University of Southampton

Faculty of Environmental and Life Sciences

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An Exploration of Mental Healthcare Inequality for People Experiencing Homelessness

by

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Thesis for the degree of Doctor of Clinical Psychology

June 2025

Chapter 1 has been written for publication in the International Journal of Qualitative Studies on Health and Well-being (see Appendix J, J.1). Chapter 2 has been written for publication in Journal of Community and Applied Social Psychology (see Appendix J, J.2). For consistency of presentation of this thesis, appendices and references for both chapters are formatted together at the end of the document. These will be separated for publication. Both journals offer format free submission, only stipulating the style must be clear and consistent throughout. Both journals also allow authors to submit references in their preferred format. The thesis is formatted consistently in the style of the University of Southampton template, and references, tables, and figures are presented in APA format. Title pages for chapters 1 and 2 are included at the beginning of each chapter and include the submission information required by the journals.

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Abstract

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People experiencing homelessness face profound mental health inequalities. This thesis explores these inequalities through two complementary qualitative studies.

Chapter 1 presents a systematic review, synthesising findings from 57 qualitative papers exploring how people experiencing homelessness perceive mental health services. Using meta-ethnography, 22 interpretive metaphors and seven higher level themes were developed: stigma and dehumanisation, distrust and mistrust, trauma, power, lack of understanding of homelessness, intersectionality, and intergenerational poverty. The synthesis culminates in a conceptual model illustrating how factors operate at multiple ecological levels, driving three overarching mechanisms of inequality: avoidance of care, exclusion from care, and the creation of setting conditions for poor mental health. The review highlights the need to move beyond reductive, panacea-driven approaches and calls for iterative reforms across service, policy, and cultural domains, including trauma-informed, relationship-based, and culturally competent care.

Chapter 2 complements these findings by exploring healthcare professionals' perspectives on barriers to care using reflexive thematic analysis. Three interrelated themes were developed: (1) Deemed "undeserving": how stigma shapes systems of exclusion, (2) Systemic misfit: how standard service models disengage those with complex needs, (3) How to make care possible in impossible systems – relational practice as resistance. Clinicians face substantial challenges in providing mental healthcare to people experiencing homelessness in the context of structural stigma, exclusionary systems, and a lack of trauma-informed approaches. Specialist services attempt to fill the gap through flexible, inclusive, and relational care, but are overburdened and unsustainably stretched.

Together, these studies offer a systems-level understanding of mental health inequalities in the context of homelessness. The findings emphasise the need for cross-sector collaboration, integrated and flexible service models, long-term investment, and structural reform. This thesis contributes to theoretical and practical understandings of mental health inequality and provides a framework for engaging with complexity and designing more inclusive care for marginalised populations.

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Research Thesis: Declaration of Authorship

Print name: Elizabeth Grace Bodley Scott

Title of thesis: An Exploration of Mental Healthcare Inequality for People Experiencing Homelessness

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signature: .... Date: 20th June 2025

Acknowledgements

To my supervisors, Prof Nick Maguire and Dr Stephanie Barker, you have both been incredible role models, and I feel very fortunate to have had the opportunity to learn from you and work alongside you during such a significant chapter of my professional life. Thank you for your patience, encouragement, support, and understanding.

Thank you to Charlie and Charlie for your expertise and valuable contributions to this research. Your input enriched this thesis in important ways, and I truly appreciate the time and energy you brought to it.

I would like to thank the participants who generously gave their time to share their insights with me. It was a privilege to hear about your experiences, your passion, and your unwavering dedication, and I thoroughly enjoyed learning from you. Your contributions to this research were invaluable, and I hope this work can, in some small way, contribute to improving healthcare for people experiencing homelessness.

To my wonderful friends and family – thank you for your endless love, thoughts, prayers, and encouragement. Your messages, pep talks, and cups of tea and coffee kept me going. I appreciate you all more than I can say and could not have done this without you. You lived this marathon with me, and your faith in me never wavered.

A special thank you to my amazing Mum for your endless love and support – no doubt accompanied by many sleepless nights! I know you will breathe a big sigh of relief as this chapter closes. You supported my educational endeavours from the very beginning, and I am eternally grateful to you. To my fiancée, Alex, thank you for every affirmation, every word of encouragement, and all the delicious dinners. You held me through the hardest moments, and you’ve been my rock. To my best friend and honorary sister, Jess, thank you for being there for me during the hardest time in my life, you always knew when to nudge, when to distract, and when to just sit with me in it. I am so grateful for your friendship.

Finally, to my amazing Dad, an incredibly wise, joyful, and compassionate human being. You always created an atmosphere of peace and laughter and helped me to stay grounded. You were my biggest supporter throughout my psychology career, and I know how proud you would have been of me and this achievement. I wish more than anything that you could be here to celebrate this moment with me, and to see the culmination of all the years you cheered me on. I miss you deeply, and I dedicate this thesis to you.

Definitions and Abbreviations

NICE	National Institute for Health and Care Excellence
LGBTQ+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic, pansexual, non-binary, two-spirited, and other non-cisgender and non-heterosexual identities
SDoH	Social determinants of health
ACEs	Adverse childhood experiences
ETHOS	European Typology of Homelessness and Housing Exclusion
Homelessness	Rooflessness or Houselessness
Rooflessness	People living/sleeping rough or people staying in a night shelter (ETHOS)
Houselessness	People in accommodation for the homeless (hostels, temporary accommodation, transitional supported accommodation), women's shelters, accommodation for immigrants (reception centres, migrant worker accommodation), people due to be released from institutions (penal, medical, children's homes), people receiving longer-term support due to homelessness (residential care for older homeless people, supported accommodation for formerly homeless persons) (ETHOS)
EBE	Expert by experience: In the field of homelessness, this is "someone who is able to articulate lessons and suggestions from their own 'lived' experience of homelessness and health challenges" (Pathway, 2017)
First-order constructs	The primary data reported in each paper (participant quotes) (Schutz, 2012)
Second-order constructs	The primary authors' interpretations of the primary data (themes or concepts) (Schutz, 2012)
Third-order constructs	The reviewers' higher order interpretations developed by synthesising the first and second order constructs from the included papers (Schutz, 2012)

NICE Guidelines (2022)…..	In 2022, the National Institute of Clinical Excellence (NICE) released guidelines for integrated health and social care for people experiencing homelessness, with the aim of improving access to and engagement with health and social care. The guidelines recommend specialist homelessness multidisciplinary teams that offer wrap-around support, provide and coordinate care across all levels of provision and across sectors. Alternatively, in areas where there are few people experiencing homelessness, mainstream services should have designated homelessness leads that consult with specialist teams to ensure appropriate care for people experiencing homelessness.
Gatekeeper………………….	In the context of healthcare, a system or person that controls the accessing of services. The actions or decisions of the person and/or system may facilitate, expedite, delay, or exclude people from accessing services.

Chapter 1 Understanding Inequality in Mental Healthcare for Homeless People: A Systematic Review and Meta-Ethnography

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The authors report there are no conflicting interests to declare.

Data availability statement. All primary studies synthesised are publicly available and cited in the manuscript. The synthesised data translation table is provided in the online supplementary materials. NVivo-coded data are not publicly available due to software format constraints but are available from the corresponding author upon reasonable request.

CRediT Author Contributions Statement. Elizabeth Scott contributed to conceptualisation, data curation, formal analysis, methodology, project administration, visualisation, writing – original draft, and writing – review & editing. Dr Nick Maguire contributed to conceptualisation and supervision, and writing – review & editing. Dr Stephanie Barker contributed to supervision and formal analysis. All authors agree to be accountable for all aspects of the work.

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1.1 Abstract

People experiencing homelessness experience significant mental health disparities. This meta-ethnographic systematic review aimed to synthesise qualitative evidence on experiences of mental healthcare for people experiencing homelessness to understand the disparities in access, experience and outcomes.

MEDLINE, CINAHL, PsycINFO, Scopus, and Web of Science, and forward and backward citations were searched for studies published up until 1st November 2024. Key search terms related to the concepts of “homelessness” (population), “mental health services utilisation” (intervention), “experiences” (outcome), and “qualitative” (study design). Fifty-seven qualitative papers were synthesised using meta-ethnography, following Noblit and Hare’s method and eMERGe reporting guidelines.

Twenty-two key interpretive metaphors encapsulate the lived experiences contributing to healthcare inequities. A line of argument synthesis generated a conceptual model conveying how the metaphors operate dynamically across contextual domains (individual, interpersonal, healthcare systems, homelessness, and societal), reinforcing one another, and creating a cycle of exclusion, avoidance, and health inequities. Seven higher-level themes were identified: stigma and dehumanisation, distrust and mistrust, trauma, power, a lack of understanding of the realities of homelessness, intersectionality, and intergenerational impact of poverty. Participant-derived recommendations emphasise the importance of trauma-informed, culturally competent, and relationship-based care, alongside systemic reforms to address exclusionary policies and fragmented services.

This review highlights the interconnected drivers of mental healthcare inequities for people experiencing homelessness, offering actionable insights for policymakers and practitioners. Addressing these inequities requires engagement with complexity, cross-sector collaboration, and multi-level interventions that prioritise dignity, trust, and inclusivity.

Keywords: homelessness; mental healthcare access; health inequalities; stigma; meta-ethnography; qualitative evidence synthesis; trauma-informed care; structural barriers; systems thinking

1.2 Background

Homelessness is a public health issue affecting millions of people worldwide. Definitions of homelessness vary between countries, making it challenging to understand the full scale of the problem, however, conservative estimates of global homelessness stand at 150 million (World Economic Forum, 2021). The widely adopted European Typology of Homelessness and Housing Exclusion (ETHOS; Edgar, 2012) considers a person "homeless" if their housing situation is deficient in at least two of three domains: physical, legal, and social (Busch-Geertsema, 2010; Pleace et al., 2011). Despite economic resources, governments of high-income countries have failed to "solve" the issue of homelessness (Kaspraw, 2023), which is now at record levels (National Audit Office, 2024; National Alliance to End Homelessness, 2023).

1.2.1 Causes of Homelessness, Complexity, and Challenges

Homelessness is driven by a complex and multifaceted interaction of individual, systemic, and societal factors (Nooe & Patterson, 2010). These include adverse childhood experiences (ACEs; Liu et al., 2021), mental illness and substance use (Gutwinski et al., 2021), childhood poverty, lack of social support (Bramley & Fitzpatrick, 2018), criminal justice involvement (Caton et al., 2005), lack of affordable housing, wealth inequality (Shinn, 2007), social exclusion and cultural attitudes (Cuthill, 2022). This complexity reflects ecological theories of human development (Bronfenbrenner, 1977) which understands health outcomes to be influenced by multiple, interrelated systems (McLeroy et al., 1988). Macrosystem level issues such as inequality impact outcomes at the community and individual levels, with higher levels of mental health stigma, mental illness, drug use, and poorer child wellbeing in more unequal countries (Pickett et al., 2024). However, policy and intervention design often rely on reductive, linear models that ignore this interconnectedness, leading to limited effectiveness.

