness and who have gone through traumatic experiences you need to have a good understanding of what they have been through, where they are now and why they may do particular things like sex work or drug use and just learn, I guess yeah, just learn how to work with them in a more appropriate and healthy way,*
>
> *(Participant 1)*

Sex work or drug use, and other behaviours, are therefore framed as unacceptable and deviant and mental health services may enforce societal expectations on women by trying to encourage them to conform, rather than, as the participants request, responding in a "healthy" compassionate way.

From the point of assessment, participants described the process promoted by mental health services – especially IAPT and CMHTs – as very difficult for the women. The expectation that women will be able to share their experiences of trauma quickly with an unfamiliar person with no guarantee of support was seen as unhelpful and retraumatising. A few participants shared women would "downplay" their experiences as they did not want to speak about their painful traumatic experiences. Participants described this being due to fear of it being retraumatising or exhaustion from repeating their stories to multiple services.

> *"When people meet someone for the first time, they don't feel comfortable being completely honest or might not necessarily understand what's being asked of them or what is asked of them, and then just kind of going along with it and then not actually getting to the nitty gritty and like understanding the support"*
>
> *(Participant 8)*

Even if women were able to progress through the assessment process, participants explained the support available to women from services was often not adequate for the trauma the women had experienced. Many participants described women being offered medication for their distress and this did nothing to "get to the bottom" (Participant 12) of the difficulties or support women with the trauma they had experienced

> *"If someone's just fled an abusive family and they're now like really low mood, struggling to sleep and they're trying out sertraline and promethazine and they're like "it's not working", so like that's not the only support you need to fix your mental health"*
>
> *(Participant 8)*

A few participants described psychotropic medications as addictive and considered them inappropriate given women were often experiencing substance misuse to cope with their trauma. The use of psychotropic medications aiming to resolve trauma and abuse, could be considered to individualise the affects of the negative assertion of power, placing the problem and need for solution within the individual. By doing this, the power asserted over the woman is concealed rather than acknowledged.

However, participants also share talking therapies – which were positioned as an alternative to medication – were also ineffective for the women they supported due to the complexity of the trauma they have experienced. Participants shared therapies were often expected to be time-limited, particularly CBT, with an emphasis on women speaking about their trauma. This short-term nature and the focus on talking about trauma when women were not ready to do so, was seen as something women struggled to engage with and was unlikely to support and create meaningful change for the women in the future.

> *"And if they are lucky enough to be engaged with mental health services[...] they get put onto more medication which is equally addictive as, you know, the street drugs that they are taking. Talking therapies and that for them is very, very painful because they're reliving all of that trauma and most of them just can't. They can start it, but they don't complete it".*
>
> *(Participant 13)*

Instead of these treatment options, service-providers shared building long-term trusting relationships was central to supporting the women, with a recognition and knowledge of the context of trauma women have experienced. This relationship-building takes time due to the trauma women have experienced and can often not be accommodated within mental health services. Mental health professionals were seen as not having the time, a focus on short-term goals and not prioritising "soft outcomes" (Participant 2) which may not be clear visible changes. Participants also highlighted these relationships were often best in an "informal" rather than clinical context where professionals did not try and talk about feelings, mental health, or trauma straight away but gave the women time.

> *"The women need longer than the funding or caseloads allow, like you might have to work with someone for a year until you get any form of engagement with them"*
>
> *(Participant 8)*

However, these forms of relationships were seen as rare within mental health services. The point of discharge following therapeutic work highlighted mental health services not respecting relationships. Many participants spoke about the endings of mental health services being abrupt, with little thought or preparation for how the women would cope with or manage these endings of significant relationships.

> *“I do think the relationships are often ended too abruptly. I’ve been thinking about this quite a bit recently because I was thinking about relationships in real life, unless it's negative, there's a negative situation you don't often end a relationship in real life like that [click fingers] […] I don't think that that is thought about enough”*

(Participant 14)

Together, assessment, treatment and discharge were often seen as unhelpful by participants due to the lack of focus on trauma and relationships. The focus on short term fixes through medication of short-term therapies could be seen to neglect the abuse women have experienced within a patriarchal society and obscure the power structures which have made that abuse possible. Instead, these treatments individualise the consequences of such abuse. Participants appear to be highlighting this individualistic approach to mental health distress is ineffective for women.

The majority of participants also described mental health support for women was often provided in mixed-sex spaces which made it challenging for women to engage with, due to negative experiences of men. These mixed-sex spaces included mental health groups, as well as mental health staff members. The majority of participants shared it would be helpful to have the option of female only support or the ability to choose whether women engaged in single-sex or mixed-sex spaces. However, participants described this as rarely being the case.

> *“We asked adult social care and the mental health doctor: “Can we change social worker? She works better with women. Could she have a woman social worker?”. That was declined, and it is frustrating when you have got a client that says “I can’t work with him, I can’t work with him. He is the one that triggers my anxiety, my aggression”, so I am just thinking like, if we can recognise her triggers, why can the NHS staff and adult social care not see it too”*

(Participant 7)

Requesting such spaces, indicates women are aware of male power operating within public services. Requests can be seen as a means of resistance to try to counteract and resist this power. However, denying women the right to women only spaces indicate services are reluctant to support women's right to resist the patriarchy and create spaces in which they feel comfortable.

Specialist homelessness mental health services were also seen to struggle to support women who had experienced significant trauma and were entrenched rough sleepers, as participants described the mental health services were not able to provide the flexibility needed to cope with women's trauma responses such as their aggressive behaviour or self-medicating. Participants spoke of women engaging and disengaging with mental health services multiple times and *"nothing really sticks" (Participant 11)* due to services not being flexible enough for high levels of trauma.

> *"For the majority of them is trauma[…] their coping mechanisms are, whether that's self-medicating or like behaving in a certain way, they're the ones that miss out and there needs to be some service that reaches them"*
>
> *(Participant 8)*

Women who are likely to have experienced more trauma, and so have more complex needs do not receive support designed in their interest. The individualistic mental health services offering medication and talking therapy, which frame women as the problem in need of a solution, do not offer the required outcomes.

3.4.3. Discriminatory and Coercive

Alongside mental health services retraumatising women through generic, uncompromising and punitive service policies and a general lack of awareness of the women's trauma, participants described mental health services being actively discriminatory and coercive towards women experiencing homelessness which resulted in further harm. This was often in the context of women accessing emergency care and being subject to involuntary admissions. Multiple participants spoke about mental health services' reliance on the police and this being a traumatic and coercive experience. One participant shared women were treated like "criminals" rather than women in distress.

> *“Two policemen arrive, there she was in the shower, and they dragged her out of the shower and then dragged her into a room like naked[…]they were so horrible, so then she was even more distressed than before”*
>
> *(Participant 8)*

Such experiences were seen to heighten women’s experiences of trauma, often at the hands of men. The use of coercive control by the state to further disempower women can be seen as state agents acting within a patriarchal system. Rather than offering means of recovery, the state continues to assert male power over the women.

A few participants described the coercive experience of detention on wards as particularly difficult for women who have experienced trauma due to women valuing control or autonomy due to their past trauma experiences. Participant 7 described a woman she worked with being “triggered” over everyday decisions she was no longer allowed to make when on a ward such as controlling her money, who she could contact and the deprivation of her liberty. Women are therefore controlled within the mental health system and continue to experience the negative assertion of power over their lives, which is particularly distressing for women who have sought to take back control within their lives following earlier experiences from earlier abusers

These experiences of coercion and lack of control mirrored experiences participants described under community mental health teams with women being deprived of control or consent to their care, for example by being forcibly given medication or being referred to services without their knowledge or consent. Many participants spoke about needing to put women in control of their care and this often not happening.

> *“She was having depot injection every couple of weeks[…]the side effects of her medication had such a huge impact on her[…] and I think struggling to advocate for herself. She wanted her medication to be changed, and I looked into trying to find kind of advocacy services for her, and I wasn't able to find any services”*
>
> *(Participant 11)*

Mental health services are framed as a power in which women need to “advocate” against, highlighting the control the services can have over women’s decisions. Alongside experiences of coercion, participants also described mental health services as discriminating and “judgmental” towards women. There were descriptions of health professionals across the referral pathways, from GPs through to community and emergency mental health staff stigmatising women. Participants described women experiencing stigma and discrimination due to their homelessness status, or due to the trauma they had experienced being blamed on them and framed as “lifestyle choices”. Participants shared woman could be blamed for not engaging with a gatekeeping and uncompromising mental health system, which was framed as them making wrong “choices”, resulting in them being denied care. Participants described mental health professionals as seeing women as unworthy of care due to sex working, being homeless, using drugs or self-harming. As a result, participants described mental health services as dismissive, not taking the women seriously or offering the compassionate care needed. A few participants shared women were labelled as “attention seeking” when seeking support rather than seen to be expressing a genuine need.

> *“I think they [women] need to be taken a bit more seriously, because I do think they do have this particular attached to them that they are “oh they are homeless, they are drug addicts” or “oh well they are sex workers””*
>
> *(Participant 7)*

> *“[Mental health services] coming in and being quite judgemental, or not wanting, or saying that it is difficult to work with someone because they are not engaging, is not productive, it’s not useful, and it’s not the women’s fault either when they have been through so much.”*
>
> *(Participant 1)*

Framing women as making the wrong choices and as lifestyle decisions can be seen within the context of a patriarchal society which objectifies and polarises women into “good” and “bad.” Women experiencing homelessness who also engage in behaviour considered socially deviant such as sex-working, are punished for not meeting the societally held standards of what it means to be a woman. By not meeting societal expectations, women are therefore dehumanised and objectified, their suffering is not appreciated, and they are treated dismissively.

Participants also described mental health services could be judgmental towards the women for many other reasons including race, age, religion, and gender.

> *“I think with women there is intersectionality, so like race, gender, religion. Sometimes that comes into play. I think for some women for example, with regard to access to mental health, they do feel a sense of, as I said previously, like stigma, or a feeling that they are going to be judged”*
>
> *(Participant 1)*

Alongside experiencing sexism, women may be further oppressed by mental health services through other intersecting identifies they hold. Women from racially minoritised backgrounds appear to experience judgement from both their identity as a woman experiencing homelessness, but also fear about being judged due to societal representations of race and associated stigma. Thus, racism and sexism intersect within services to mean women of different identities are likely to experience different barriers to mental healthcare.

3.5. Ambivalent Interface between Third Sector and NHS Mental Health Services

A final theme constructed from the data spoke to the relationship between service-providers and the NHS mental health services. The first subtheme captured how third sector service-providers, many of whom are not mental health professionals, are offering significant mental health support. The second theme reveals how many service-providers feel unsupported by the NHS in doing so. Finally, the third subtheme speaks to what service-providers value about specialist mental health services.

3.5.1 Service Providers offer Significant Mental Health Support

A large majority of participants spoke about provision of housing as being the most important support women could receive to improve their mental health. All participants described homelessness exacerbating women's mental health problems and most participants described it being their priority to support women with accessing their basic needs of housing and food which would improve their psychological distress. All service providers recognised social determinants of health, such as housing, poverty, discrimination as impacting psychological wellbeing. Referring to mental health services was therefore not the first consideration for service-providers in how to support women with their psychological distress.