1.2.2 Health Inequalities for Homeless People

Compared to the general population, homeless individuals experience disproportionately high levels of mental health problems and substance misuse, suicidality, neuropsychiatric problems, communicable and non-communicable diseases, unintentional injuries, chronic diseases, and age-related conditions (Fazel et al., 2014; Hossain et al., 2020; Gutwinski et al., 2021; Hertzberg & Boobis, 2022; Topolovec-Vranic et al., 2017). These conditions contribute to excess mortality, with homeless people being significantly more likely to die prematurely than their housed counterparts (Fazel et al., 2014;ONS, 2022). The stress of unstable housing, inadequate nutrition, exposure to harsh conditions, trauma, disease, and injury, combined with the psychological toll of social marginalisation – has a deleterious effect on mental and physical health and exacerbates substance use (Fazel et al., 2014; Hertzberg & Boobis, 2022). This vicious cycle means people experiencing homelessness often experience a downward spiral of worsening health outcomes.

1.2.3 Barriers to Access

Despite the theoretical promise of universal healthcare in countries including the UK and Canada, many people experiencing homelessness are excluded from mainstream services through practical, financial, organisational, attitudinal, and structural barriers (Fazel et al., 2014; Hertzberg & Boobis, 2022; Jackson et al., 2024; MEAM, 2022; Reilly et al., 2022). Many avoid healthcare services, only seeking help when their health has deteriorated to the point of crisis through emergency services (Jackson et al., 2024). Existing reviews focussing on homeless people's experiences of health and social care have identified barriers at multiple levels including internalised stigma, pride, autonomy, negative interactions with healthcare staff, stigma, discrimination, and trust and safety concerns (Magwood et al., 2019; Omerov et al., 2020), as well as systems issues such as inflexible, fragmented systems, and lack of staff training (Siersbaek et al., 2021). These factors operate in the structural context of intergenerational poverty and trauma, oppression and structural violence (Magwood et al., 2019). As a result of these barriers, many people experiencing homelessness have significant unmet health needs.

1.2.4 Additional Barriers to Mental Health Services

In mental health services, homeless people often fall through the gaps between services – being deemed "too complex" for one and "not severe enough" for another (MEAM, 2022). Individuals with co-occurring mental health and substance use needs are often declined mental health treatment until they have addressed their substance use (Houghton et al., 2021), which is problematic given the high prevalence of reported self-medication (Jackson et al, 2024; Hertzberg & Boobis, 2022).

There is stigma related to homelessness, mental illness, and substance use (Canham et al., 2022; Skosireva et al., 2014; Zerger et al., 2014) – and it is amplified for those with multiple intersecting marginalised identities (Canham et al., 2024; Weisz & Quinn, 2018). Internalised stigma, perceived stigma from healthcare professionals and the public is linked to avoidance of healthcare and worse health outcomes among people experiencing homelessness (Canham et al., 2022, 2024; Reilly et al., 2022).

1.2.5 Importance of Understanding Barriers to Mental Health Service Use

It is unsurprising, then, that the estimated prevalence of a current mental health disorder is 76.2% among homeless individuals in high-income countries (Gutwinski et al., 2021), and many have multiple mental diagnoses (Hossain et al., 2020). Although these conditions are often treatable, homeless individuals' mental health needs are largely unmet (Gutwinski et al., 2021). Studies have linked current mental health diagnosis to an increased risk of mortality in the homeless population (Jones et al., 2020; Nielsen et al., 2011). Mental illness and substance misuse are factors that increase the risk of experiencing homelessness (Fazel et al., 2014; Hertzberg & Boobis, 2022; Zhao, 2023; Nilsson et al., 2019) – and operate as key factors in homelessness chronicity, reducing a person's chances of exiting homelessness (Nilsson et al., 2019; Patterson et al., 2012; Zhao, 2023). This highlights the importance of understanding and addressing the barriers to mental health service use that are perpetuating inequalities for people experiencing homelessness.

1.2.6 The Current Study

While there is a large and growing body of qualitative research (Toye et al., 2014; Sattar et al., 2021) within the field of homelessness and healthcare, to the authors' knowledge, no reviews have focussed specifically on the experiences of homeless people relating to mental healthcare. We believe synthesising accounts of homeless individuals' experiences would enable us to understand the full picture of (a) experiences of mental healthcare, (b) what factors are implicated in the use and non-use of services, (c) what drives inequality in this area, and (d) what needs to change to enable services to better meet the needs of this underserved population. This study aims to explore the experiences and dynamics that perpetuate inequalities in mental health service access, experiences, and outcomes (Bansal et al., 2022) for people experiencing homelessness through a meta-ethnographic synthesis of qualitative research. Ultimately, we aim to use this understanding to develop a new conceptual model that can inform approaches to interventions, practice, and "make valuable knowledge accessible to healthcare professionals and policy makers" (Sattar et al., 2021).

1.3 Methods

1.3.1 Meta Ethnography Rationale and Approach

Meta-ethnography, a form of qualitative evidence synthesis developed by Noblit and Hare (1988), is particularly well-suited to studying issues relating to inequality and marginalisation (Flemming, 2022). Rather than aggregating findings, it reinterprets concepts to generate new insights that transcend individual studies (Sattar et al., 2021). Widely used in health and social care research (France, Uny, et al., 2019), meta-ethnography is useful for understanding complex social phenomena and developing theoretical and conceptual insights to inform healthcare policy and practice (France et al., 2016).

We followed the seven iterative, overlapping phases described by Noblit and Hare (1988) (see Table 1.1), guided by the eMERGe Reporting Guidance for meta-ethnography (France, Cunningham, et al., 2019) and the PRISMA guidelines (Moher et al., 2009; Page et al., 2021).

Table 1.1

Meta-Ethnography Phases

Phase	Name of Phase	Summary of Phase
1	Selecting meta-ethnography and getting started	Identify the aims and rationale for meta-ethnography.
2	Deciding what is relevant	Search strategy, inclusion and exclusion criteria, and screening process.
3	Reading included studies	Repeated reading of studies, data extraction, and noting of key concepts, themes, and metaphors.
4	Determining how studies are related	Explore the relationships between the studies, comparing study characteristics.
5	Translating studies into one another	Synthesise findings across studies by "translating" concepts into each other.
6	Synthesising translations	Develop overarching concepts by synthesising the translations into a new conceptual framework.
7	Expressing the synthesis	Summary of findings explaining new insights and implications derived from the synthesis.

1.3.2 Research Team and Experts by Experience

The research team (ES, SB, NM) had “relevant and varied expertise” in the area (Luong et al., 2023; Sattar et al., 2021). Two experts by experience (EBE), with lived experience of homelessness, mental health difficulties, and mental health service use, who work in peer support roles in the homelessness sector advised and contributed to this review. Their involvement helped refine the review focus in phases 1-2; and identify key themes and refine the synthesis through collaborative discussion in phases 3–6.

1.3.3 Phase 2: Deciding What is Relevant

1.3.3.1 Search Strategy

We (ES) conducted a comprehensive search of five databases: MEDLINE (EBSCOhost), CINAHL (EBSCOhost), PsycINFO (EBSCOhost), Scopus, and Web of Science, for studies published up to 1st November 2024. We imposed no restrictions on the searches. The search strategy included key words and phrases related to the concepts of “homelessness” (population), “mental health services utilisation” (intervention), “experiences” (outcome), and “qualitative” (study design). The search terms were devised using the PICOS framework (Tacconelli, 2010), developed iteratively and refined through conversations within the research team. Broader health care terms such as “primary care” were included in the search strategy because (a) primary care often serves as a point of access to mental health services; (b) mental health care is part of the general healthcare system; and (c) schemas and beliefs around health services and healthcare professionals are likely to generalise to mental health service settings. The full search strategy reported according to the updated PRISMA search reporting guidance (Rethlefsen et al., 2021) is provided in Appendix A.

1.3.3.2 Inclusion and Exclusion Criteria

Studies were included if the majority of participants were currently or formerly homeless (ETHOS defined). If the sample had mixed respondents (e.g. providers), only themes pertaining to the perspectives of people experiencing homelessness were included. Studies reporting on experiences of mental health services, specialist mental health interventions, or routine healthcare where mental health is discussed, were included. Studies could refer to experiences of healthcare access, utilisation, help-seeking, service delivery, or about experiences of care by specific providers. Studies discussing mental health needs without reference to service use were excluded. Finally, studies were included if they used a qualitative method for data collection and analysis, and if the qualitative data was conceptually rich (Toye et al., 2013). See Appendix B for full criteria.

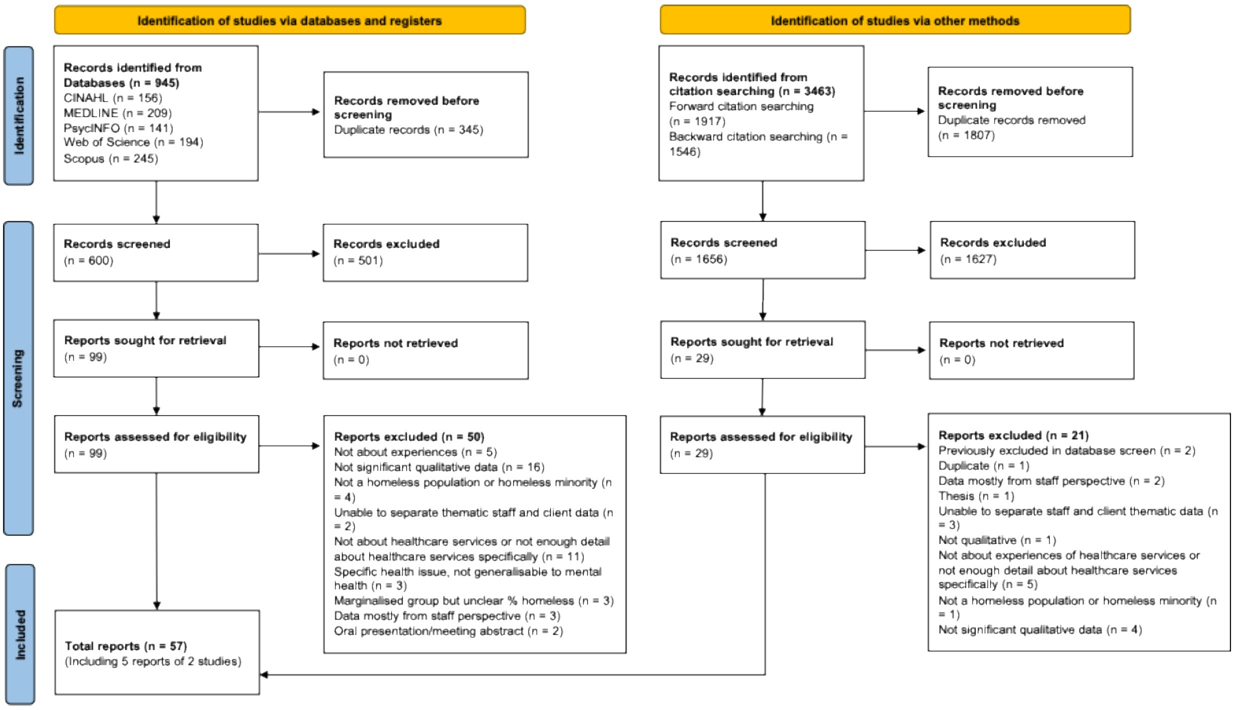
1.3.3.3 Screening Process

Database searches identified 945 records (see Figure 1.1). These were imported into Zotero where duplicates were automatically removed. Study references were exported into MS Excel, where ES and SB independently screened study titles and abstracts, with high inter-rater agreement (97%); any disagreements were resolved through discussion. Full text articles were independently reviewed by ES and SB and 49 papers were included. Forward and backward citation searching using citationchaser (Haddaway et al., 2021) on 1st November 2024 identified eight additional papers for inclusion, making a total of 57 papers.

While this is a larger number of studies than meta-ethnography was designed for, comprehensive literature searches yielding a larger number of studies prompted adaptation of the method (France, Uny, et al., 2019). There is now precedent for conducting a meta-ethnographic synthesis of a larger number of studies, with adapted methods (e.g. Toye et al., 2014).

Figure 1.1

PRISMA Diagram – Outcome of Study Selection



Note. This figure displays the systematic search and screening process.

1.3.3.4 Quality Assessment

We (ES and CA) independently assessed study quality using the Critical Appraisal Skills Programme (CASP; 2023) Checklist. We did not use the CASP to exclude studies. In line with meta-ethnographic tradition, conceptual richness was prioritised over detailed reporting of methods (Atkins et al., 2008; France et al., 2014). The assessment supported critical reading, establishing the overall strengths and weaknesses of included studies, and helped contextualise study findings (Toye et al., 2014).

1.3.4 Phase 3: Reading Included Studies

There are various methods of conducting phases 3-6 within a meta-ethnography (Lee et al., 2015). Our analysis is informed by Toye et al. (2014), Atkins et al., (2008), Pound et al., (2005), Malpass et al., (2009) and Sattar et al. (2021). Reviewers (ES and SB) engaged in detailed reading of the included studies, to identify notable, analytically meaningful ideas or themes: “concepts” (Toye et al., 2014; France, Cunningham, et al., 2019). The 57 papers were imported into NVivo 14 and the “data” (first- and second- order constructs, see Table 1.2) from the results and discussions sections were coded together.

One reviewer (ES) extracted data for all studies, and SB independently extracted data from a selection (20%) of studies (Atkins et al., 2008). Reviewing the extracted data indicated no meaningful differences in how the reviewers understood the concepts within the studies. Therefore, ES extracted the data from the remaining studies. Study characteristics were extracted into an Excel database (Appendix C) and imported into NVivo to provide contextual information for the interpretive synthesis (Sattar et al., 2021).

Table 1.2

Definition of First-, Second-, and Third-Order Constructs (Schutz, 2012)

Level of construct	Definition
First-order	Participant quotes from primary studies
Second-order	The primary study authors’ interpretations of the first-order constructs – themes/concepts
Third-order	The review team’s interpretation of the first- and second-order constructs

1.3.5 Phase 4: Determining How Studies are Related

Using NVivo, similar and recurring concepts were grouped into “conceptual piles” based on shared meaning (Toye et al., 2014) and revised through an iterative process of constant comparison, discussion, and re-reading of studies (Toye et al., 2014). We drew “conceptual maps” (Malpass et al., 2009), to record the concept relationships within each primary study (France, Uny, et al., 2019). We identified relationships between concepts at different contextual levels (e.g. individual, interpersonal, systemic) and organised concepts into these higher-level categories, recording the relationships between them to preserve depth, complexity, and nuance, while managing the large amount of data. We determined that studies addressed two primary domains: (a) experiences contributing to inequality in access, experience, and outcomes, (b) descriptions of good practice and desired approaches to care. These were synthesised separately to preserve conceptual clarity. The data in each of the conceptual piles formed the starting point for the reciprocal and refutational translations in Phase 5 (Sattar et al., 2021). The structure of the conceptual piles and an example of an iteration are presented in Appendix D.

1.3.6 Phase 5: Translating Studies Into One Another

Translation (Table 1.3) involves comparing the concepts from one study to those in others, to develop key overarching concepts that encompass meaningful ideas from multiple papers (Munro et al., 2007; Noblit & Hare, 1988).

Table 1.3

Translation – Exploring How Studies Relate (Noblit & Hare, 1988)

Translation method	Ways studies relate	Purpose
Reciprocal translation	The studies are about similar things	To explore commonalities
Refutational translation	The studies contradict one another	To explore and explain differences, contradictions and exceptions
Line of argument synthesis	The studies are about different aspects of the topic	Higher level interpretive synthesis – to make the whole into more than the sum of the parts imply

The conceptual maps from Phase 4 were compiled to create group concept maps for each of the five contextual levels, and links to concepts in other groups were recorded to maintain the conceptual structure (Pound et al., 2005). We developed these in chronological order, beginning with the earliest-published studies to retain historical context (Atkins et al., 2008; Sattar et al., 2021). This helped to refine concepts and inform translation.

We used both reciprocal and refutational translation, comparing the data within each conceptual pile, with reference to study contextual data (France, Cunningham, et al., 2019). The first author (ES) wrote an interpretation of the data within each conceptual pile, resulting in textual summaries that define each key concept. These were then refined through discussions with the EBEs, forming third-order constructs. Descriptive labels for the key concepts were refined into key metaphors that encapsulate the meaning of the data within. The key concepts and their definitions (third-order constructs), along with the corresponding study citations are displayed in Appendix E.

1.3.7 Phase 6: Synthesising Translations

A line of argument synthesis (Table 1.3) involves an interpretation of the relationship between concepts. Two reviewers (ES and NM) independently worked through the translation table, identifying similarities, differences, and relationships between key concepts (Sattar et al., 2021). During this process, we identified mechanisms and cross cutting themes that span multiple concepts and contextual levels of the analysis. We created a matrix of key concepts, higher order themes, and recorded how they relate in Excel. Constant reference to source and analytical data ensured conceptual richness was preserved. We drew links between key concepts in diagrammatic format, forming an overall conceptual model each, which we discussed and merged to form the final model. The process of developing the model is shown in Appendix F.

1.4 Results:

1.4.1 Characteristics of Included Studies

A summary of the characteristics of included studies is presented in Table 1.4. Studies were published between 2001 and 2024. The full table of study characteristics is provided in the Appendix C.

Table 1.4

Summary of Study Characteristics

Included Study Characteristics	Number of articles
Age group	
Adults	40
Young people	16
Mixed	1
Gender	
Mixed male and female	7
Mixed gender including trans, non-binary and two spirit	7
All male or majority male (>60%)	31
All female or majority female (>60%)	9
Not specified	3
Ethnicity	
Heterogenous / diverse	21
Majority ethnically minoritised people	5
Majority black	1
Majority white	13

Included Study Characteristics	Number of articles
Not specified	17
Country	
USA	27
Canada	12
UK	9
Australia	5
Ireland	2
Sweden	1
Europe (Austria, Greece, Spain, UK)	1
Service type studied	
General healthcare	30
Mental health services	9
Specialist mental health service	3
Primary care	3
Primary care and specialist primary care	2
Specialist primary care	1
Integrated healthcare	2
Mobile clinic / street outreach	5
Emergency care	2
Setting	
Supported housing	6
Community organisations	4
Hostels	3
Shelters	11
Street	1
Primary care clinics	3
Mobile clinic	3
Specialist healthcare service	1
Mental health service	4
Hospitals	3
Shelters and streets	4
Drop in / day centre	3
Mixed	9
Virtual	1
Not reported	1
Publication year	
2001 - 2005	4
2006 - 2010	10
2011 - 2015	5
2016 - 2020	18
2021 - 2024	20

1.4.2 Key Interpretive Metaphors

We developed 22 key "metaphors" relating to the research question and a further metaphor relating to desired approaches and solutions. The names of the key metaphors are presented in Table 1.5 and aim to encompass the meaning of the key concepts within.

Table 1.5

Key Metaphors

Contextual level	Key Metaphors
Individual factors	Lasting psychological scars Past experiences form a blueprint Health as survival, not perfection It's a gamble I'm not willing to take Healthcare is not for me
Interpersonal factors in healthcare encounters	Seen as less, treated as less Stripped of voice, stripped of power Seen but not cared for Out of touch Left out of the conversation I don't trust them
Systemic issues in healthcare provision	Getting in the door The non-care system Patchwork services A system that waits for crisis
Homelessness experience and community	Living and surviving on the street Homelessness weathers you, physically and emotionally Homeless at home Fragile connections
Societal and cultural factors	Us and Them Built to exclude The system is rigged against us
Desired solutions across levels	Adjusting the cogs

Note. The corresponding study citations for each metaphor are displayed in Appendix E.

This section provides a narrative description of the 22 key interpretive metaphors that relate to the research question, structured by contextual group. The desired solutions are discussed in the line of argument synthesis. All of the references in this section are to the included review papers. The names of key metaphors are written in italic and "people" refers to people experiencing homelessness.

1.4.2.1 Individual Factors

For many people experiencing homelessness, there is a foundation of poverty and trauma interwoven with struggles with mental health, substance use, and homelessness, and studies connected these issues in their narratives. Abuse, neglect, family instability, conflict, domestic violence, parental substance misuse, loss, estrangement, or placement into foster care left *lasting psychological scars* that made people vulnerable to mental health issues. Some turn to substances as a coping mechanism which provides short-term relief, but exacerbates instability, homelessness, loneliness, isolation, and mental health problems in the long-term. Homelessness itself creates further traumatic experiences such as exposure to violence, victimisation, stigmatisation, and the stress of survival, leading to a vicious cycle of trauma, mental health issues, and substance use. Although these issues are interconnected, services tend to address these issues in isolation.

On the pathway to homelessness, people felt they were let down and "set up to fail" (Clark et al., 2020) by formal and informal support systems – they "burned all bridges" (Narendorf, 2017) and were left homeless. A sense of abandonment, rejection, mistrust, and betrayal is linked to these experiences and shapes the attitudes people have towards *help*, valuing self-reliance and independence over being "beholden to anyone" (Collins & Barker, 2009). People believe it is safer to be "suspicious of help" and "look after your own problems" (Collins & Barker, 2009) to avoid hurt, disappointment, and protect themselves emotionally. This is a barrier to seeking care. Furthermore, negative experiences with healthcare services – such as being treated disrespectfully, receiving inadequate care, feeling unwelcome, or experiencing stigma/discrimination related to homelessness or drug use – *form a blueprint* of how they can expect to be treated in future interactions. There is a deep distrust towards healthcare systems and professionals and a scepticism about the system's ability or willingness to meet their needs. For some there is a cultural or generational distrust of formal support systems or fear of authority figures linked to historical and systemic abuses of power. These experiences lead to care avoidance, minimisation of problems, and postponement of help-seeking – only seeking care in a crisis. Peoples' experiences of past trauma, discrimination, marginalisation, and internalised stigma mean they may also be more alert to the negative behaviours and attitudes of healthcare professionals. Subtle indicators gleaned through non-verbal communication and attitudes of healthcare staff can signal unwelcomeness and judgement. Feelings of low self-worth, inferiority, and alienation means they may be more likely to feel judged or "looked down on" in healthcare settings (Austin et al., 2021; Darbyshire et al., 2006; Leipersberger, 2007; Mc Conalogue et al., 2021; O'Carroll & Wainwright, 2019).