> *"The best thing I can do for somebody's mental health and wellbeing is try and get them into secure accommodation and try and get them into a property[…] homelessness is caused by poverty, it's caused by social problems, and that probably will make mental health problems more likely"*
>
> *(Participant 15)*

Alongside this housing support which helped women's mental health, participants also shared they would offer other forms of social and practical support such as connecting them with community or social activities, as well as offering the women significant emotional support. Service-providers did not frame this support as a mental health intervention, but it nonetheless was supportive of women's mental health. Participants often compared this informal support favourably to the clinical support offered within mental health services. Participants shared they would place time and attention on developing trusting relationships with women. Kindness, compassion, and listening were emphasised within the context of these “informal” trusting relationships with an aim of developing women’s “confidence” and “self-worth”. Participants shared they tried to ensure women were in control of their support and felt valued.

> *“It falls a lot on our role to make them feel that they are valued, and you know, “It does not matter what circumstances you are in, you are still a human being. You are still a woman; you are still powerful”.*
>
> *(Participant 7)*

Such relationships therefore can be seen as a form of resistance, to counteract the objectifying narrative and negative assertion of power currently provided within mental health services and to allow women to regain control and a sense of power.

Most participants spoke about this emotional support being offered within face-to-face informal conversations or activities – for example going for walks with participants or having a cup of tea. While some services spoke about not being able to offer emotional support during national COVID lockdowns, most participants shared their services had adapted during COVID to continue to try to provide this emotional support in person and a few compared their work favourably to the remote services offered by NHS mental health services during national lockdowns.

> *“We hardly do anything over the phone even during the whole pandemic we have been really visible, we are really face to face we are very practical and hands on and doing physical things with them, you know cooking and chatting and having tea and stuff like that, and I think that, quite rightly, they have got used to that really personal service. Then the thought of having to do something [NHS assessment] that is practically faceless it is quite alien and scary”*
>
> *(Participant 2)*

Some participants spoke about joining women for mental health appointments and finding the support offered was little different to the support they provided women themselves.

> *“I've sat there and listen to the conversations [with the care coordinator], they’re, nothing more than what I do”*
>
> *(Participant 8)*

Alongside the emotional, social, and housing support which were all recognised to support women’s mental health; participants also spoke about their services offering in-house psychological or counselling support or were using charity donations or funds to pay for women to receive talking therapy. Some participants framed this support as a holding space while women waited for NHS support, whereas others framed it as an alternative to NHS support.

> *“We really wanted to get some counselling for her, so in the end we ended up using some of our amenity fund which consisted of sort of charitable donations […] to get some counselling for the women in the house”*
>
> *(Participant 14)*

Alongside offering this individual therapy for women, these in-house qualified mental health professionals helped support workers to work more helpfully with women, for example through training support workers in trauma-informed approaches or offering reflective spaces. However, alongside this clinical support, mental health professionals were also described as a resource in negotiating the NHS mental health systems.

> *“Within my team we've just had a clinical psychologist hired for three days a week who now works permanently in my team, who's able to help us like navigate CMHTs and understand, you know the needs of our clients”*
>
> *(Participant 10)*

These in-house mental health professionals were seen as valuable members of the team in offering this form of support.

3.5.2. Service Providers Feel Unsupported by NHS Mental Health Services

This subtheme captured the distrust participants felt towards NHS mental health services, with many of them expressing negative experiences of requesting support with their roles. Some participants described a fractious relationship with mental health professionals rather than a collaborative relationship between the services.

Throughout the interviews, many participants made frequent references to needing to "fight" with mental health services to help women get support, rather than seeing them as a helpful partner organisation. Participants had low expectations and were often distrustful of mental health services, expecting the service to gate-keep, so participants saw it as their responsibility to advocate for the women. Service providers shared they needed to be "proactive", "tenacious" and "advocate" for the women to be able to access helpful support. The NHS was therefore seen as a more powerful organisation and asserting power over both the women and also the service-providers. Some participants described this as harder to advocate during COVID, as they could not always attend mental health services with women due to social distancing regulations – for example A&E.

> *"Even though our women have us to advocate for them on their behalf, I often find myself arguing with mental health workers, erm, and care coordinators"*
>
> *(Participant 2).*

> *"During COVID, we can't go to the hospital with them, we can't actually go in and be their advocate, we can't say, "Actually I'm speaking on her behalf, and this is how she is feeling duh duh duh," because we have to sit in the car or sometimes literally leave them"*
>
> *(Participant 7)*

Many participants described experiences of being abandoned or left in "limbo" by mental health professionals when participants described wanting mental health professionals to support them with women's distress. One participant described women being discharged from a community mental health service suddenly, and it being the service-provider who needed to respond and support the women because of this. Many participants also described it being difficult to contact mental health services, with mental health teams not answering phones or allocated mental health workers not responding to participant enquiries or visiting their clients. The most notable examples of being abandoned were around times of crisis. Participants described crisis teams or A&E teams leaving service-providers to manage significant risk when they did not feel able to do so. For example, one participant described her experience of a crisis team worker:

> *"[The crisis team worker] came out and literally, well told us that "oh I think you have got it all under control". No. We are not specialised in mental health. We support and we signpost, and we guide, but we are not specialised. And for a crisis worker to say, "oh I think you have it all in hand" and then to leave us with the police and ambulance there"*
>
> *(Participant 7)*

The low regard participants held NHS mental health services in, meant they would often avoid referring women for support, or only refer as a last resort due to expecting it to be of no use. Participants spoke about needing to think carefully about whether a referral would be worthwhile or not or may in fact be damaging due to services being retraumatising or offering poor care.

> *"My prior, is that we will have to look elsewhere, because it [NHS mental health service support] will not happen in the way that you want it to. So, you know, I think my experience with frontline services is that our expectations are quite low, so we don't necessarily go through a normal route of going through a GP, then the CMHT"*
>
> *(Participant 10).*

Participants described trying to use third sector counselling or community-based support before referring to the NHS, but this being more difficult during the COVID pandemic due to many third sector organisations no longer operating in the same manner. One participant described noticing she was referring more women to NHS services as a result of this. Participants also reflected on third sector service-providers hiring their own clinical psychologists, and a few described this as a frustrating situation.

One described seeing it as a “failure” the third sector was having to step in and fund resources which the NHS had failed to provide women.

> *“The charity sector is now investing in psychology support and[…]my feeling is that that is a response to the fact there's a feeling that the NHS services aren't able to provide what's felt is needed[…] but I think that's a real sign of like, failure”*
>
> *(Participant 10).*

3.5.3. Value of Specialist Homelessness Mental Health Services

Participants with access to specialist homelessness NHS mental health services did describe these as helpful and supportive resources. Multiple participants based in London spoke highly of local specialist homelessness GPs. Onward referrals were described as easier due to the specialist GPs being more accessible and having a good knowledge of homelessness and appropriate available services.

Specialist homelessness mental health services within the NHS, including multidisciplinary teams informed by PIE principles and the Psychology in Hostel Programmes, were seen as having different expectations of the women compared to generic services. These teams offered greater flexibility or understanding of the women's needs. Outreach appointments and a range of times for appointments were valued, as well as not being punitive or rigid with discharge policies. Participants described these services seeking to adapt to the women's needs, rather than expecting women to fit into pre-defined mental health systems, which was helpful. Participants also shared specialist mental health services were better placed to communicate with the service-providers and liaise with specific homelessness services.

> *"Just easiness to access of the service not like "oh they missed their appointment today they only have two left. Can you make sure they come? Otherwise, we're going to discharge them"[...]just better multi agency work themselves and them again going above and beyond to reach the needs of our clients as opposed to our clients having to reach them.*
>
> *(Participant 8)*

Participants in areas with specialist mental health services also described these services as better able to understand gendered trauma and the context of women experiencing homelessness and therefore able to offer a better service. Participants familiar with these teams spoke about how there was a different model of mental health support with an emphasis on longer term support and relationships, without forcing engagement to achieve goals. For example, one participant spoke about workers dropping into hostels at the same time each week for months bringing books or other resources, before women started to greet the clinicians. Participants shared these services working specifically with homeless populations had been trained with a better awareness of specific needs around homelessness

> *"This is why the [NHS Trust specific mental health homelessness team] in [Borough] are so amazing, because they come into the hostel, and they have a knowledge and understanding of this client group and the trauma and the violence that they have experienced"*
>
> *(Participant 4)*

Many participants spoke about how specialist homelessness mental health teams were valued for offering support to service-providers. Participants spoke about the emotionally demanding nature of their roles; one participant described the "vicarious trauma" she experienced as a result of hearing about the gendered abuse women had been subjected to, and a few participants spoke about feeling unsure in how to manage mental health problems of the women they supported and needing more mental health training. Participants with access to specialist NHS appreciated the reflective spaces psychologists provided for service-providers to think about how to support women, as well as training opportunities to work with women in psychological distress.

> *"Psychologists provide reflective practice for the staff team which is much needed in a service where you are working with lots of people with lots of problems"*
>
> *(Participant 4)*
>
> *"I do work, day to day, with women who have been through trauma and have lots of training with our psychiatrists who run lots of our trainings like trauma informed care"*
>
> *(Participant 8)*

Many participants frequently shared there was not enough specialist support, and they wanted more specialist homelessness mental health services which understand the context of women's homelessness. Participants spoke about different models for these mental health services. For some participants, Housing First models were promoted as a way of offering mental health support by collaborating across organisations and providing wrap-around care to women. However, regardless of the model, participants shared they wanted more services to cater for women experiencing the multiple disadvantages of homelessness, mental health problems, substance misuse and domestic abuse.

> *"I mean, just I don't think there are enough specialists [mental health] services available for that level of trauma, with the complexities of, specifically, what women experience […] I mean services that specifically are able to provide support around domestic abuse to women who are homeless"*
>
> *(Participant 11)*

Service providers were therefore indicating that even with specialist mental health providers, women experiencing high levels of marginalisation are not receiving appropriate support. Women who have been abused as children, often within domestically abusive relationships are then further abused or let down by mental health services.

4. CHAPTER FOUR: DISCUSSION

Many of the barriers and facilitators identified in this current study have been identified in previous UK and international research exploring barriers to mental healthcare among the wider homeless population. However, it is useful to specifically identify these as barriers to women and as prevalent within English NHS services. The current study also indicates many of these previously identified barriers impact women differently, as well as women experiencing additional gender specific barriers.

4.1 What are the barriers to accessing mental healthcare for women experiencing homelessness?

4.1.1. Double Impact of Gendered Abuse and Trauma

The scoping review would indicate that this is the first study which highlights how such gendered abuse acts as a barrier to NHS mental healthcare access among women experiencing homelessness. This study supports findings identified in the scoping review and beyond, indicating women experiencing homelessness experience complex traumatic abuse before and during homelessness, including forms of domestic, sexual, physical, and other forms of gendered abuse and violence (Huey et al., 2014; Lewinson et al., 2014; Milaney et al., 2020; Reeve, 2018). From a feminist perspective, this abuse operates within a patriarchal system which can perpetuate and normalise such male violence (Nash, 2020).

This study identified coercive control within intimate relationships as a barrier to mental healthcare among women experiencing homelessness. This barrier has not been previously identified in literature exploring barriers to accessing mental healthcare among women experiencing homelessness in England. However, coercive control has been documented in the analogous literature exploring access to UK substance misuse services (St Mungo’s, 2020), and in a wider systematic review of barriers to mental healthcare among women experiencing domestic abuse (Rodríguez et al., 2009). Participants also described partners using children as a means of control which is well documented in wider domestic abuse literature (Stark & Hester, 2018). This study, by identifying coercive control as a barrier to mental healthcare specifically among women experiencing homelessness, supports emerging calls, particularly among feminist scholars, advocating for women's homelessness and domestic abuse to be considered together (Bimpson et al., 2021; Bretherton & Mayock, 2021; Wardhaugh, 2012).