Homelessness is a "big black hole" (Martins, 2008) that strips away personhood, identity, and renders a person invisible and disconnected from society. People feel worthless, inferior and alienated, like "a sorry excuse for a person" (Leipersberger, 2007). This diminished sense of self-worth prevents people from asking for help due to feeling undeserving or inferior – a sense that *healthcare is not for me*. In healthcare, they felt like an “intrusive visitor” (Kneck et al., 2021), where they were deprioritised and forgotten about – left “on the back burner” (Wise & Phillips, 2013). Some felt healthcare staff “would not care even if they died” (Wise & Phillips, 2013), reinforcing feelings of worthlessness, and a sense of dehumanisation. Being ignored or feeling invisible in healthcare settings also reinforces a sense of not counting like the rest of the population – that they are separate or alienated from the rest of society, that they are an “anomaly” and “do not fit in” – further undermining self-worth and putting people off seeking care (Kneck et al., 2021; Nichols & Malenfant, 2022; Strange et al., 2018).

The metaphor *it’s a gamble I’m not willing to take* refers to the emotional, psychological, and social factors that operate as internalised barriers to help-seeking. Being seen as having mental health difficulties (“crazy” or “different”) (Chaturvedi, 2016; Darbyshire et al., 2006; Leipersberger, 2007) adds an extra layer of stigma on top of already being part of a marginalised group, who are often stereotyped as “bums” or "low-lifes” (Ensign, 2004; Leipersberger, 2007; Purkey & MacKenzie, 2019). In discussions with the EBEs, one described how he experienced stigma from his peers for attending the local community mental health centre. People anticipate being judged and stigmatised in healthcare encounters and are driven to avoid seeking help by a desire to preserve a semblance of pride and dignity. People fear the unknown of therapy, fear they will be unable assert themselves and communicate their needs, fear opening up will expose them to judgement and misunderstanding, or have scepticism of "bio-chemical" explanations for mental health and fear the use of medication. People may believe seeking help is “futile” (Sturman, 2020), have “fatalistic” beliefs (O’Carroll & Wainwright, 2019) and feel trapped, powerless, and resigned to their circumstances after repeated efforts and disappointments. Feeling ready to engage meaningfully with services is described as extremely personal and people need to decide this on their own terms.

Health is viewed *as survival, not perfection*, reflecting the challenges of – in many cases – managing multiple chronic health conditions, mental health issues, and substance use disorders in the context of social disaffiliation and the lack of resources to manage health. The burden of managing multiple health conditions alongside physical, mental, or cognitive conditions affecting mobility, ability to socialise, and/or remember appointments impacted people’s ability to manage health and attend appointments. This complexity is also challenging for healthcare providers as multiple chronic conditions require multidisciplinary support, which is often fragmented or inaccessible to those experiencing homelessness, leading to further deterioration of health. This metaphor also reflects the conceptualisation of “health” as broader and more holistic than the absence of physical disease; health is defined by functionality, freedom, respect, dignity, and a sense of control. Health is a means to support daily survival, maintain a sense of autonomy, and exit homelessness. Achieving basic needs such as stable housing, nutrition, and hygiene is prioritised over health, as these are seen as prerequisites to being able to focus on improving health and wellbeing.

1.4.2.2 Interpersonal Factors in Healthcare Encounters

The key metaphor *seen as less, treated as less* highlights how homeless people frequently experience bias, prejudice, and discrimination in healthcare, where they are dehumanised and treated as "less than human" (Anastasiya et al., 2024; Moore-Nadler et al., 2020) or invisible. Implicit biases among staff – viewing them as sub-human, “lazy,” (Thompson et al., 2006; Wen et al., 2007) or “junkies” (Austin et al., 2021; Gilmer, 2020; Moore-Nadler et al., 2020; Younas et al., 2022) – result in dismissive, inadequate care and emotional distress. Disclosing homelessness or substance use often triggers a noticeable shift in staff demeanour, leading to disrespectful, condescending interactions, minimisation of concerns, and judgmental attitudes. "Anytime you have 'homeless' put on your records, your care goes down almost immediately… it's everything, it's attitude" (Christian et al., 2022). This label followed them through healthcare interactions, as though they had been “flagged”, influencing staff attitudes, overshadowing participants’ health needs, and reducing the quality of care received. Judgemental attitudes may be linked to the concept of the “inappropriate attendee” – the view that homeless people overuse emergency services and are “wasting” hospital resources (O’Carroll & Wainwright, 2019). Assumptions of “drug-seeking behaviour” (Gilmer, 2020; King et al., 2020; Meehan et al., 2023; Moore-Nadler et al., 2020) further stigmatise people, resulting in denial of needed care and feelings of alienation and devaluation. Dehumanising interactions were likened to being treated as “cattle” (Black et al., 2018; Leipersberger, 2007; Martins, 2008; Rae & Rees, 2015) or a “statistic” (Moore-Nadler et al., 2020). Metaphors of being “treated like dirt” (Leipersberger, 2007; O’Carroll & Wainwright, 2019; Wise & Phillips, 2013) or placed “on the back burner” (Wise & Phillips, 2013) encapsulated the feelings of being looked down upon and deprioritised. Experiences of unwelcomeness, both from healthcare staff and “regular people” in the waiting room (Kneck et al., 2021), amplify feelings of exclusion, mistrust, and alienation, perpetuating poor health outcomes and barriers to accessing essential services. The EBEs resonated with and contributed to this metaphor, describing the phenomenon as the “homeless tag”. They noticed a shift in the treatment they received from healthcare professionals before and after they became homeless. In inpatient care, one EBE said there was a hierarchy in how people were treated, depending on judgements about whether their situation was “self-inflicted”.

A common sentiment was that healthcare staff were *out of touch* and "have no idea" about the causes and lived realities of homelessness (Darbyshire et al., 2006; Henderson et al., 2022; Hudson et al., 2010). This lack of understanding was conveyed through intolerance and judgement of behaviours and/or appearance and perpetuated feelings of exclusion.

The metaphor *stripped of voice, stripped of power* encompasses the disempowerment experienced in healthcare settings through not being listened to, heard, or feeling as though their perspective is not valued. Participants sensed being "stripped of" (Kneck et al., 2021) their voice, power, and autonomy, with decisions made for them rather than with them. This leads to frustration, disempowerment, and lack of safety in healthcare, especially for women, and ultimately disengagement. Participants felt *left out of the conversation*, where conversations were one-way and not mutually engaging, with little room for patient input. Participants disliked the authoritative or "lecturing" (Ensign, 2004) communication style of healthcare professionals. Unclear or absent explanations regarding their treatment, and the use of complex medical jargon left them feeling confused and excluded from understanding their care. This increased people's feelings of vulnerability and fear, and agitated behaviour. One EBE was stripped of his voice when he was a service user, describing how people would talk directly to his key worker on his behalf, leaving him out of the conversation, an example being "does he take sugar?" when making a cup of tea. Another EBE said decisions are made on your behalf and "you are not listened to; you are dictated to".

Poor interpersonal skills from healthcare staff such as a lack of empathy, compassion, not being listened to, inattentiveness, and rudeness makes people feel undervalued and uncared for. This impersonal approach with a lack of focus on building rapport made participants feel *seen but not cared for* and put people off seeking care. The issues described in this section lead to distrust and a and feeling healthcare professionals do not have their best interests in mind (*I don't trust them*). The impact of distrust is particularly severe for people experiencing homelessness, as their limited access to care makes each interaction significant, and a lack of trust leads to avoidance of and disengagement with healthcare.

1.4.2.3 Systemic Issues in Healthcare Provision

Getting in the door to services is challenging when rigid, exclusionary criteria, normative assumptions, and systemic gatekeeping puts up barriers to access. The prioritisation of rules, procedures, and efficiency over adaptability and equitable access to care fails to recognise the complex, intersecting needs of marginalised populations. This leaves people feeling abandoned and unsupported with no alternatives. People with "dual diagnosis" are often denied mental health support until they address their substance use, despite being interrelated issues, keeping them stuck in cycles of unmet need. Systemic inequity is embedded in healthcare systems and assumes access to resources that many marginalised people do not have, creating financial and logistical barriers. Limited allocation of resources means the healthcare system is strained and there are long waiting lists, and a lack of availability for mental health services. During discussions with the EBEs, they shared experiences of long waits to receive care in which time they became more acutely unwell.

The non health care system (Martins, 2008) refers to how standard models of healthcare fail to address the needs of people experiencing homelessness, reinforce social inequities, exclusion dehumanisation, and discourage people from seeking care. Hospitals are perceived as exclusionary, stigmatising, and "uninviting places" (Paradis-Gagné et al., 2022) that made people feel unwelcome, marginalised and like "intrusive visitors" (Kneck et al., 2021) – outsiders rather than patients deserving of care. Hospitals were not perceived as safe and supportive, but "confrontative" environments, that heightened their vulnerability, and “stripped [them] of their dignity” (Kneck et al., 2021). The medical approach to mental health is perceived as inadequate, with an overreliance on medication and lack of focus on holistic, person-centred care, that considers social context. Participants described being “labelled” and felt reduced to a set of symptoms. Psychiatric hospitals were likened to “prisons” due to their rigid protocols, isolation, and the institutional environment (Voisard et al., 2021). In US studies, a common view was that the medical system is “broken” (Christian et al., 2022; King et al., 2020) and designed for financial gain – a cynicism that it only exists to make money and prioritises profit over patients. High costs were a significant barrier, leading to poor health and lack of trust in the system.

Fragmented, poorly coordinated, *patchwork services* create barriers to effective care. Siloed working, inadequate communication and collaboration between services, and high staff turnover results in missed referrals, inadequate follow-up, and care that fails to address interconnected needs. Poor discharge planning often left people without adequate support or housing. Falling through these gaps exacerbated feelings of abandonment and rejection. High staff turnover was a barrier to forming trusting relationships, and meant people feel emotionally drained from having to repeat stories and “re-explain your whole, entire friggin’ story to them” (Anastasiya et al., 2024; Austin et al., 2021; Black et al., 2018; Darbyshire et al., 2006; Gunner et al., 2019; Thorndike et al., 2022). A lack of continuity, integration and collaboration perpetuates cycles of being let down, poor health, and disengagement. Discussions with EBEs contributed to this metaphor, with one EBE describing how when they were a service user, they saw five different psychiatrists which was a barrier to developing an effective therapeutic relationship.

A system that waits for crisis refers to how systemic barriers (e.g. administrative, attitudinal, logistical) to preventative healthcare force people into a crisis-driven approach to managing their health, exacerbating health disparities. They endure their health problems and illnesses and seek care as a “last resort” (Paradis-Gagné et al., 2022), relying on “underground resourcefulness” to manage health (Martins, 2008). Emergency services are often the primary means of addressing health issues. This results in what is described as “inappropriate use” of emergency care, but rather, it should be viewed it as a necessary response to the failings in access to preventative care (O’Carroll & Wainwright, 2019). Barriers lead to an “endless cycle” (Nichols & Malenfant, 2022) of avoidable crisis, where without access to effective preventative care, mental and physical health deteriorates, putting people at risk of involuntary admissions. Long-term issues remain unaddressed, and instability worsens, further undermining access.