The scoping review also indicates that this study is contributing to identifying fear and mistrust of children's social care as a barrier to accessing mental healthcare. While this has been identified as a barrier to mental healthcare services among women experiencing homelessness previously in the US (Bassuk & Beardslee, 2014; Weinreb et al., 2007), this has barrier has not been identified in England. This study supports previous literature in the US and UK, indicating women have contact with children's social care as children (Schwan et al., 2018) and many are traumatised by the experience of child loss via social care (Gordon et al., 2019; Groundswell, 2020a). As such, mothers fear not being able to see their looked after children, or having children removed if they access mental health services and share the nature of their psychological distress. Feminist perspectives would advocate that this fear is not unfounded, as the state is a patriarchal force which can assert power over women through child removal (Stark & Flitcraft, 1988). This study suggests that women are not provided with the necessary resources to maintain care of their children – such as mother and baby units. Instead, women are treated punitively with child removal, when they do not meet state expectations for mothering – a pattern identified by feminists as "patriarchal mothering" (Stark & Flitcraft, 1988). Mental health professionals, with a duty to safeguard children, share information with children's social care and so form part of this patriarchal and unsupportive system for women. Mistrust of mental health services and social care can thus be seen as a barrier to mental health care, but also women seeking to protect themselves and their children from the assertion of patriarchal power.

Participants considered women's greater experiences of abuse and trauma, including from public services, to contribute to women's greater mistrust of professionals compared to men. This study indicates signs of professional status are treated with suspicion, such as identity badges, formal clothing, or lanyards. This is the first research in England to identify this as a barrier woman experiencing homelessness face when accessing mental healthcare. Previous research in the US with women experiencing homelessness has indicated women are likely to be acutely aware of power differentials in relationships with professionals, which can make it harder to build relationships (Weinreb et al., 2007). Again, from a feminist perspective, this suspicion would not be problematised, but rather normalised and acknowledged as women seeking to protect themselves in a hostile patriarchal context (Ridgway, 2014). However, given therapeutic trusting relationships are central for working with mental health problems and trauma (Herman, 2015; Van der Kolk, 2014), this mistrust of professionals and fear of forming trusting relationships can be seen as a barrier to mental healthcare.

4.1.2. NHS Mental Health Services seen as Stretched Gatekeepers

This study supports previous research conducted in the UK with mixed gendered homeless populations, and also the Groundswell (2020a) study identified in the scoping review, indicating NHS services act as barriers to women experiencing homelessness from accessing mental healthcare due to a lack of resources. The pervasive nature of financial and staffing shortages across the NHS mental health sector has been widely reported (Bannister, 2021; The Kings Fund, 2022) and was supported by findings within this study. Underfunding health services has been critiqued by feminists for disproportionately impacting women, as women account for most patients and staff within the NHS (Women's Budget Group, 2012). Women experiencing homelessness mental health concerns, higher rates of diagnosed mental health issues, suicidal thoughts and attempts, and adverse childhood trauma than men experiencing homelessness (Milaney, 2020) also supporting the suggestion that such underfunding disproportionately impacts women.

A further barrier identified within this study was the difficulties women face with service eligibility criteria and referral pathways, particularly the reliance on GPs to refer to mental health services. This finding supports the Groundswell (2020) study with women experiencing homelessness identified in the scoping review, and also previous mixed-gendered studies in the UK indicating that difficulty accessing GPs to secure an onward referral to mental health services is a barrier due to GP requests for ID when registering, or long waiting lists for appointments (Bhui et al., 2006; Groundswell, 2020a; St Mungo's, 2016). Such findings indicate that NHS patient registration guidelines which state patients do not need ID or a fixed address to register (NHS England, 2015), are not being followed, and homelessness organisations are campaigning to increase GP awareness of such (Meakin, 2017).

An important finding of this research is that complex referral pathways are particularly poorly suited to women experiencing homelessness, presenting with mental health problems alongside experiencing domestic abuse and/or substance misuse. This study indicates that services are frequently being commissioned and structured to support one area of need, so often do not accept referrals or are unable to adequately support women experiencing more than one need. The combination of substance misuse and mental health problems resulting in a lack of mental health care support is well documented in mixed-gendered literature (Canavan et al., 2011; Gunner et al., 2019; Youn et al., 2019), and identified in the scoping review of women only homelessness research exploring barriers to mental healthcare (Groundswell, 2020a; Kneck et al., 2021; La Mar, 2021). This study indicates that women are not offered care in line with NICE (2018) guidelines for Complex Trauma which recommends people are not excluded from treatment for trauma based solely on comorbid drug or alcohol misuse.

However, this research offers a novel contribution to English research by explicitly identifying that these complex NHS mental health referral pathways exclude women experiencing both mental health problems and domestic abuse. The studies in the scoping review identify high rates of domestic abuse (David et al., 2015; Groundwell, 2020; Huey et al., 2014; Kneck et al., 2021). Kneck and colleauges (2021) Swedish study indicates that healthcare services are not designed to meet the needs of female victims of violence; however this is the first study in England exploring mental health care access to identify that the complexity of NHS referral pathways exclude women experiencing domestic violence. As an issue which predominantly impacts women (Wardhaugh, 2012), a feminist perspective may be that such referral pathways and systems are designed with men’s needs in mind and neglect the needs of women.

A further barrier identified within this subtheme was the denial of mental health services to women experiencing homelessness with NRPF. This finding supports the Groundswell (2020a) study identified in the scoping review, which indicated that immigration status is a barrier to mental healthcare for women experiencing homelessness within England. However, combined with other findings within this research, such as that women have experiencing significant sexual violence, this research can offer a novel contribution in suggesting that women are not being provided with the treatment to which they are entitled. NHS guidance stipulates free treatment should be provided for mental health problems caused by torture, female genital mutilation, domestic abuse, or sexual violence, regardless of immigration status (Office of Health Improvement and Disparities, 2021a). The findings from this study, along with other literature, indicate many women experiencing homelessness experience these forms of gendered abuse (Christensen et al., 2005; Duke & Searby, 2019; Huey et al., 2014; Kushel et al., 2003; Lewinson et al., 2014) and consequently experience mental health problems (Bimpson et al., 2021; McCarthy et al., 2022; Rayburn et al., 2005).

Together, findings from this study and the wider literature suggest mental health services may be applying NRPF guidance inappropriately by denying women access to mental health services they are eligible for. Taking an intersectional feminist perspective, (Crenshaw, 1991), such a finding demonstrates how women experiencing homelessness experience different barriers to mental healthcare depending on their immigration status – which is more likely to impact women from racially minoritised backgrounds. However, findings from this study also indicated women were fearful of healthcare services due to their immigration status, and so it may not simply be a question of mental healthcare services operating in isolation to remove barriers, but recognising how the wider state – including the Home Office – can alienate and oppress this group of women to create barriers to mental healthcare (JCWI, 2021; Worthing et al., 2021).

Finally, the NHS operating as stretched gatekeepers creates barriers to women accessing mental healthcare through only offering crisis support. This study identified waiting lists for accessing most mental health services as inappropriate for women experiencing homelessness who often cannot wait due to their changing circumstances. Waiting lists have been identified as a barrier in previous mixed-gendered research exploring access to mental healthcare among people experiencing homelessness

(Brown et al., 2016; Youn et al., 2019). The Groundswell (2020a) study identified in the scoping review also identified waiting lists as a barrier to mental health care within London. As has been identified in mixed-gender studies, waiting lists seemed to contribute to women only accessing mental health support in an emergency, often via A&E (Christiani et al., 2018; Devine & Bergin, 2020; Hodgson et al., 2014). This study offers a contribution in indicating that in other regions across England, outside of London, waiting lists continue to be a barrier to women experiencing homelessness accessing NHS mental healthcare services.

A further barrier identified within this study is the difference transport can make to barriers to mental healthcare between rural and urban areas for women experiencing homelessness – a novel finding this study contributes to the literature not identified in the scoping review. Findings from this study suggest the reliance on accessing mental healthcare via A&E is a particularly important barrier in rural areas, due to a lack of public transport and the frequent need to travel long distances to access support. Such findings support wider research indicating there are greater barriers to healthcare access for the general population in rural communities than in urban populations (LGA, 2017). Although there is growing recognition rural communities are experiencing an increase in homelessness (Jarvis et al., 2020), there is no research on barriers to healthcare access for the homelessness population in UK rural communities.

4.1.3. NHS Mental Health Services are Unforgiving and Retraumatising

NHS mental health services were characterised as unforgiving and retraumatising through “inflexible and punitive” practices, a “lack of awareness of gendered trauma” and “discriminatory and coercive practices”. The retraumatising nature of mental healthcare can be understood with a feminist understanding of institutional trauma. Adopting a feminist approach, Thompson (2021) argues in the use of “institutional betrayal” is a form of institutional trauma used to describe where failures in institutional processes produce or compound trauma (p.111). The findings from this study would indicate that the NHS is operating to both produce and compound trauma women have experienced and thus party to this betrayal.

One such example of the NHS mental healthcare services producing such betrayal is the use of "inflexible and punitive" policies which act as a barrier to mental health care while reproducing socio-political relations of socio-economic status, gender inequality and racism. Findings from this study indicate women experiencing homelessness are expected to abide by rigid expectations to receive care, supporting Kneck and colleagues (2021) study identified in the scoping review, which elucidated how women are expected to conform to policies rather than the reverse. Such expectations include the timings and locations of appointments, requiring phones and a fixed address – which has been identified in mixed gender research in the UK (Bhui et a., 2006; Omerov et al., 2020) and Kneck and colleagues (2021) study.

Drawing on feminist theory of institutional betrayal, such rigid expectations reproduce oppressive socio-political relations and – drawing on intersectionality (Crenshaw, 1991) – disproportionately impacts women experiencing homelessness due to the positions they occupy. For example, this study indicates the inflexibility in appointment times for is a particular barrier for women who may be sex working – a finding supporting Kneck and colleagues (2021) study. Similarly, inflexible expectations were evident for women who do not speak English and require interpreters but cannot access them through GPs or mental health services. A lack of interpreters has been identified as a barrier to healthcare in mixed gender studies in the UK previously (Shelter, 2021). The provision of interpreters is part of NHS guidance (Office for Health Improvement and Disparities, 2021b) and such findings indicate the NHS is not providing women with the standard of care expected. These findings indicate that expectations women will conform and fit in to service provision, reinforce racist patriarchal norms which exclude those who do not meet these standards – with those further away from those standards facing more marginalisation, such as women who sex work or do not speak English.

Findings from this study also indicate that a barrier to NHS mental healthcare is services behaving "putatively" when women do not meet these rigid expectations and are discharged suddenly from services – a finding supported by the Groundswell (2020) study identified in the scoping review. Thompson (2020) adopting a feminist perspective argues that institutions, such as the NHS, reproduce violence which subsequently reproduces trauma, and it is important to see the institutional power which makes this possible. Here, the NHS operates from a position of significant power over the women to punish and retraumatise women by denying care to those who do not comply.