1.4.2.4 Homelessness Experience and Community

The experience of *homelessness weathers you physically and emotionally*. Exposure to violence, trauma, harsh weather, social isolation, and lack of basic necessities means people live in survival mode, and chronic stress impacts mental and physical health. Women face additional risks from gender-based violence. One participant said, “It makes me crazy being outside [...] The stress of being homeless makes people crazy” (Thorndike et al., 2022). Living on the street makes it impossible to manage health, and even in hostels, people struggle with sleep deprivation, substance use, and conflicts with other residents. *Survival* is the priority, and efforts are focused on shelter, food, safety, and income generation. These “competing priorities” mean managing health falls to the “bottom of their priority list” (O’Carroll & Wainwright, 2019; Wise & Phillips, 2013). The “chaotic” nature of homelessness and substance use adds additional challenges to managing health. In the face of these challenges, homelessness forms strengths and values around resilience, resourcefulness, autonomy and independence. People find creative ways to meet their needs, such as through sharing medication and information (Martins, 2008). However, these strengths can serve as barriers to care, as self-sufficiency may make asking for help feel like failure. Condescending, “paternalistic” staff who disregard autonomy lead to frustration and mistrust (Thompson et al., 2006; Voisard et al., 2021).

Fragile connections refers to the social networks participants described. Some found solidarity and companionship in shared experiences. However, mistrust among peers is a common experience – many avoid relying on peers due to fears of exploitation, conflict, or theft. People in recovery from substance use often isolate themselves from peers in active addiction to maintain progress (Mc Conalogue et al., 2021). A lack of trust worsens the isolation they experience from homelessness and is linked to worse health outcomes. Within the homeless community, people often see themselves as different from others, creating an “us vs. them” divide and “stigma among the stigmatized”(Kerman et al., 2019). People try to distance themselves from those described as “crazies,” “junkies,” or “out of control”, which can be a barrier to accessing services (Kerman et al., 2019). Such distinctions were made to maintain a sense of identity and avoid behaviours they did not want to be associated with. The physical environment of hostels and shelters often feels unsafe, chaotic, and unhygienic. Participants described issues with bedbugs, syringes, lack of privacy, and noisy, chaotic settings heighten stress and disrupt mental health. This environment lowers self-worth: "There is still cockroaches everywhere. Nobody says anything, we don't matter" (Kerman et al., 2019; Thompson et al., 2006). Essential services are viewed as being located out of the way in unsafe areas ("back alleys") so "normal people" would not have to be "exposed" to homeless people (Thompson et al., 2006). Living in hostels/temporary accommodation is linked to feeling *homeless at home* and feelings of being disconnected and estranged from others.

1.4.2.5 Societal and Cultural Factors

Homelessness, using drugs, or mental illness are stigmatised and not "value-neutral states" (Darbyshire et al., 2006). Homeless people are aware of societal judgment and perceive this to be expressed through "the gaze" – the relentless stares or pitying looks from the public, leading to shame, rejection, and alienation (Darbyshire et al., 2006). They view themselves as distinctly "separate" or "different" from society – a sense of *us and them* and being treated as "second class citizens" (Wise & Phillips, 2013). People believe power structures try to make them invisible, and they feel unwanted in wider society. "Segregated waiting rooms" (Nichols & Malenfant, 2022), being "ushered" out of sight, and perceived "social triage" where people of higher social status are given priority in healthcare settings (Nichols & Malenfant, 2022), reinforces the "us and them" divide. Some develop a "go-against attitude" in protest to stigma and exclusion (Austin et al., 2021).

The EBE's views were valuable in developing this metaphor. They said there is a "moral value around drug use" and that it is human nature to judge. They resonated with the idea of "us and them" and said alienation from society is the definition of homelessness – there is a sense that you are "at the periphery", "not a valued member of society", and "not as good as everyone else". The stress and stigma experienced in waiting rooms was highlighted by the EBEs, and the idea of the "go against attitude" was described as becoming a "rebel against the system", and may involve walking out, recoiling, or becoming aggressive.

Structural inequality influences the health experiences of people experiencing homelessness. Growing up in deprivation may involve domestic violence, parental substance use, or foster care, increasing health risks and vulnerability to homelessness. However, healthcare systems do not acknowledge these social determinants of health (SDoH). Healthcare systems often feel as though they were *built to exclude*, "designed by middle class people for middle class clients" (Purkey & MacKenzie, 2019). A "classist" (Meehan et al., 2023) two-tier system ensures those who can pay receive better care, while people in poverty, particularly women and racialised communities, experience dismissive treatment. Accounts emphasise that without structural changes, marginalisation and health disparities will persist. People experiencing homelessness feel as though *the system is rigged against us* – through policies criminalise homelessness and leave them excluded and inadequately supported, perpetuating a revolving door of homelessness.

1.4.3 Reciprocal Translations

There was significant concurrence between studies, particularly around issues relating to the accessibility and availability of services (*getting in the door* and *patchwork services*), the experiences of stigma, bias, dehumanisation and discrimination within healthcare (*seen as less, treated as less*), the impact of past experiences on help seeking (*past experiences form a blueprint*), the impact of trauma and links to mental health and substance use (*lasting psychological scars*) and the impact of homelessness on health and wellbeing (*homelessness weathers you*). The most significant agreement between studies was for concepts from the metaphor *desired solutions: adjusting the cogs*, highlighting the value of approaches that make patients feel heard, understood, and valued – “they made me feel like I mattered” (McDaniel, 2024) and the importance of systems change to deliver accessible services, structured in a way to enable engagement with relationship-based care.

1.4.4 Refutational Translations

While the studies were deemed similar enough in focus for reciprocal translation, refutational translations identified some key differences along contextual lines. Studies of specialist services (mental health, primary care, mobile, integrated) e.g. (Archard & Murphy, 2015; Clark et al., 2020; Hirst & Cuthill, 2021; MacKinnon et al., 2022; McDaniel, 2024; Paradis-Gagné et al., 2022; Parsell et al., 2018; Taylor et al., 2007; Voisard et al., 2021) were more likely to report more positive experiences of support (*adjusting the cogs*). These studies emphasised the benefits of practical and relational support, building trust and rapport, responsive services, and approaches to overcome practical barriers. This improved wellbeing and facilitated recovery, but studies also emphasised the need for systemic change. Studies of general/mainstream services (e.g. Anastasiya et al., 2024; Gilmer, 2020; Henderson et al., 2022; Leipersberger, 2007; Martins, 2008; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Whitley, 2013; Wise & Phillips, 2013) were more likely to discuss stigma, discrimination, and dehumanisation (*seen as less, treated as less*), barriers to access (*getting in the door*), exclusion (*the non-care system*), marginalisation, and poor care (*seen, but not cared for*).

Studies from the US e.g. (Christiani et al., 2008; Martins, 2008; Meehan et al., 2023; Stanhope & Henwood, 2014; Sweat J et al., 2008; Woith, 2016) often cited financial barriers to healthcare due to their insurance-based system. In the UK, studies discuss the National Health Service (NHS) and its limitations for homeless populations. Themes include difficulties with GP registration, restrictive policies on access without a fixed address, attitudinal barriers, and the role of specialist services to bridge these gaps (e.g. Gunner et al., 2019; Mc Conalogue et al., 2021; Rae & Rees, 2015). For those in rural areas, e.g. parts of Canada (Nicholas et al., 2016; Paradis-Gagné et al., 2022, 2023; Ramsay et al., 2019), Ireland (O'Carroll & Wainwright, 2021), and rural USA (Whitley, 2013), geographic barriers are more prominent with limited healthcare infrastructure in sometimes vast, sparsely populated areas.

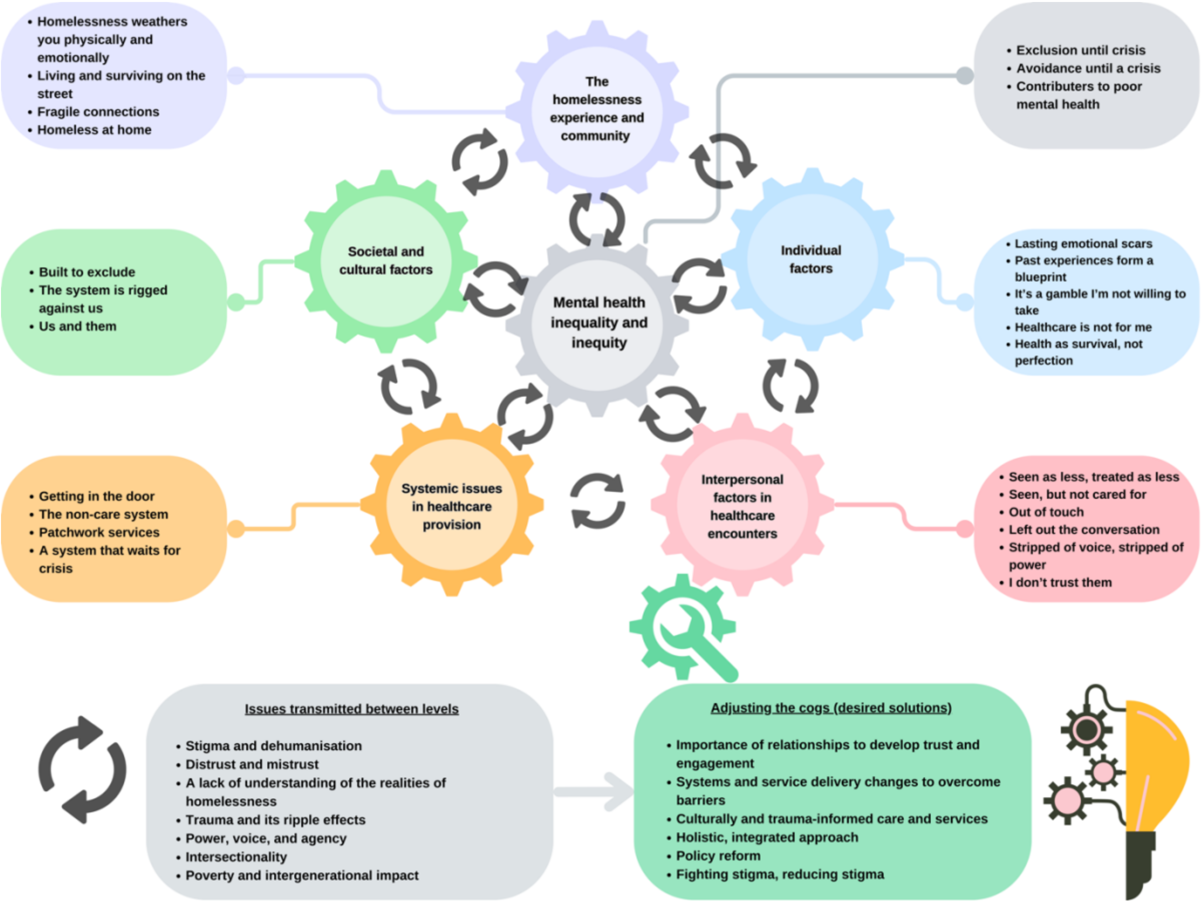
Studies within the concept *relationship to help* all focussed on young people. An attitude of self-reliance may be linked to recently finding independence, or a self-protection mechanism to avoid further disappointments in the wake of recent trauma/betrayal from being "kicked out" or "let down" by adults. The concept *stigma around seeking help for mental issues* included mostly studies of young people (Chaturvedi, 2016; Collins & Barker, 2009; French et al., 2003; McCormick, 2022; Nicholas et al., 2016). Homelessness is already a marginalised characteristic and mental health issues add another layer of stigma. This may be particularly impactful for young people who are still constructing their identity. *Perceiving themselves as different from other service users* is another concept from studies of young people – this may too be to preserve a sense of identity. Alternatively, this may be linked to a sense of vulnerability around older service users, especially for young women.