The “lack of awareness of the impact of gendered trauma” findings can also be interpreted from Thompson’s (2021) feminist perspective of institutional trauma. Findings from the study suggest most women seeking mental health support are predominantly offered medication by mental health services, as found in other mixed-gendered research with people experiencing homelessness (Brown et al., 2016; Devine & Bergin., 2020; St Mungo’s 2016) but not previously identified in a study focussed on women. The use of medication to support people with significant experiences of trauma does remain controversial due to addictive properties and a lack of evidence base for some drugs (Read & Moncrieff, 2022). Thompson (2021) argues that this pathologises trauma and constructs it as an individual pathology, and as such can hide the socio-political context and power dynamics which often negatively affect the most marginalised. Indeed, the findings from this study fit with wider patterns of prescribing in the UK where women and people from lower socioeconomic groups are more likely to be prescribed psychiatric drugs (NHSBSA Statistics, 2020; Rhodes, 2019; Wise, 2014). Participants indicated women are offered talking therapies less often than medication, when offered, therapies are short-term and goal-focused which participants considered inappropriate given the women’s traumatic histories. La Mar’s (2021) study with women experiencing homelessness indicates women want to stay with mental health services for a long time to build meaningful therapeutic relationships in order to benefit from them. Currently then, from a feminist analysis, English mental health services may be exerting institutional power over women to pathologise trauma offering medication or short-term therapies.

Such findings also indicate women may not be accessing appropriate support as stated in the NICE guidance for Complex Trauma (2018), which only recommends medication for people who have drug treatment as their preference. This guidance also recommends longer term therapeutic support, additional sessions to build trust and encourages services to consider personal circumstances, specifying housing circumstances, and how this may impact engagement with treatment.

Furthermore, the “lack of awareness of gendered trauma” extended to how women cope following traumatic experiences. People who experience trauma can develop adaptive ways of coping which can be considered unhelpful in different contexts, such as aggression or anger (Sweeney et al., 2018) or refusing to work with men – both can be seen as forms of resistance against the patriarchy. Participants described mental health professionals being punitive when women refused to work with male staff. From a feminist standpoint, separation from men has been seen as a means of creating safe spaces which are free from male-defined and male-dominated roles, relationships and activities and a means of creating solidarity between women (Leathwood, 2004). Advocates for single-gender service provision have argued the importance of understanding trauma-responses and providing single gender spaces and gender informed care (Agenda & AVA, 2017; Department of Health and Social Care, 2018a). By denying such care, NHS mental health services again operate institutional power over the women to reproduce trauma and create a barrier to mental healthcare for women experiencing homelessness.

Findings in this study indicating services are “discriminatory and coercive” further support Thompson’s (2021) assertion of institutional power retraumatising women rather than offering them space for recovery. Findings indicated women were offered little choice and control by mental health services; with examples ranging from referrals being made without consent to forcible medication use and police detention. Previous research with the wider population indicates coercion is prevalent within mental health services, particularly in acute settings (Department of Health and Social Care, 2018b) and such practices can retraumatise people (Sweeney et al., 2018). As a result, The Independent Review of the Mental Health Act proposed several recommendations to improve care and reduce coercion in mental health services which have been introduced as a government white paper (Department of Health and Social Care, 2018b. There is little research specifically on women experiencing homelessness and their experiences of being forcibly detained. However, findings from this study indicate the

NHS mental health care services can “institutional betray” women through promising care but offering further retraumatisation through the assertion of coercive power.

4.2. What are the facilitators to women experiencing homelessness in accessing mental healthcare?

This research supports David and colleagues (2015) research in identifying consistent facilitators which support women to access mental healthcare. This research indicates third-sector service-providers offer mental health support by supporting women’s basic social determinants of mental health, including accommodation, finances, work activities and relationships. Practical help can also be offered, such as attending appointments for moral support or dropping women off. This study’s findings suggest mental health services could make better use of relationships and inter-agency working with third-sector service providers, given the importance of the support they are offering women. Many of these facilitators are identified in David and colleagues (2015) study. Service-providers often highlighted how their relationships prioritised kindness, compassion, and confidence building – which David and colleagues (2015) advocate for – the kind of long-term, trusting relationships that are often lacking in mental health services. Such relationships appear to be less hierarchical than those within mental health services and appear to empower women, which would be more in line with a feminist approach to mental health support advocating for the redistribution of power between practitioners and people using services (Bondi & Burman, 2001).

The subtheme “The Value of Specialist Homelessness Mental Health Services” captures how specialist teams can facilitate access to mental health support by offering outreach and meeting women in convenient locations, such as hostels or familiar community settings. Outreach has been identified as a facilitator for access in previous mixed gender studies with people experiencing homelessness (Brown et al., 2016; Canavan et al., 2011) and David and colleagues (2015) study. Participants considered outreach as giving women a sense of control when meeting mental health professionals. Recent policies are supporting these more flexible models of working with the homeless population. The NHS Long Term Plan (NHS, 2019a) dedicates further funding for homelessness outreach mental health services and the NICE (2022) guidance for homelessness promotes outreach mental health work and flexible opening and appointment times.

Participants considered that specialist mental health teams put more emphasis on building trusting relationships than generic teams. The importance of being respectful, consistent, and patient with people experiencing homelessness in mental healthcare is supported by many previous mixed gendered and women's studies (Canavan et al., 2011; Chaturvedi., 2016; David et al., 2015). There is a growing evidence base across attachment literature and complex trauma research, suggesting trusting relationships are important in effective therapeutic engagement and mental health recovery (Bucci et al., 2014; Herman, 2015; Van der Kolk, 2014). The NICE guidance for people experiencing homelessness (2022) highlights the importance of building relationships over time, as does La Mar and colleagues (2021) study identified in the scoping review. Many homelessness services are promoting PIE and Trauma Informed Care, which emphasise relationships and person-centred psychologically informed care rather than tightly following protocols such as discharge policies (Keats et al., 2012; Wilton & Williams, 2019).

Compared to generic mental health teams, specialist homelessness teams were also appreciated for being better able to cope with the complexity of needs and gendered trauma women present with. This is interesting as specialist homelessness mental health services offer support to both men and women. Some studies, and participants within this study, have suggested that women's only services would be helpful to offer this gender informed approach (David et al., 2015; St Mungo's 2016). It may be that as specialist services offer outreach into women's only spaces, they are better able to meet the women's needs without having to operate a service dedicated to women. Regardless of the approach adopted, this research indicates women only provision – which can be seen as a form of resistance against the patriarchy (Leathwood, 2004) – would be a useful facilitator for mental health access for women experiencing homelessness.

Advocates for specialist mental health services argue there are not enough (Bhui et al., 2006; Devine & Bergin, 2020; Reid & Klee, 1999) and this study suggests outside of

London, specialist mental health homelessness services are limited. The NHS Long Term Plan (NHS, 2019a) places a focus on developing these specialist homelessness mental health services, which is a development supported by findings in this study, alongside future services considering how to meet women's needs.

Finally, participants appreciated reflective practice and mental health training provided by mental health services. Findings from this study and previous international literature indicate service providers can struggle with vicarious trauma and feeling untrained in supporting women with their mental health (Burke, 2005; Devine & Bergin, 2020). Training and reflective practice within this study, and in previous literature was seen as helpful to manage some of these difficulties as well as supporting women (Ava & Solace Women's Aid, 2018; Breedvelt, 2016). Reflective practice is a key feature of increasingly popular PIE (Johnson, 2015) and psychology in hostels approaches (Rhodes, 2016). Reflective practice can also be expanded beyond understanding the impact of gender on women's experiences but also used within intersectional framework to consider how other inequalities and oppression related not just to gender but also to sexuality, class, race can influence women's experiences (Mattsson, 2014).

4.3. How has COVID-19 impacted on women experiencing homelessness in accessing mental healthcare?

The scoping review indicates that this is the first study which has explored the impact of the pandemic on the barriers to mental healthcare access for women experiencing homelessness in England. As such, many of the findings identified here offer novel contributions to the literature.

Findings indicates that the NHS as an under-resourced service which does not have flexibility within the system for the additional stress created by the pandemic. Participants identified that many of the women they worked with experienced increasing mental health problems during the pandemic, as initial research has found across the general population (Moreno et al., 2020). However, participants considered that the increase in demand for mental healthcare was not reflected in an increase in provision. Participants described noticing the pandemic creating additional needs on mental health teams with high levels of staff sick leave or staff shielding, which impacted on the mental health services' ability to respond effectively and offer appropriate mental healthcare to women.

In addition, participants shared that the pandemic had impacted third sector mental health provision. Participants spoke about often using charities to provide the mental health support for the women they worked with, either because it is more specialised for their needs or because they did not want women to have to wait for the NHS. However, participants shared they had noticed the third sector during the pandemic often closed their services and were not offering support, meaning they had to refer to NHS services instead. Ultimately, participants viewed these factors as exacerbating an existing barrier by creating longer waiting lists for women needing mental health support. While the impact of the pandemic is being evaluated, initial research indicates the pandemic creating longer waiting lists for mental health provision for people experiencing homelessness (Groundswell, 2020c).

The pandemic also appears to have exacerbated the difficulties of accessing support via the GP. During the pandemic, participants reported longer waiting lists in accessing GP appointments since the pandemic began. Research suggests during the first national lockdown, GP appointments fell to the lowest levels on record, creating a severe backlog in care, alongside additional pressures of managing the vaccine roll out (Atkins et al., 2021). As has been discussed, the reliance on GPs for access to mental health services increases the waiting time for accessing support and contributes to the “complex and exclusionary referral pathways”.

However, the introduction of “Everyone In” and the use of COVID hotels was identified as an important way women could access support on site, without having to go through such a complex process to access care. Participants with experience in this setting described primary care and some mental health workers being present on site to offer immediate support to women if needed without a long waiting list. The inter-agency support and having a range of professionals in one place was also identified as helpful. Such findings mirror research noting co-location of services, inter-agency working and drop in options are helpful models in providing healthcare for people experiencing homelessness (Brown et al., 2016; David et al.,2015; Hamilton et al., 2012; Youn et al., 2019).

Participants also highlighted those within hotels were being housed and then offered support around their accommodation, which was considered by many participants to be helpful. While this is not a Housing First initiative, in the sense that the principles of this approach have not been followed, findings from this study support this body of literature suggesting accommodating people first can be beneficial to then offer additional services alongside (Housing First Europe, 2022).

Importantly, many GPs and mental health services offered telecare or remote services following the onset of the pandemic (Hutchings, 2020). Participants described the introduction of digital care as creating a barrier for many of the women they work with and described services as inflexible in providing alternative face to face provision. A finding supported by Adam and colleagues (2022) mixed gendered research. Participants described speaking over the phone or on video calls as a barrier to communication, especially for women with English as a second language or those with experiences of abuse, which make it difficult to form relationships remotely. In addition, digital provision requires women to have access to phones, laptops, phone data or an internet connection, which some women cannot afford, or struggle to access consistently. Such findings support existing research demonstrating how people experiencing homeless can be excluded from digital healthcare due to privacy problems, poor literacy, or poor access to technology (Dorney-Smith & Gill, 2021; FEANTSA, 2021; Groundswell, 2020b). Drawing on intersectional feminism, the findings also indicate the pandemic had a greater impact on more marginalised women, such as those unable to access technology or requiring face to face communication due to speaking limited English.

Alongside exacerbating barriers, the pandemic also limited access to facilitators of mental healthcare access. Participants described that they were unable to drive women to appointments due to social distancing rules, which meant transportation to mental health appointments became more difficult for women. In addition, participants shared that before the pandemic they would often attend appointments with the women and help them communicate or advocate for their needs, including in A&E.