1.4.5 Line of Argument Synthesis

The line of argument synthesis led to the generation of a visual model to represent the findings, which is presented in Figure **1.2** and explained in the text. The model has a central cog representing health inequalities and the main mechanisms driving the inequities. Five outer cogs representing the contextual levels, comprised of the key metaphors maintain inequities through these mechanisms. The cog structure symbolises the interactions between different levels of influence – individual, interpersonal, systemic, homelessness, and societal – emphasising how these factors are not isolated but work together to perpetuate inequities. The box labelled "issues transmitted between levels" is linked to the bidirectional arrows and shows higher-level themes that operate across all levels of influence. Linked to this is the box titled "adjusting the cogs", which symbolises solutions derived from the accounts that can help to reduce the perpetuation of disparities. The findings of the line of argument synthesis are discussed in the context of the wider literature.

Figure 1.2

Model of Mental Health Inequity for People Experiencing Homeless and Desired Solutions



1.4.5.1 Mechanisms

During our analysis, from the included accounts, we identified key mechanisms of the maintenance of mental health disparities:

a) Avoidance of or disengagement from healthcare and support services until a crisis. This avoidance reflects both a coping/self-protection mechanism and a systemic issue driven by inadequate and inaccessible services that disempower people and put people off seeking care.

b) Exclusion from care until a crisis: Structural, organisational, relational, and social practices that exclude and marginalise and alienate individuals experiencing homelessness.

c) Contributors to poor health: Experiences that provide the setting conditions for poor mental health.

Each of the key metaphors operates directly (e.g. a belief that *healthcare is not for me* leads to avoidance of services) or indirectly (e.g. feeling *homeless at home* contributes to *homelessness weathers you* which contributes to poor health) through one of these mechanisms to perpetuate mental health inequities. This is represented by the central grey cog in Figure **1.2**.

1.4.5.2 Higher-level themes

The line of argument synthesis identified seven higher-level themes that operate across contextual levels, reflecting the multifaceted and interconnected drivers of inequalities in mental healthcare access, experiences, and outcomes for people experiencing homelessness. This is represented in the diagram by the bidirectional arrows between cogs, and the grey box labelled "issues transmitted between levels". These multi-level themes are descried and discussed in the text in this section.

1.4.5.2.1 Stigma and dehumanisation

Cultural narratives stigmatise homelessness as a personal failing, labels people as "junkies", "bums" or "dangerous" and dehumanise people experiencing homelessness. People internalise this stigma which leads to feelings of worthlessness and avoidance of healthcare. When they do engage, being judged, dismissed, and treated as "less than human" (Anastasiya et al., 2024; Moore-Nadler et al., 2020) reinforces internalised stigma. Feeling unwelcome in healthcare settings can provoke emotional distress and behaviour that is misunderstood, feeding back into stigmatising attitudes and exclusion. This phenomenon was described as "if you're treated like shit, you'll act like shit" by EBEs. At the systemic level, processes and practices that prioritise efficiency over dignity perpetuate a sense of dehumanisation. Stigma within homeless communities and issues with access to hygiene while homeless can limit access to services, due to self and public perceptions (e.g. O'Carroll & Wainwright, 2019).

Previous reviews have identified stigma, discrimination, and dehumanisation as key factors that influence the accessibility and acceptability of healthcare (Magwood et al., 2019; Omerov et al., 2020). This theme explains how these factors operate as a multi-level mechanism to maintain health inequities, supported by the wider literature. Canham and colleagues (2022) describe how stigma at the intrapersonal, interpersonal, and structural levels drive the behaviour of "homeism" – discrimination against homeless people, and research has linked stigma to poorer healthcare, housing, and wellbeing outcomes for people experiencing homelessness (Mejia-Lancheros et al., 2021).

1.4.5.2.2 Distrust and mistrust

Individual histories of personal and institutional betrayals create a foundation of mistrust of formal sources of support. This operates within a context of cultural mistrust in institutions (Collins & Barker, 2009; O'Carroll & Wainwright, 2019), and the reality that survival while homeless often necessitates the mistrust of peers, creating layers of mistrust. Interpersonal dynamics in healthcare settings often confirm and reinforce existing mistrust. The transient and unstable nature of homelessness in combination with fragmented health systems mean there is often poor continuity of care, with further erodes trust and prevents the building of long-term relationships with healthcare professionals. This helps to explain why trust and safety are highly valued in healthcare interactions (Magwood et al., 2019).

1.4.5.2.3 Trauma and its ripple effects

The theme of *trauma and its ripple effects* highlights how early-life instability and repeated adversity influences healthcare engagement for people experiencing homelessness. Individual trauma histories affect relationships to help and engagement with healthcare. Healthcare encounters that are not trauma-informed and fragmented services that require repeated re-telling of stories, can be retraumatising. Exposure to further trauma, such as violence, victimisation, and marginalisation while homeless compounds this trauma, creating a vicious cycle that contributes to chronic mental health issues.

The metaphors *past experiences form a blueprint* and *it's a gamble I'm not willing to take* portray this avoidance as a protective mechanism. Healthcare environments where people may experience personal questions, retelling of stories, stigma, and dismissive or unreliable services could be perceived as sources of threat. From a cognitive-behavioural perspective, avoidance serves as a short-term coping strategy to escape reminders of past trauma or anticipated harm (Hayes et al., 1996). Such avoidance may temporarily reduce distress but ultimately delays care until crisis. Attachment theory states early relational experiences create a "blueprint" for future interactions (Ainsworth et al., 1978; Bowlby, 1969), and can be useful for understanding help-seeking behaviour. Narratives of mistrust, avoidance, rejection and abandonment reflect patterns consistent with insecure attachment styles. Healthcare professionals may be perceived as unreliable or threatening, leading to mistrust, disengagement, or inconsistent engagement. Trauma-informed, relationship-based care is key; models that prioritise empathy, consistency, and psychological safety can help to rebuild trust, address avoidance, and promote engagement.

1.4.5.2.4 Power, voice, and agency

Many people experiencing homelessness feel powerlessness to advocate for themselves in healthcare settings. Rigid, exclusionary systems, and healthcare professionals who are not sensitive to the inherent power imbalance in healthcare interactions often reinforce disempowerment. Homelessness forces people to make “impossible choices” to survive, reflecting a broader sense of powerlessness. Over time, this erodes a sense of agency and fosters a sense of fatalism, reducing engagement in healthcare. Magwood et al., (2019) highlight the importance of autonomy for engagement in healthcare settings.

1.4.5.2.5 A lack of understanding of the realities of homelessness

Individuals believe healthcare providers and systems lack insight into the realities of surviving homelessness and fail to accommodate their basic needs to make healthcare accessible. This echoes Omerov et al.'s, (2020) findings that unmet basic human needs overshadow engagement with healthcare. Training for healthcare professionals does not (generally) cover homelessness, meaning they have gaps in homelessness cultural competence. Policies reflect a general lack of understanding or compassion towards homelessness (e.g. criminalisation of homelessness and substance use), resulting in exclusion, inadequate support and resources, and the perpetuation of homelessness (Herring et al., 2020).

1.4.5.2.6 Intersectionality

Intersecting marginalised identities – such as race, gender, sexual orientation, and migration status – compound health inequalities and increase vulnerability to discrimination and cultural insensitivity in healthcare. For instance, women described a lack of safety in healthcare (Kneck et al., 2021), and inadequate attention to gender-based violence. Transgender individuals described the impact of structures that enforce a gender binary (Nichols & Malenfant, 2022). While homeless, intersectionality puts people at higher risk of victimisation and violence, and structural inequalities such as systemic racism or sexism, amplify health inequities and perpetuate cycles of marginalisation (Anastasiya et al., 2024; Carmichael et al., 2023; Kneck et al., 2021; Nicholas et al., 2016; O’Carroll & Wainwright, 2019; Purkey & MacKenzie, 2019; Wise & Phillips, 2013). Magwood et al., (2019) suggest that healthcare services should incorporate anti-oppressive approaches and principles of trauma informed care to address structural violence.

1.4.5.2.7 Poverty and intergenerational impact

Poverty limits access to basic needs including food, housing, and healthcare. People experiencing homelessness are “the tip of the iceberg called poverty” (Leipersberger, 2007) and spend significant time and energy meeting their basic needs (Voisard et al., 2021). O'Carroll & Wainwright (2019) hypothesise links between poverty and poor engagement with healthcare among people experiencing homelessness through mechanisms such as stress and family dysfunction, and substance misuse linked to deprivation. Experiences of poverty and instability are often tied to intergenerational cycles of disadvantage and adversity among homeless families (Cutuli et al., 2017; Lafavor et al., 2020). Childhood poverty is linked to ACEs (Farooq et al., 2024), chronic health problems, and depression in adulthood (Lee et al., 2021). Structural issues such as wealth inequality and economic policies perpetuate cycles of poverty, exclusion and poor health outcomes (Pickett et al., 2024), and can be understood as structural violence (Farmer, 2004), preventing individuals from meeting their basic needs, such as housing, which exposes them to harm. Mental health inequality thus cannot be addressed through individual-level interventions alone; structural and systems change are essential.

1.4.5.3 Desired solutions: "adjusting the cogs"

The analysis also identified key concepts describing desired approaches and solutions. Created from the first and second order accounts from included studies, these are key to overcoming the factors highlighted in the higher order themes which keep the cogs turning.

1.4.5.3.1 Importance of relationships to develop trust and engagement

An approach of relationship-based care where providers develop trust and psychological safety through interactions that embody respect, empathy, genuineness, understanding, reliability, active listening, good communication, compassion, and are non-judgemental, allows patients to feel seen, heard, and valued (McDaniel, 2024). This forms the foundation for engagement. Support with addressing basic needs builds trust and engagement. A therapeutic alliance, based on mutual respect, autonomy and a personalised approach is valued and can empower people to manage their health. Longitudinal care, where there is consistency in healthcare providers, reduces the burden of repeatedly telling their story and facilitates the building of a working alliance. This recommendation echoes those of previous reviews (Magwood et al., 2019; Omerov et al., 2020; Siersbaek et al., 2021)

1.4.5.3.2 Systems and service delivery changes to overcome barriers

Service delivery models should be redesigned to effectively meet the needs of people experiencing homelessness. Effective systems must address practical barriers, inflexible time constraints on staff and patients, fragmentation, and inflexible eligibility requirements. Services that address these barriers directly – such as mobile/street clinics, integrated, "one stop shop" services, on-site clinics within hostels, and community-based clinics – improve access and help to meet need. Services can be more inclusive, flexible, responsive, and accommodating to the realities of homelessness by offering flexible appointments, informal approaches, and culturally competent practice. Involving peer approaches in service delivery can support this. Inter-service collaboration and communication across organisations is key to prevent patients from falling through the gaps. Service design to facilitate continuity of care and longitudinal, relationship-based care is important and may require a philosophical shift from protocols, targets, and system requirements, to focusing on working alliance (McCormick, 2022). In their realist review, Siersbaek et al. (2021) highlight the importance of systems change to improve access such as through long-term funding for services and building of inclusive cultures.

1.4.5.3.3 Culturally and trauma-informed care and services

Effective care requires healthcare professionals to be understanding and knowledgeable of homelessness, culture, trauma, substance use, and SDoH that shape the lives of people experiencing homelessness. They should work to reduce inequitable power relations. Training is needed for healthcare professionals and should include inter- and intra-personal skills to address biases and stigma, engage compassionately and effectively, and may be developed during educational training, ongoing professional development and reflective practice. Employing people with lived experience of homelessness as staff or peer workers is useful to build understanding, cultural competence, engagement, and trust. Approaches to engagement should be informal, proactive, consistent, and patient – “not giving up” (Darbyshire et al., 2006). Physical and organisational environments impact engagement – thoughtful design, compassionate policies, and trauma-informed practices can help environments to feel inclusive, welcoming and facilitate a sense of safety, and encourage engagement. Services that recognise the impact of trauma on emotions/behaviours and are understanding and tolerant to behaviours (e.g. within waiting rooms) can reduce rejection and exclusion. This recommendation is aligned with the psychologically informed environments framework (PIE; Johnson & Haigh, 2010).

1.4.5.3.4 Holistic, integrated approach

A holistic approach recognises that health is not just the absence of illness but a state of overall wellbeing, encompassing physical, mental, emotional, and social dimensions (Mc Conalogue et al., 2021; McCabe et al., 2001). Holistic, multidisciplinary, integrated care models that address interconnected issues such as mental health, substance use, housing, nutrition, hygiene and shelter are needed to improve access and engagement. Starting by meeting basic (e.g. housing, food, hygiene) and personalised needs first helps to build trust and engagement. Incorporating health education into healthcare provision helps people manage their health, builds self-efficacy, empowerment, engagement and improves health outcomes. Incorporating alternative and complementary approaches into services may improve engagement (Ensign, 2004; Gilmer, 2020). Bell et al. (2022) provide qualitative evidence that holistic care – integrating mental and physical health support with attention to SDoH, flexible delivery, and strong interagency collaboration – is valuable for improving health equity among homeless populations.

1.4.5.3.5 Policy reform

Structural changes in political will, economic resources, and public health policies are needed to address the systemic inequities that perpetuate health disparities for people experiencing homelessness. Central to this is the recognition that housing is central to health, wellbeing, and stability and policies should consider integrating health services within supportive housing. Policies must address systemic barriers to healthcare by addressing SDoH and target risk factors for homelessness such as ACEs, poverty, and systemic racism to prevent homelessness and improve long-term health outcomes. Healthcare institutions and professionals have a role in using their influence to advocate systemic changes and equitable healthcare (King et al., 2020). Investment in workforce development is required to facilitate trauma-informed, culturally competent care to help to break the cycle of rejection, exclusion, and traumatisation. A shift is needed from punitive models toward supportive, evidence-based approaches that reduce harm and support recovery such as safe injection sites, crisis response teams, and harm-reduction models. One participant stated, “Addicts should get prescriptions from a doctor and go to safe using sites and use. Addiction is an illness.” (King et al., 2020). Evidence supports the use of safe-consumption rooms and harm reduction approaches (Magwood et al., 2020; Miler et al., 2021).

1.4.5.3.6 Fighting and reducing stigma

Stigma shapes identities, healthcare experiences, and outcomes for people experiencing homelessness. Accounts described the importance of a culture of parity between mental and physical health to shift public attitudes and reduce stigma around seeking help for mental health problems. Policies that institutionally stigmatise mental illness (e.g. benefit award decisions or health insurance decisions) should be reviewed. Healthcare professionals should advocate for people experiencing homelessness to receive respectful, dignified care, and challenge discriminatory behaviours among their peers and within systems. Mejia-Lancheros and colleagues (2021) recommend that stigma should be addressed at all levels. Public awareness campaigns and normalisation, alongside interventions and opportunities for people experiencing homelessness to develop identities outside of homelessness may help to deconstruct stigmatised identities and shift public views – but more research is needed on anti-stigma interventions (Reilly et al., 2022).

1.5 Discussion

This meta-ethnography aimed to understand inequalities in mental healthcare access, experiences, and outcomes for people experiencing homelessness. Through an interpretive process, 22 metaphors relating to mental health inequality were developed and organised across five contextual levels, contributing to the three identified maintenance mechanisms of health inequalities – avoidance of healthcare, exclusion from healthcare, and creating the setting conditions for poor mental health. Seven higher level themes which operate dynamically across contexts were generated through a line of argument synthesis and desired solutions to address these issues were derived from the primary study data. The findings were synthesised into a visual conceptual model that conveys the dynamic, interacting mechanisms through which mental health inequalities are perpetuated. It demonstrates that inequalities are not the result of isolated failings or individual vulnerabilities but emerge from a complex interplay of factors. This study highlights the need for a paradigm shift in how healthcare systems respond to the needs of people experiencing homelessness with mental health difficulties – moving away from reductive, panacea-driven approaches and towards an engagement with complexity.

1.5.1 Strengths and limitations

This meta-ethnography addresses a gap identified in a recent umbrella review, which called for more research on the contextual factors and determinants influencing mental health service use among people experiencing homelessness to inform effective policy and decision making (Hossain et al., 2020). By synthesising metaphors across contextual levels, the meta-ethnography contributes to theory-building on how mental health inequalities are maintained, provides a conceptual model that supports complexity-informed systems thinking, and offers stakeholders a practical tool to engage with complex health inequalities.

Furthermore, this research incorporates participants' perspectives and insights on effective interventions, such as relationship-based care and trauma-informed approaches, and suggests actionable insights for policymakers and practitioners. The perspectives of EBEs also enriched the analysis, ensuring that findings were grounded in the realities the lived experience of homelessness. The use of metaphors captures the essence of participants' lived experiences, enables patient experiences to be represented within the systematic review evidence base (Moser & Korstjens, 2023), and provides accessible frameworks for understanding complex systemic issues.

However, a number of limitations should be acknowledged. The included studies predominantly originated from high-income Western countries, limiting generalisability to other socio-cultural contexts. The review included only English-language publications, introducing potential language and cultural bias. Underrepresentation of specific subgroups (e.g. women) may further constrain the breadth of perspectives captured. The large number of included studies necessitated deviating from Noblit and Hare (1988)'s method and the use of conceptual piles, which may have affected the depth of the analysis. As with all meta-ethnographies, the interpretive construction of metaphors is shaped by researcher positionality and may carry a risk of oversimplification. Additionally, this review only included qualitative research, which limits insight into quantitative outcomes. However, qualitative research methods are valuable for conducting research with populations who are considered vulnerable or marginalised, such as those experiencing homelessness (Maginn et al., 2008).

1.5.2 Reflexivity

The research team brought varied expertise in homelessness, mental health, and qualitative methodologies. The emphasis on systemic barriers reflects the team's shared commitment to addressing structural inequities and the synthesis was influenced by Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1977). Regular engagement with EBEs helped to ensure the interpretations were grounded in lived experience of homelessness and mental health service use, as well as through an academic lens. Reflexive discussions throughout the synthesis process ensured that interpretations also remained grounded in the data.

1.5.3 Implications

Desired solutions: adjusting the cogs communicates recommendations created from the primary study data, and includes approaches that facilitate the development of trust, empowerment, understanding, address stigma, and are sensitive to the realities of homelessness. Participants desire services that are trauma-informed, relationship-based, integrated, holistic, culturally competent, and include peer approaches. Policy reform and systems change to enable relationship-based care, address barriers, and create more equitable access to and experience of services is needed. These approaches are key to overcoming the themes described in this review. Policymakers and healthcare professionals can use these recommendations to develop services that are consistent with the needs and preferences of the people they are aiming to serve.

Future research should explore the perspectives of under researched subgroups including women and transgender individuals. Evaluative research is needed to examine the real-world impact of interventions in the context of homelessness and mental health (e.g. peer-led and relationship-based models of care, integrated health and housing models, and policy interventions). Longitudinal research could examine the impact of various factors linked to mental health inequality mechanisms, using quantitative methods to strengthen evidence for systemic change. For future research in this area, embedding people with lived experience as partners in the process can produce findings that are more meaningful, equitable, and action oriented.

1.5.4 Conclusion

This meta-ethnography highlights that meaningful change requires more than individual-level interventions; it calls for the transformation of systems. Building trust and therapeutic alliances is essential, but these efforts must be embedded within health systems that are flexible, inclusive, and responsive to the lived realities of people experiencing homelessness. The model developed through this synthesis rejects simplistic, panacea-driven solutions. Instead, it embraces the complexity of homelessness and mental health inequality, which are rooted in structural violence and wealth inequality (Pickett et al., 2024; Wilkinson & Pickett, 2010). It offers a conceptual scaffold through which policymakers, practitioners, and researchers can navigate the relational, institutional, and cultural dynamics of exclusion, and explore how systems might be restructured to foster equity and inclusion. Rather than prescribing a singular intervention, the model advocates for “adjusting the cogs”: implementing iterative, multi-level changes such as embedding trauma-informed, person-centred care; addressing the social determinants of health; ensuring continuity and relationality in services; supporting peer-led approaches; and reforming exclusionary policies. By identifying mechanisms and solutions across contextual levels, the model facilitates systems thinking in service design, pointing towards coordinated, sustainable responses that advance mental health equity.

Chapter 2 Barriers in Access to Mental Health Services for People Experiencing Homelessness: Perspectives and Attitudes of Clinicians

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The authors report there are no conflicts of interest to declare.

The data that support the findings of this study are available on reasonable request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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2.1 Abstract

People experiencing homelessness face significant barriers in accessing mental health care. Existing research has largely focused on patient perspectives. This study aimed to explore the barriers to mental health services for people experiencing homelessness, from the perspective of clinicians working in specialist and mainstream services.

Semi-structured interviews with 12 healthcare professionals working in NHS services that engage with homeless populations were conducted. Reflexive thematic analysis was used to analyse the data and generate themes.

Analysis generated three key themes. (1) Deemed “undeserving”: how stigma shapes systems of exclusion, (2) Systemic misfit: how standard service models disengage those with complex needs, (3) How to make care possible in impossible systems – relational practice as resistance.

Clinicians face significant challenges in delivering mental health care to people experiencing homelessness due to systems design, structural stigma, and a lack of trauma-informed practices in mainstream services. Specialist homelessness healthcare services play a crucial role but are under-resourced and overburdened. To address these disparities, systemic reform is required, including long-term funding strategies, integrated service delivery models, specialist mental health provision, and widespread implementation of trauma-informed care.