This is the first piece of research, identified within the literature review, to explore the impact of the pandemic on barriers to mental healthcare for women experiencing homelessness. Overall, while COVID hotels may have had a limited positive impact, the COVID-19 pandemic resulted in several new barriers to mental healthcare access, exacerbated many of the existing barriers and reduced some of the facilitators that were present before the pandemic.

4.4. Critical Review and Reflections

4.4.1. Reflexivity

Reflexivity is considered an important part of the process of qualitative research (Willig, 2013) and central to reflexive TA (Braun & Clarke, 2022). Willig (2013) outlines two forms of reflexivity: personal and epistemological.

4.4.1.1. Personal Reflexivity

Throughout this study I have sought to reflect on how my own values, assumptions, experiences, and social identities have shaped the research (Braun & Clarke, 2013; Braun & Clarke, 2022; Willig, 2013). I have recognised my role as an active participant in the research (Braun & Clarke, 2022) and made use of journaling in my reflective log and speaking with my supervisor and colleagues to remain curious and hold a reflexive stance.

I have sought to reflect on my identity throughout the research process and wondered if my identity as a woman likely shaped the research questions and attracted me to a project exploring women's access to services. This aspect of my identity, and perhaps being more attuned to gender discrimination because of it, also likely impacted how I generated data collection and the themes within the analysis process – for example, noticing aspects of gendered trauma.

My identity as a white woman may have meant that racially minoritised participants felt less able discuss how race and gender can intersect during the interviews. My identity as a cisgender woman, may also have impacted the research and meant that opportunities to look beyond the gender binary were missed – for example failing to probe interviewees when discussing gender in binary terms.

I may also have overlooked other opportunities to probe interviewees when discussing aspects of marginalisation, I do not experience, which may mean other aspects of intersectionality have been missed. During analysis at the stages of coding and theme development, I may have neglected how intersecting identities I do not occupy impact barriers to care. Women may therefore be viewed as a homogenous group in the analysis rather than intersections being addressed sufficiently.

I have also reflected on not having lived experience of homelessness and the implications of this in how I have constructed research questions, interview schedules and the analysis. Participatory research methods are increasingly recognised as important within homelessness research (e.g Groundswell, 2020a) and I am aware that by researching women experiencing homelessness, without involving women themselves, I may be contributing to practices which disempower.

My reservations about medical models of mental health (Engel, 1977; Read & Moncrieff, 2022) and appreciation for social determinants (Allen et al., 2014) may also have shaped the construction of my themes. Throughout this research process and during interviews with participants, I have been aware of a dissonance in my mind between wanting to increase accessibility to mental health services, but also being unsure about how helpful medicalising mental health services can be. It has been helpful to reflect on and be transparent with my supervisor when constructing themes to notice and reflect on these assumptions and beliefs.

4.4.1.2. Epistemological Reflexivity

Epistemological reflexivity requires reflecting on the assumptions about the world and how knowledge is created during the research, which can be helpful for considering implications of the research findings (Willig, 2013). I adopted a critical realist perspective – recognising there is a reality but there may be different perspectives of it (Archer et al., 2016; Maxwell, 2012).

Inherent within the research questions are ontological assumptions, for example: the definition of homelessness; that mental health exists; the NHS should be offering mental healthcare to women experiencing homelessness; women should be able to access NHS care; and there are barriers and facilitators to accessing such care. These assumptions have been framed by my status as an NHS professional and the wider social and political context which positions the NHS as a service available to all. Such assumptions impact how the study has been conducted and the findings which have been produced. I am aware that a researcher approaching this topic from a different position, perhaps outside of the NHS, may have asked different questions from a different ontological position.

Epistemologically, I have assumed service-providers can transparently communicate their context dependent perspectives which may not reflect the “true” barriers and facilitators to mental healthcare access experienced by women (Willig, 2019). Interviewing women experiencing homelessness themselves would have likely generated different perspectives on such barriers and facilitators. The NHS is promoting the voices and perspectives of people using services (Department of Health, 2012) and homelessness organisations emphasise the importance of involving and listening to those with lived experience (Groundswell, 2022; St Mungo’s, 2017a). It is important to recognise the knowledge created here is formed from service-provider context and experiences.

Epistemological reflexivity also considers methodology. The choice of a qualitative study and TA will have influenced the findings. I, as a lone researcher, have become familiar with the data and a different researcher is likely to have constructed different themes from the data. While this is accepted within reflexive TA and not considered a limitation (Braun & Clarke, 2022), it is important to hold in mind when considering implications.

4.4.2. Quality of the Research

Generic principles for qualitative research, such as having a secondary coder, utilising a coding framework, or triangulating data, are not appropriate with a critical realist epistemology and the analytic approach of reflexive TA (Braun & Clarke, 2022). This study utilised Braun and Clarke’s (2022) 15-point checklist for good reflexive TA which outlines quality standards across the process from transcription to writing the research report. To select a few from the checklist: data were transcribed at a detailed level and checked against the transcripts; the coding process was thorough; themes were checked against coded transcripts and the original dataset; the ontological and epistemological positions have been considered throughout; and the extracts selected evidence the analytic claims.

Although the necessity for using generic quality measures for TA are debated (Braun & Clarke, 2022), this study also considered the four criteria identified by Lincoln and Guba (1985) to reflect on the quality of the research. Research is credible when there is confidence in the truth of the findings, given the context in which it was conducted, and when readers with similar experiences can recognise the findings of the data (Lincoln & Guba,1985; Johnson, & Rasulova, 2016; Sandelowski, 1986) To meet the credibility criteria, there was prolonged engagement with the transcripts, with data analysis taking place over four months to avoid pre-closure of the analysis and allow time to check preliminary findings against the interviews (Braun & Clarke, 2022). Provisional themes were also discussed with peers engaged in homelessness research. Furthermore, the research findings were presented at an annual homelessness conference and the findings were recognised as representative of experiences of those working within the field.

Transferability is the extent to which findings are relevant to another context (Nowell et al., 2017). This project has purposefully sampled across a range of homelessness services and provided detailed descriptive information of the participants and their settings (Johnson & Rasulova, 2016). While the epistemology posits that it would be difficult to transfer findings completely, the response at the homelessness conference indicates that the findings do resonate with other third-sector service-providers.

Dependability is the consistency and traceability of the research process (Lincoln & Guba, 1985). The methodology is clearly outlined and documented (Krefting, 1991), including an example of a coded transcript in the appendix (Appendix I). To reach confirmability, I have demonstrated that findings are derived from the data (Nowell et al., 2017) and clearly outlined the reasons for methodological and analytic decisions throughout the research process. A reflexive log has also been utilised to think about why decisions were made.

4.4.3. Limitations of the Study

This study recruited third sector providers to understand barriers and facilitators to women experiencing homelessness. While the advantages of this have been described, this sample is also a limitation in they are one step removed from the women’s direct experiences of mental health services.

Furthermore, this sample, and the findings constructed, may not be reflective of women experiencing some forms of “invisible” homelessness, such as women sofa-surfing or remaining in abusive relationships. Most participants were service providers from the homelessness sector, working in hostels or housing first services. Many women experiencing “invisible homelessness” do not access homelessness services (Bimpson et al., 2021; Bretherton & Mayock, 2021). Despite contacting services supporting women experiencing domestic abuse and explaining the inclusion criteria, these services were less likely to respond to participate. One response from a domestic abuse service stated that the service did not support women experiencing homelessness – despite providing temporary accommodation to women fleeing abuse. The use of the word “homeless” on recruitment materials may therefore have limited access to service-providers working with women experiencing more invisible forms of homelessness.

As a result of this, many of the participants were from services who supported “single women” or women who did not have their children with them. Mothers with their children experiencing homelessness are believed to be a large proportion of the homelessness population and may experience separate barriers to mental healthcare access which need to be further explored.

The sample recruited was predominantly white female. In more rural areas, participants identified that most women supported were white, whereas in London, participants identified that they supported women from many racial backgrounds, both reflective of the local populations. The researcher did attempt to recruit from services set up to support women from racially minoritised backgrounds to capture a broader range of experiences; however, service providers from the services contacted did not respond or decided not to participate. It was notable that the impact of racism was most often discussed when speaking to racially minoritised participants. Given the recruitment and the researcher being white, the more nuanced understandings of racism and the impacts of race on healthcare access may have been lost when probing in interviews and also when analysing transcripts.

The impact of race is likely to be an important consideration with many women considered NRPF and homelessness as a consequence, more likely to be racially minoritised (Women and Equalities Committee, 2020). In addition, the barriers to mental healthcare access among racially minoritised people is well documented (Bignall et al., 2019; Kapadia et al., 2022; NHS England, 2020). The study could have benefitted from purposive sampling to interview a certain number of participants from minoritised backgrounds as done in Bhui and colleagues' study (2006). The interview schedule could also have included additional prompts to consider race.

Similarly, other intersecting identities and demographics, such as sexuality and disability, were not explored in detail within this study which may be an avenue for future research.

4.4.4. Strengths of the Study

This study is the first study in England to explore barriers and facilitators to mental healthcare for women experiencing homelessness and so this study offers a novel contribution to this limited knowledge base. This study demonstrates numerous barriers to accessing healthcare with clear implications for how services can be improved for a population who struggles to access appropriate support. By exploring facilitators and what is already working well, this study also suggests areas of improvement for services to better deliver support.

There was also a good level of engagement and interest in the relevance of the study, with fifteen service-providers from across different regions in England choosing to participate in the research. Service-providers were also from different homelessness services providing perspectives from services across the sector.

The findings of this research study are also timely. There is increasing focus on women's homelessness as demonstrated by recent research (Bretherton & Mayock, 2021; La Mar, 2021; Milaney et al., 2020). Healthcare for the homeless population is also in recent focus with the publication of the NICE guidance in March 2022. Thus, the implications of this research can contribute to ongoing conversations within the field.

4.5 Implications

4.5.1. Preventing and Responding to Gendered Abuse

The findings of this research indicate the need to take a longitudinal approach to understanding the barriers women face to accessing mental healthcare. The "Double impact of Gendered Trauma" across a woman's lifespan appears to enhance mental health problems and prevent access to mental healthcare gives rise to implications to prevent such abuse from happening in the first place.

Change at the societal level is needed to prevent and minimise the harm caused by abuse such as domestic or sexual violence. The recent introduction of the Domestic Abuse Act (2021) indicates political will to support victims and offers new legal safeguards; however, it has been critiqued for not offering migrant women the same protections around housing provision (Women's Aid, 2021a). In terms of sexual violence, the proportion of women experiencing abuse remains high, while conviction rates for sexual abuse and rape remain low (BBC, 2022). The government has released a Government Strategy for Tackling Violence Against Women and Girls (HM Government, 2021b) which seeks to prevent women experiencing violence. However, the strategy has been criticised for being separated from the strategy for domestic abuse and being inadequately funded (Women's Aid, 2021b). While the findings from this research cannot suggest implications for how to prevent violence, it does indicate the importance of violence reduction for women's mental health and risk of homelessness.

Mental health services also need to improve how they respond to women experiencing homelessness and gendered abuse. As has been elucidated in the "*Gendered Trauma"* theme, domestic abuse presents unique challenges to mental health services. This study supports previous research (Bretherton & Mayock, 2021) indicating public services need to be able to understand and offer better provision to women experiencing homelessness alongside domestic abuse and additional needs. Mental health services could be better placed to identify "partner intrusion tactics" (Rodríguez et al., 2009) and work with partner organisations to support women rather than discharging them.

Findings from this study also suggest women experiencing homelessness struggle to access mental health support for trauma in line with NICE (2018) guidance. While such guidance is not adapted for women experiencing homelessness, adopting the guidance could go some way to helping women access the support they need. The guidance recommends longer term therapeutic support with medication for those with a preference for it, rather than a primary treatment, as well as encouraging clinicians to consider housing and how people will engage with services as a result.

Findings indicate mental health services should aim to offer trauma informed services which do not retraumatise (SAMHSA, 2014). Findings from this study indicate attention needs to be paid to mental health service design across the journey from referral to assessment, through to treatment and discharge, to consider the impact on women who have experienced gendered trauma. For example, offering longer assessment periods to build rapport, meeting in informal comfortable settings and attuning to power dynamics throughout. Findings suggest reframing difficult or aggressive behaviour as responses to trauma and considering updating discharge and behaviour management policies as a result. Different models of trauma informed care exist and are being promoted within mental health services (Sweeney et al., 2016; Sweeney et al., 2018; Wilton & Williams, 2019) and could be considered. Specialist homelessness mental health teams appear to be guided by trauma informed principles; however, there are implications for generic mental health teams also adopting similar approaches.

Within some trusts, such as Camden and Islington NHS Mental Health Trust, there is a move away from traditional CMHT models to a pilot integrated community teams from health, social care, and the voluntary sector. Neighbourhood Mental Health Services which offer integrated and holistic forms of care across services. Teams include community workers, occupational therapists, peer workers, population health nurses, psychologists, social workers and specialist doctors and nurses (CANDI, 2021). Alongside healthcare, the team hopes to support with housing, employment and managing finances. The findings of this research suggest that integrated working should also include domestic abuse workers as well as housing representatives.

The use of coercion within mental health services could also be reviewed, considering the gendered trauma women experiencing homelessness have faced. The Independent Review of the Mental Health Act (2018) highlighted how mental health services can retraumatise and has advocated for a greater choice and control, especially around detention, treatment, and the use of medication (Department of Health and Social Care, 2018b). The report is yet to be implemented although the Reforming the Mental Health Act White Paper was published in August 2021. The findings from this study support such changes to coercive mental health practices, and the impact of future changes in legislation will need to be evaluated.

Findings also indicate the need for more training across mental health services on the legal rights of migrants with NRPF who have experienced gendered trauma. This research indicates many women with NRPF are unable to access mental healthcare due to their immigration status. However, given many of these women are likely to have developed mental health problems because of gendered trauma, these women are eligible for support. Improved awareness of legal rights and screening for domestic abuse and gendered violence within mental health services is likely to ensure these women are better able to access the support they need. The importance of providing interpreters for migrants is also emphasised within the NICE guidance and supported by the findings in this research.

4.5.2. Improving Awareness of the Impact of Child Removal

There are further implications for women who have had children removed by social care. This research indicates women experiencing homelessness struggle with their mental health following child removal. Findings from this study support good practice guidance for state intervention at childbirth which advocate for trauma informed practice (Mason et al., 2022).

For mental health services, there is already a need to improve the awareness of the impact of child removal in terms of longstanding grief and a need to improve access to care (Broadhurst et al., 2017). Women experiencing homelessness are at further disadvantage in accessing such services due to their housing status. Perinatal mental health services may be well placed to support women as the services work in a gender informed way and support women through childbirth and loss. The NHS Long Term Plan (2019a) also commits to expanding access to such services. Generic mental health services, perhaps through homelessness leads, also need to be aware of the impact of child loss for this population.

There also needs to be greater specialist support to help women. Currently the only scheme with significant government funding available to support women following child removal is the Pause programme (Department for Education, 2017). However, the government has not made support post-removal a statutory obligation (Broadhurst et al., 2017). Pause is not available in every local authority and has been criticised for requiring women to be on contraception to receive support (Tickle, 2017). This programme is also not specifically designed to support women experiencing homelessness so is likely to require adaptation such as more outreach and flexible working to support the homeless population.

4.5.3. NICE guidance for Integrated Health and Social Care for People Experiencing Homelessness (2022)

Many of the implications for mental health services suggested by the findings in this research support the recently published NICE (2022) guidance for homelessness, which promotes health services adapting to the needs of people experiencing homelessness. Recommendations include self-referral and open-door options, rather than relying on GPs or other referrers; meeting expressed needs immediately, without waits, to encourage longer term engagement; more outreach services; flexible opening and appointment times; one-stop shops with multiple services available on site; and flexible discharge policies. The importance of relationships within healthcare is also stressed by the NICE guidance. Several recommendations are likely to improve relationship engagement such as offering to meet people in informal settings and providing consistent healthcare professionals as well as building a relationship over time with the person. The guidance also stresses the importance of reflective practice when working with people experiencing homelessness. Such recommendations are likely to go some way to removing the barriers identified in accessing mental healthcare identified within this study.

The findings of this research also support the NICE guidance recommendations for more specialist homelessness health services. Specialist mental health services were valued by participants for supporting women directly and having an awareness of homelessness and gendered violence. Some mental health provision was offered in-house although some mental health services offered outreach - the difference in outcomes according to each provision needs to be evaluated. Where specialist teams are not practicable, the guidance recommends generic services create Homelessness Leads to liaise with other services and provide support to team members on how best to support those experiencing homelessness. Findings from this study indicate that Leads will also need to ensure they are aware of the role of gendered violence and trauma in women's experiences of homelessness and have good knowledge of how to support women who have experienced gender-based violence. Knowledge of domestic abuse is not named within the NICE guidance for Leads and future editions could do to mention this explicitly.

The guidance also recommends services consider the specific needs of women experiencing homelessness. It recommends services ask if the person has any children or dependents and how this is likely to affect their needs, and promotes services liaising with domestic abuse services, as required. However, gender is not a focus of the guidance and can easily be overlooked. For example, when discussing the "wrap around support" homelessness MDTs should offer, support for domestic abuse is not mentioned, despite being a large need for women experiencing homelessness. Future guidance may benefit from having specific recommendations for working with women experiencing homelessness and considering gendered abuse and trauma systematically throughout.

4.5.4, Preventing and Resolving Women's Homelessness

Findings from this research highlight the detrimental role homelessness has on women's mental health and the need to prevent it occurring. Public organisations need to ensure they are correctly implementing The Homelessness Reduction Act (2017) to meet the prevention duties. Professionals need to be adequately trained to identify people at risk of homelessness (Homelessness Link, 2018). Many professional bodies have called on the government to provide mandatory training resources to staff (Royal College of Physicians, 2019) and some have produced their own guidance, such as the Guidance for Midwives on the Homelessness Reduction Act (2019a). The findings from this research indicate that such resources should explain how women's homelessness can present differently; perhaps by naming forms of homelessness which professionals may not immediately recognise, such as women experiencing domestic abuse or "survival sex".

This research also adds further weight to the role domestic abuse plays in contributing to women's homelessness. Piloting more initiatives which rehouse perpetrators while women remain at home, if it is safe to do so, may help reduce women's homelessness (Bimpson et al., 2021; Clarke & Wydall, 2013). Collecting gender-segregated data would also be helpful to better understand and respond to women's homelessness (Bimpson et al., 2021). The introduction of the Domestic Abuse Act (2021), when implemented, may also reduce women's homelessness and will need to be evaluated.

4.5.5. Implications for Future Research

Future research could evaluate how effective training is in improving professional understanding of the needs of women experiencing homelessness. This could include broadening professionals' understanding of homelessness from rough sleeping to include forms of invisible homelessness more likely to impact women; improving knowledge of women's rights to access services if they have experienced domestic abuse while having NRPF; and improving knowledge of the impact of child removal on women who have experienced homelessness.

Studies in the future could explore barriers and facilitators to mental healthcare for mothers, racially minoritised women or LGBT women specifically. These women are likely to experience additional barriers to mental healthcare access due to their intersecting needs. People experiencing homelessness in rural areas may experience additional barriers when accessing mental healthcare which could be further explored.

Further research is needed to evaluate the impact of specialist mental health teams and the different models of mental healthcare available. Some teams offer outreach services as part of specialist homelessness MDTs, while other forms of mental healthcare involve psychologists operating inhouse within hostels. While initial research indicates both models can have positive outcomes (Rhodes, 2016; Tischler et al., 2002) further research would be helpful to understand the benefits of each.

It may be helpful to evaluate the impact of recent legislative and policy changes. For example, the source of referrals, waiting times, location of appointments and housing status of service-users could be audited within mental health services to see if the NICE guidance for homelessness is being implemented (2022). The Homelessness Reduction Act (2017) and Domestic Abuse Act (2021) could be evaluated by exploring the number of women declared intentionally homeless following domestic abuse. Such studies would be helpful to see how emerging guidance is shaping women's experiences of homelessness.

4.6 Conclusions

The scoping review indicates that this is the first study which has explored the impact of the pandemic on the barriers to mental healthcare access women experiencing homelessness in the UK and as such is the first to highlight how gendered abuse – including domestic abuse and coercive control – acts as a barrier to English NHS mental healthcare access among women experiencing homelessness. The findings of this study build on previous international research to highlight the importance of considering gendered abuse and trauma when supporting women experiencing homelessness in accessing mental healthcare.

This study suggests adopting a longitudinal and joined up approach to barriers and facilitators to women's mental healthcare, recognising how trauma from across women's lives can intersect and compound to create barriers to mental healthcare access in the present. To truly attempt to break down such barriers, a systemic approach beyond mental health services is needed to integrate support for women's homelessness, domestic and sexual violence and child-loss through social care. This research then joins growing calls to consider women's homelessness alongside domestic abuse.

However, the findings also suggest mental health services can act in the shorter term to reduce barriers and build on existing facilitators. Trauma informed care, more informal, flexible, compassionate services and specialist homelessness mental health services could enhance women's access to mental healthcare. Such mental healthcare would focus on relationships with women experiencing homelessness, as well as liaising with and supporting third-sector staff within the homelessness sector. All the while, holding in mind the importance of gendered needs.

Such changes require funding and findings from this study indicate NHS mental health services are currently underfunded, overwhelmed and unable to provide the thoughtful and relational care required. There are many positive policy and legislative developments as well as financial commitments being pledged; however more needs to be done to specifically consider women experiencing homeless.

> *"Our women are warriors and survivors, but they do get angry […] but scratch the surface and you have an amazing woman who is just in a lot of pain and I think you know, it is professionals, particularly from the mental health service, sort of looking beyond that a little bit."*
>
> *(Participant 2*).

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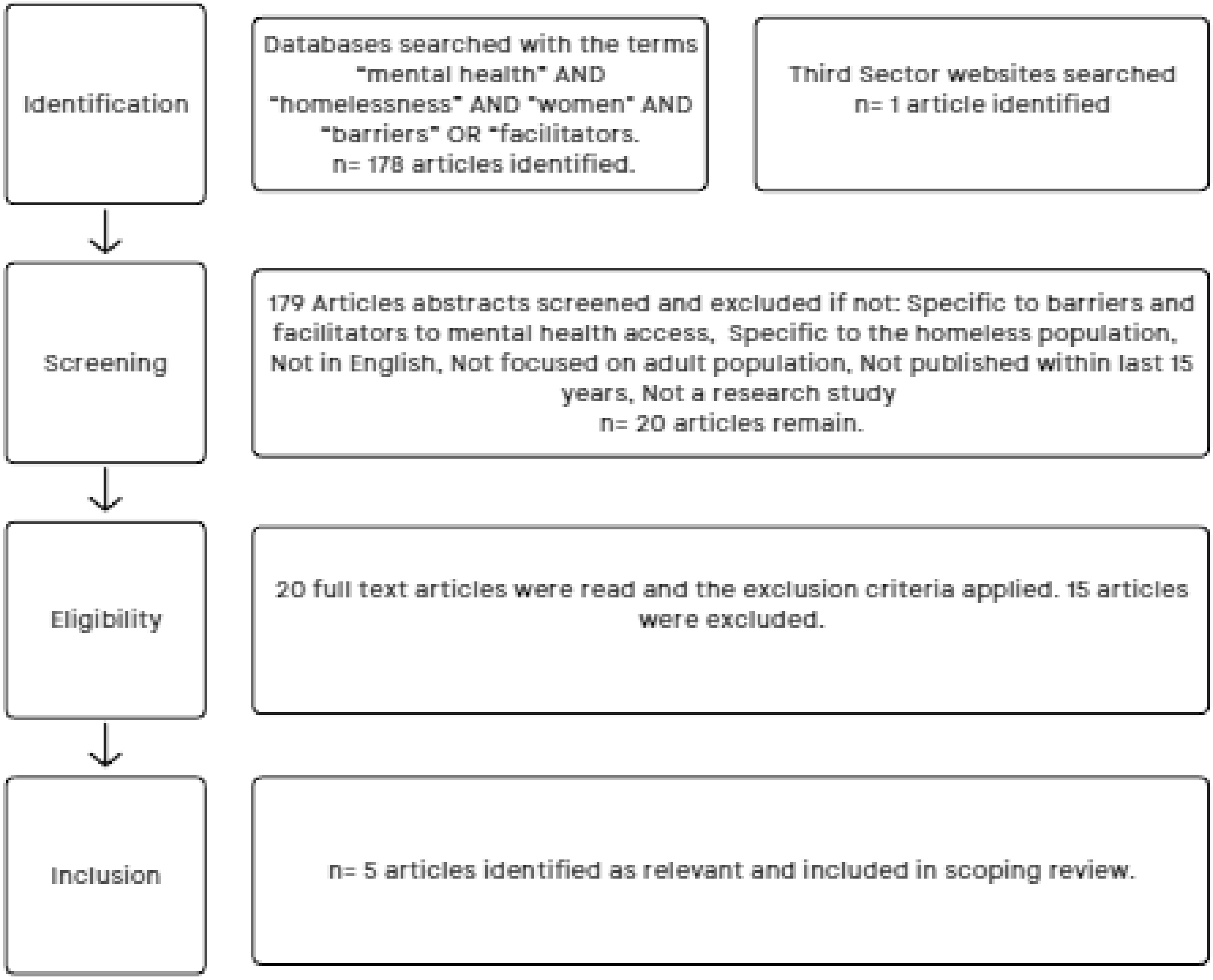
APPENDIX A: SCOPING REVIEW FLOW CHART



Databases searched with the terms "mental health" AND "homelessness" AND "women" AND "barriers" OR "facilitators.
n= 178 articles identified.

Third Sector websites searched
n= 1 article identified

179 Articles abstracts screened and excluded if not: Specific to barriers and facilitators to mental health access, Specific to the homeless population, Not in English, Not focused on adult population, Not published within last 15 years, Not a research study
n= 20 articles remain.

20 full text articles were read and the exclusion criteria applied. 15 articles were excluded.

n= 5 articles identified as relevant and included in scoping review.

APPENDIX B: PARTICIPANT INVITATION LETTER

University of
East London

PARTICIPANT INVITATION LETTER

6th May 2021

Homelessness, Women and Mental Health: Service Provider Perspectives

You are being invited to participate in a research study exploring what helps and hinders women experiencing homelessness accessing appropriate mental health support. Please take time to read the following information carefully.

Who am I?

My name is Alice Kaye. I am a Trainee Clinical Psychologist studying at the University of East London. I am conducting this research as part of my studies for a Professional Doctorate.

What is the research about?

Mental health problems disproportionately affect people experiencing homelessness; however, they often struggle to get the mental health support they need. This study seeks to understand what helps and what stops women who are experiencing homelessness in accessing mental health support. This research also seeks to understand how the pandemic has impacted on women accessing this mental health support.

Why have you been asked to participate?

This research is interested in the perspectives of employees and volunteers who work directly with women experiencing homeless in organisations offering them support.

These can be organisations supporting women who may be sleeping on the streets or women experiencing other forms of “invisible” homelessness involving unstable housing.

What will your participation involve?

If you agree to participate, I will arrange to meet with you to ask you a few questions. These will be about your experiences working with women experiencing homelessness and getting them access to appropriate mental health support. The discussion will take place via an online video call and will last around 1 hour. The conversation will be recorded for research purposes and later transcribed. Your participation is voluntary, so you will not have to answer all questions and can stop your participation at any time.

What will I do with what you tell me?

The conversations will be recorded and these recordings will be stored securely and deleted once the research has been completed. Transcripts of the conversations will be anonymised and all identifying information removed. Transcripts will be stored for three years.

Anonymised extracts of the interviews will be used within the thesis and within publications sharing research findings, such as reports or presentations. The thesis will be publicly accessible via UEL’s institutional repository.

Broad demographic information may appear in the thesis, but you will not be identified on any written material resulting from the data collected, or in any write-up of the research.

What are the risks and benefits of taking part?

The research is designed to minimise any potential risks. However, it is possible that talking about aspects of your work with women experiencing homelessness may be distressing. Please be aware that you do not have to share anything that you do not feel comfortable with. You do not have to answer all of the questions and you are free to pause or stop the interview at any time.

Benefits of participation include contributing to the development of knowledge on the mental health of women experiencing homelessness. The aim is to publish the results of the study in an academic journal which may contribute to a body of knowledge of how to improve mental health services for women in the future.

What if you want to withdraw?

You are free to withdraw from the research study at any time. You may also request to withdraw your data up to 3 weeks after the interview. Following this point, data analysis will begin, and withdrawal will not be possible.

Contact Details

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

Name: Alice Kaye

University Email: u1945467@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: Lorna Farquharson, L.Farquharson@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: Trishna Patel t.patel@uel.ac.uk)

APPENDIX C: CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent Form

Homelessness, Women and Mental Health: Service Providers Perspectives

I confirm that I have read the information sheet dated 06/05/2021 for the above study and that I have been given a copy to keep. ☐

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, 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 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 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 agree to take part in the above study. ☐

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

……………………………………………………………………………………..

Researcher’s Signature

………………………………………………………………………………………

Date: …………………….……..

APPENDIX D: DEBRIEF FORM TEMPLATE

University of
East London

PARTICIPANT DEBRIEF LETTER

Homelessness, Women and Mental Health: Service Providers Perspectives

Thank you for participating in this research study. This letter offers information that may be relevant following participation.

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.

- Transcripts of the conversations will be anonymised and all identifying information removed.
- Participants will not be identified on any written material resulting from the data collected, or in any write-up of the research.
- Following completion of the research project, recordings will be deleted. Transcripts will be stored for three years and then deleted.
- The anonymised research findings will be published as a university doctoral thesis, submitted to an academic journal for publication and shared with relevant organisations.
- You may request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected.

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, if you have been affected please do contact me or my supervisor if you have specific questions or concerns.

Contact Details

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

Name Alice Kaye

University Email u1945467@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: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: Trishna Patel t.patel@uel.ac.uk).

APPENDIX E: INTERVIEW SCHEDULE

Interview Schedule

Demographics

1. What is your ethnic group?
    a. White, Mixed/Multiple Ethnic Groups, Asian/Asian British, Black/African/Caribbean/Black British, Other Ethnic Group
2. What is your gender?
3. What is your age?
    a. 18-24, 25-34, 35-44, 45-54, 55-64 and 65+

Organisation Context

4. Could you tell me about your organisation?
5. What support is offered to women experiencing homelessness?

Mental health Context

6. Could you tell me a bit about the mental health needs of the women you work with?
7. What mental health support is available for women you work with?
    a. Your organisation?
    b. Other organisations?
    c. NHS mental health services?
8. How do women access NHS mental health services?
    a. Knowledge of services?
    b. Referral processes?

Barriers

9. What gets in the way of women accessing NHS mental health services?
    a. Practical barriers?
    b. Service barriers?
    c. Personal barriers?

Facilitators

10. What helps women access mental health services?

    a. Practical Facilitators?
    b. Service Facilitators?
    c. Personal Facilitators?

11. What are your thoughts on the support NHS mental health services provide women experiencing homelessness?
    a. Appropriate options?
    b. Liaison with your organisation?

COVID

12. How has the pandemic impacted the mental health of the women you work with?
13. What impact has the pandemic had on the women's access to NHS mental health services?
    a. How have the identified barriers changed?
    b. How have the identified facilitators changed?

Summary

14. Is there anything else you think is important to mention regarding women experiencing homelessness and access to mental health support?
15. Is there anything you would like to ask me?

APPENDIX F: ETHICAL APPROVAL

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: George Georgiou

SUPERVISOR: Lorna Farquharson

STUDENT: Alice Kaye

Course: Prof Doc in 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

Minor amendments required *(for reviewer)*:

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):*

Student number:

Date:

(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?

N/A

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).

Reviewer *George Georgiou*

Date: 14th May 2021

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

<u>RESEARCHER PLEASE NOTE:</u>

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

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: Y

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. Note: templates for these are included at the end of the form.

- The participant invitation letter Y
- The participant consent form Y
- The participant debrief letter Y

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 Y or

  Not required (because no participation adverts will be u N)
- A general risk assessment form for research conducted off campus (see section 6).

  Included N or

  Not required (because the research takes place solely on campus or online) Y
- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included N or

Not required (because the researcher will be based solely in th Y)

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

Included No r

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

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

Included N or

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

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

Included N or

Not required (because you are not using pre-existing questionnaires o Y tests)

- Interview questions for qualitative studies.

Included Y or

Not required (because you are not conducting qualitative intervi N)

- Visual material(s) you intend showing participants.

Included N or

Not required (because you are not using any visual mate Y)

2. Your details

2.1 Your name: Alice Kaye

2.2 Your supervisor's name: Lorna Farquharson

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

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: Homelessness, Women and Mental Health: Service Provider Perspectives

3.2 Your research question:
3.2.1 What are the barriers for women experiencing homelessness in accessing mental health support?
3.2.2 What are the facilitators for women experiencing homelessness in accessing mental health support?
3.2.3 How has COVID-19 impacted on women experiencing homelessness accessing mental health support?

3.3 Design of the research: This study is a qualitative study that will utilise semi-structured video interviews conducted on Microsoft Teams. These interviews will be recorded on Teams and then transcribed by the researcher. The transcripts will then by analysed using thematic analysis.

3.4 Participants: The study will aim to include 12 semi-structured interviews with specialist service-providers who support women experiencing homelessness across the UK. A diverse range of organisations will be contacted to reflect the different organisations offering support to women experiencing homelessness.

3.5 Recruitment: Purposive sampling will be used to identify service-providers for interviews. Participants will be recruited by contacting organisations involved in supporting women experiencing homelessness with an information sheet about the study. Organisations will also be asked to circulate information about the study to their relevant partner organisations.

3.6 Measures, materials or equipment: Semi structured interviews will be conducted using an interview schedule.

3.7 Data collection: Interviews with service-providers will take place via video call. These interviews will last approximately 60 minutes. These interviews will be recorded on Teams and will then be transcribed by the researcher and the transcripts analysed. Data will be anonymised at the time of transcription and each participant will be given a research number to maintain confidentiality.

3.8 Data analysis: Thematic Analysis will be used to analyse the data. Firstly, familiarising self with data through transcription before coding the data and organising it into themes. Data collection will proceed in an iterative manner with a small sample of interviews being transcribed, coded and analysed before further interviews are conducted until the study reaches “saturation”, which may be around 12 interviews.

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)?

At transcription, all transcripts will be anonymised. Any identifying information from the participant will be removed and their organisation will be described in broad terms to contextualise the data without providing identifying information.

4.3 How will you ensure participants details will be kept confidential?

Data will be anonymised (names and identifying information removed) at the time of transcription. Some non-identifiable information about the organisations will remain to contextualise the data.

Each participant will be given a research number which will not be stored alongside identifiable information. Each recorded file will be named with the participants' initials and the date of the interview. Transcript file names and Nivo files will be research numbers.

Recordings, transcripts and Nvivo files will be stored separately in different folders and saved on the researcher's UEL Onedrive for Business.

4.4 How will the data be securely stored?

Interviewees will be sent consent forms via UEL email address prior to participation and consent forms will be returned via email. These consent forms will be stored securely for the duration of the study on the researcher's UEL Onedrive for Business drive.

Microsoft Recordings are stored on the Microsoft Stream Library following recording. Immediately after recording, they will be moved onto the researchers UEL Onedrive for Business. The researcher will ensure that local copies made in downloads, temporary folders, are immediately deleted after successful transfer to the UEL for Onedrive for Business drive.

Recordings of the interviews will be transcribed and stored as a word document on the researchers UEL Onedrive for Business drive.

Transcripts will be analysed using NVivo. These files will be stored securely on the researchers UEL Onedrive for Business drive.

Research numbers will not be stored with identifying information.

4.5 Who will have access to the data? The lead researcher will have access to the interview recordings and transcripts. The researcher's supervisor will be shown transcripts. Examiners may request to see the transcripts.

4.6 How long will data be retained for? The data will be retained for the duration of the study and then the consent forms, recordings will be deleted. The transcripts will be retained for 3 years and stored on the supervisors UEL One Drive.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: Y

5.2 Your research question: Y

5.3 The purpose of the research: Y

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

5.5 That participation is strictly voluntary: Y

5.6 What are the potential risks to taking part: Y

5.7 What are the potential advantages to taking part: Y

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions ask Y

5.9 Their right to withdraw data (usually within a three-week window from the time of their participatio Y

5.10 How long their data will be retained fo Y

5.11 How their information will be kept confidential: Y

Y

5.12 How their data will be securely stored:

5.13 What will happen to the results/analysis: Y

5.14 Your UEL contact details: Y

5.15 The UEL contact details of your supervisor: Y

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?

Data will be anonymised (names and identifying information removed) at the time of transcription. Some non-identifiable information about the organisations will remain to contextualise the data.

Each participant will be given a research number which will not be stored alongside identifiable information. Each recorded file will be named with the participants' initials and the date of the interview. Transcript file names and Nivo files will be research numbers.

Recordings, transcripts and Nvivo files will be stored separately in different folders and saved on the researcher's UEL Onedrive for Business.

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?

Participants will be asked to talk about the nature of their work with women experiencing homelessness, which they will be used to thinking and talking about. However, there is still a possibility that they may find participating in an interview distressing.

Participants will be provided with an information sheet explaining the details of the study and what is expected of them so they are able to offer informed consent to participate.

Participants will be able to take breaks, stop at any point during the interviews and can also be signposted to appropriate support if they become distressed

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?

The nature of homelessness can be distressing and participants will be speaking about the mental health of the women they support. Although some of the material may be difficult to hear, I am a Trainee Clinical Psychologist working in the NHS and experienced in managing the distressing information others share. I shall be mindful of arranging the interviews with breaks in between to ensure that I am able to manage any difficult emotions arising during the interviews. I will also use my research supervisor to think about this impact and will seek appropriate professional support if necessary.

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

This is not applicable as I will be interviewing service providers, which includes employees and volunteers working in organisations supporting women experiencing homelessness, who will be familiar with appropriate support services.

6.4 Does the research take place outside the UEL campus? If so, where?

Online via video call.

If so, a ‘general risk assessment form’ must be completed. This is included below as appendix D. 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 al risk assessment form is required for this research, please tick to confirm that this has been completed:

N/A

6.5 Does the research take place outside the UK? If so, where? N/A

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:

N

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: N/A

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: N/A

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: N/A

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: N/A

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 N/A

* 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:

> I will be contacting organisations working with women experiencing homelessness. I have made initial contact employees at XX who have agreed to share the study with colleagues.

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:

N/A

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.

10. 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): Alice Kaye

Student's number: U1945467 Date: 6th May 2021

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.

APPENDIX G: TRANSCRIPTION CONVENTIONS

Notation Code for Transcript

Feature	Notation
The identity of the speaker and turn taking in talk.	The interviewer indicated by I followed by a colon. I: The Participant indicated by P followed by a colon. P: A new line is started when there is turn taking in the conversation.
Laughing or other non-verbal communication.	[Laughs] [Snaps fingers] [Nodding]
Pausing	Hesitation indicated by ellipsis … Longer pause indicated with [pause]
Spoken Abbreviations	If someone speaks with the abbreviation, then abbreviation is used (e.g CAMHS for Children's mental health service). Abbreviation not used unless used by the participant.
Inaudible Speech	[Inaudible]
Non-verbal utterances	Erm, or Err.
Use of punctation	Used to increase the readability of spoken data at the stage of transcription.
Reported Speech	When a participant provides an apparent verbatim account of another person's speech or thoughts. This is indicated with speech marks around the quotations. “”
Names of Locations, organisations or other identifying information	Details are changed to brief generic descriptions. For example, Manchester may be changed to [large city] or the name of a colleague noted described role e.g [supervisor].
Makes Quotation Marks with Hands while speaking	“Speech marks around sections of speech” [Makes speech marks with hands]

Adapted from Braun & Clarke (2013 p 165)

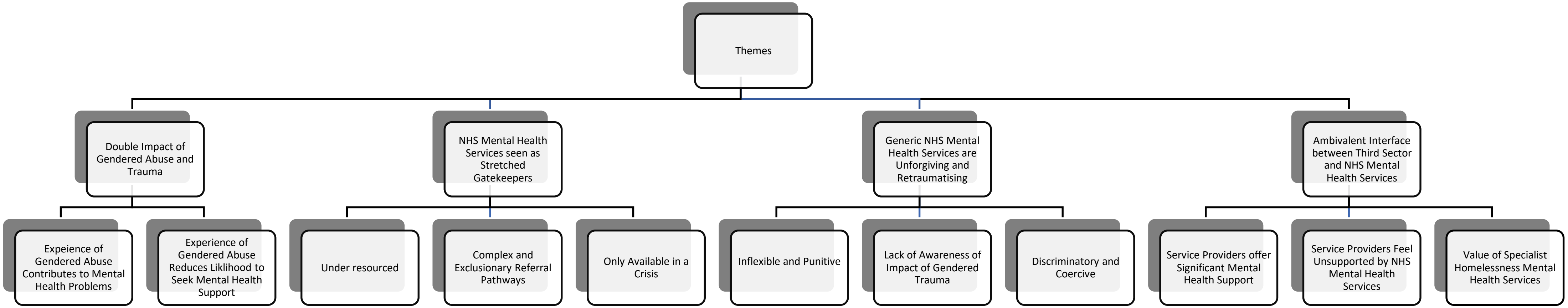
Conventions Added for Presenting Quotes for Write Up

Where it did not affect the meaning, pauses were removed to present participant quotes.

[…] indicated omitted words or sections

[text] indicated additions of content to aid clarity.

APPENDIX H: MAP OF THEMES



APPENDIX I: SAMPLE CODED TRANSCRIPT

I: So I was just thinking in terms… can you tell me a bit about your understanding about the mental health needs of women experiencing homelessness?	
P: Yeah… erm… so I would say all of the women experiencing homelessness that I have ever worked with, like pretty much all of them, have like fairly… have struggled with their mental health for quite a long time. Erm. So, I suppose a lot of them have experienced some kind of abuse in childhood, or been in the care system or have experienced… it is quite common to have experienced sexual abuse in childhood. And from there, erm, they quite understandably have really struggled and that trauma erm just compounds really. Erm. And they end up, you know invariably themselves, homeless or unstably housed. Erm. They tend to use substances to cope and numb and do whatever they need it do … and I think… The way I understand trauma, I understand trauma in quite a gendered way… so in that if you are a woman or a girl you are more likely to experience violence and abuse from…somebody very close to you. Erm… er like a partner, or a family member erm… whereas, I think men and boys, it seems to be like… maybe friends of acquaintances or someone they have a bit of beef with. So, I think the impact of that and that kind of broken trust and what that does is, I just… in that very gendered way is I think really quite… deep. And I think… it think it is just cycles upon cycles of trauma. Erm. And then you see women in a relationship with a perpetrator and then another one and then another one, and they get out of that one, and then go into another one. Erm… so it kind of resonates down the years, really. And, women, some women, have diagnoses. So some come with borderline personality disorder, some come with EUPD, erm, some come with just PTSD. Some come with generalized anxiety disorder. Some of them have diagnoses. Erm. Some don't. And…I think it's…yeah it's… it's…very difficult to… I kind of see it as the same thing. So even the ones that don't have the	Most women experience mental health problems Women have experienced social care as children Women have experienced sexual abuse in childhood Mental health problems developed from traumatic experiences Substance use to cope with traumatic experiences Gendered, Interpersonal abuse. Abuse leads to mistrust in relationships

clinical diagnoses… it's still… there can be two women with the same symptoms behaving the same way, but one of them has the diagnosis and one of them doesn't. I erm, I think that yeah… it is. It is very difficult to work with women who are that *unwell* at times. And, especially as like in housing first work, as you are working with people who are really *really* you know really struggling and on quite a lot of levels. And to feel like, you know… er…. not able to…er… you not a mental… you have no… professional qualifications and that… so you don't know quite how to support someone erm through it. So I think, yeah. I think that it is definitely trauma and from repeated interpersonal violence and abuse, particularly if it is a woman. And, as I said, some have diagnoses and some don't… it really varies. I: So your understanding of mental health needs are in the context of traumatic histories erm and some of those women have received a diagnosis for that and come into contact with services and some haven't. P: Yep, and the other things is that a lot of women who *have* had contact with mental health services in the past are *verrryyyy* wary of them again in the future. It is almost like a dirty word. For women… especially a woman who has been in like a secure unit…you even mention the word mental health, and they will be out of the door. It's like a deeply *deeply* traumatising experience. And I have worked with more than one woman who has had that... particularly women who have been in secure units. Incredibly traumatizing.	Women experience domestic abuse. Cycles of Trauma Women given range of mental health diagnosis Many women experiencing mental health problems not diagnosed Service Providers untrained to support women with mental health problems Service providers find it difficult to work with women with mental health problems Women traumatized by past experiences

	of mental health services Secure mental health units are traumatic.