Keywords: Homelessness; Mental health services; Access to care; Clinician perspectives; Structural stigma; Trauma-informed care; Qualitative research; NHS services

2.2 Introduction

2.2.1 Homelessness and Mental Health

People experiencing homelessness face extremely poor health outcomes, with homelessness described as a “health catastrophe” in a recent independent investigation into the NHS in England (Darzi, 2024). The level of health inequality experienced by homeless people has been likened to a “cliff edge” of disproportionate morbidity on the continuum of deprivation (Story, 2013). The mental health disparities are stark: 76.2% of homeless people in high-income countries have a current mental health condition (Gutwinski et al., 2021), and in the UK, 82% report a diagnosed mental health condition (Hertzberg & Boobis, 2022), compared to just one in four in the general population (Bebbington & McManus, 2020). These figures represent a significant unmet need for mental health support among people experiencing homelessness (Hertzberg & Boobis, 2022; Gutwinski et al., 2021; Homeless Link, 2023). The inverse care law: “The availability of good medical care tends to vary inversely with the need for it in the population served” (Tudor Hart, 1971), is relevant here, with socially disadvantaged groups of people being more susceptible to illness and less likely to access healthcare (Cookson et al., 2021).

2.2.2 Barriers to Mental Health Services

There are major barriers to mental health services for people experiencing homelessness; people may only receive support once their mental health has deteriorated to the point of crisis (Paudyal et al., 2023; Hertzberg & Boobis, 2022). Unmet mental healthcare needs among homeless adults are related to the availability (e.g. gaps in services), accommodation (e.g. service rigidity), and acceptability (e.g. staff attitudes) of services (Duhoux et al., 2017). Capacity pressures and the gatekeeping of limited resources perpetuates systemic exclusion for people with complex needs and/or inclusion health groups (Jackson et al., 2024). Those who do not fit neatly into existing pathways or cannot conform to service criteria are often left without care (MEAM, 2022). These systemic barriers are compounded by interpersonal or attitudinal factors, such as stigma, prejudice, and discrimination from healthcare staff, which deters people from engaging with services (Magwood et al., 2019; Omerov et al., 2020). Magwood and colleagues (2019) emphasise the importance of trust, safety, and therapeutic relationships in overcoming these relational barriers, but services are not always configured to support flexibility and person-centred practice (Siersbaek et al., 2021).

2.2.3 Policy Context

The need to address these barriers and health disparities has been recognised in policies and national strategies such as the NHS Long Term Plan (2019), the NICE Guidelines (2022), the Rough Sleeping Strategy (DLUHC, 2022), and the NHS Inclusion Health Framework (2023), with a commitment to improving access to mental health services for people experiencing homelessness through additional funding and specialist approaches.

2.2.4 Specialist Healthcare for Homeless People

Specialist homelessness primary care is an “emerging GP specialism” (Howard, 2024), where practitioners work in a “flexible, integrated, and opportunistic” way, with a focus on relationship building to effectively engage people experiencing homelessness in healthcare (Mills et al., 2015). They offer drop-in appointments, longer appointments, and work collaboratively with drug and alcohol services, hostels and day centres, and street outreach teams (Crane et al., 2023a). Such flexibility and adaptations can be challenging for mainstream GP practices, where staff report inadequate resources to work in this way (Crane et al., 2023a).

In England, there are 28 specialist homeless primary healthcare centres, 61 GP practices with homelessness services, and 12 mobile homeless teams (Crane et al., 2023b). A recent evaluation found specialist homelessness primary care models provided better continuity of care for patients with mental health and substance use issues, increased satisfaction with care, and facilitated higher levels of trust and confidence in healthcare staff (Crane et al., 2023a). However, insufficient access to mental health support for patients was an issue shared by staff across specialist and mainstream primary care services, limiting the help they could provide (Crane et al., 2023a). Although specialist services play a key part in meeting need, they operate in “challenging contexts” with high rates of staff stress and burnout. Over 73% of specialist staff believe a lack of understanding from other services regarding patient needs is a significant barrier and report having to engage in “professional shouting from the rooftops” to access vital support for their patients (Jackson et al., 2024). This perceived unresponsiveness of mainstream services may lead to stress and burnout among staff (Jackson et al., 2024).

2.2.4.1 Attitudes of Healthcare Professionals

Healthcare professionals such as GPs, psychiatrists, mental health nurses, prescribers, psychologists, and receptionists act as “gatekeepers” to mental health services and their attitudes may play a key role in facilitating or hindering access (Luchenski et al., 2018). Lester and Bradley (2001) identified GP attitudes as a major barrier, where they distinguished between the “deserving” and “undeserving” homeless person based on stigmatising assumptions around whether homelessness was “self-inflicted”. Such beliefs may consciously or unconsciously drive discriminatory practice and perpetuate social exclusion (Cockersell, 2015).

Staff attitudes about their *role* in supporting homeless people also influences practice. GPs in Lester and Bradley’s (2001) study believed their role was solely to treat physical health problems, and social care issues such as housing were not their concern, creating barriers to holistic, person-centred practice (Siersbaek et al., 2021). Some clinical psychologists working in secondary care mental health services shared the view that “homelessness is not for psychology”, which translated into practice (Xenophontos, 2020). A lack of self-efficacy, uncertainty, and helplessness when working with people experiencing homelessness can be uncomfortable and challenging for practitioners (Lester & Bradley, 2001; Xenophontos, 2020). The processes of avoidance and blame may play a role here – Buck and King (2009) describe this as countertransference, where “a patient that the physician is unable to help is judged to be "difficult".”

Understanding and knowledge of homelessness also impact staff attitudes, with “exposure” to working with people experiencing homelessness being associated with more positive attitudes (Glennerster et al., 2017; Zeien et al., 2021). Educational interventions, such as placements for psychologists, medics, and nurses improve attitudes, reduce stereotypes, and facilitate greater understanding about homelessness (Ward et al., 2024; Buchanan et al., 2004; Chung-Park et al., 2006; O Carroll & O’Reilly, 2019). Dedicated homeless healthcare teams within hospitals (who educate hospital staff about homeless healthcare) are associated with more positive staff attitudes, such as believing the hospital has a role in addressing housing issues and being unwilling to discharge people to the street (Barrow & Medcalf, 2019; Glennerster et al., 2017).

2.2.5 The Current Study and Rationale

National policy commitments and guidelines are a step in the right direction; however the practical implementation and impact of policies and guidelines is relatively unknown and, the barriers persist (Jackson et al., 2024). Staff in both specialist and mainstream services continue to face significant challenges in accessing mental health support for patients experiencing homelessness (Crane et al., 2023a) and it would be useful to explore this further.

Specialist clinicians have a unique view – understanding of homelessness and the associated issues in addition to experience from the wider NHS to drawn on. Specialist staff have usually worked in other settings and are able to provide insights from both viewpoints. As this is a relatively new field of practice, establishing their views on key barriers may help to inform future service development. Existing research has largely focused on patient-level experiences, with limited attention to the perspectives of healthcare professionals and how they understand barriers. There have been calls to explore healthcare access from a systems perspective (Siersbaek et al., 2021) and to include the views of mainstream primary care providers to better understand barriers and facilitators (Gunner et al., 2019).

Therefore, this study aims to understand the barriers to mental healthcare for homeless people, from the perspectives of clinicians (“gatekeepers”) working in specialist and non-specialist services, specifically, exploring (1) healthcare professionals’ attitudes toward homelessness, (2) how these attitudes influence their practice, and (3) how they understand the barriers to mental health service access for people experiencing homelessness.

2.3 Methodology

2.3.1 Study Design

This study is exploratory in nature and therefore qualitative methods are appropriate. Semi-structured interviews and Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2006, 2023) were used to explore healthcare professionals attitudes towards homelessness and their understanding of barriers to mental health services.

2.3.2 Participants

Participants were eligible if they were a healthcare professional (e.g., general practitioners, psychiatrists, mental health nurses) working in an NHS setting where they may encounter people experiencing homelessness in their work. Participants were recruited between July 2023 and October 2024 through local services, informal professional networks, and through snowball sampling where participants shared the study invitation with their colleagues. Participants were approached through email invitation and replied to opt in to the study.

Participant demographic information including their professional role, type of service, and gender were collected verbally during the interviews. A total of 12 participants were recruited, 67% worked in a specialist service, and 33% worked in a mainstream service. Half of participants identified as male, and half identified as female. Roles included GPs, nurses from trainee to consultant level, mental health nurses, prescribers, a psychological therapist, an ED doctor, and a service lead.

Participants were recruited until saturation was established. Rahimi and Khatooni (2024) suggest researchers can assess saturation through code or thematic saturation, meaning saturation, and theoretical saturation. Thematic saturation refers to the point where additional interviews reveal no new codes or themes, meaning saturation is assessed through the depth of the themes, and theoretical saturation is where additional data does not add further insight into a developing theory. In this study, thematic saturation was reached, where additional interviews had stopped revealing new codes and ideas. The depth of the meaning within each theme and their relationships was rich. It is unlikely we reached theoretical saturation regarding the construct of understanding of barriers to mental health services within this study, due to the contextual resource constraints in recruitment meaning interviews were predominantly with healthcare professionals from specialist services.

However, Braun and Clarke (2021) state that assessing saturation within reflexive thematic analysis is not aligned with the values of the approach, as meaning is generated from data, rather than extracted. They describe the concept of information power (Malterud et al., 2016a) as being more useful, which is influenced by the study aims, specificity, and dialogue. The information power within the dialogue is influenced by the interaction of the researcher and the participant, such that a researcher that has a background in the area is likely to facilitate rich information. The current study researcher has a background of working within the area of homelessness and mental health which helped to obtain in-depth interviews allowing for in depth exploration of meaning within the themes.

2.3.3 Materials

An interview topic guide (Appendix H) was developed through discussions with experts by experience (EBEs) and relevant literature. The EBEs believed it would be important to understand participants' level of knowledge about homelessness, trauma, and mental health. In the literature, understanding and knowledge of homelessness influences attitudes (Glennerster et al., 2017; Zeien et al., 2021). Another area EBEs recommended was to explore education and training in relation to homelessness. This too was a factor identified in the literature as influencing attitudes (Ward et al., 2024; Buchanan et al., 2004; Chung-Park et al., 2006; O Carroll & O'Reilly, 2019). Existing literature also highlighted that clinicians' attitudes towards their perceived role in supporting people experiencing homelessness influences their practice, (Lester & Bradley, 2001; Xenophontos, 2020). Attitudes of clinicians as a barrier was another area in both the literature and highlighted by EBEs (Lester & Bradley, 2001; Luchenski et al., 2018). The EBEs also thought it would be valuable to explore levels of flexibility and adapted practice, understanding of systemic barriers such as rigid processes. The questions in the topic guide therefore cover these areas and included open ended questions regarding homelessness that were designed to elicit a range of attitudes. From discussions within the research team, we also added the topic of solutions and recommendations to capture this insight.

2.3.4 Procedure

Invitation emails were distributed through local contacts, informal professional networks and contained information about the study within an attached participant information sheet. Participants who expressed interest in the study by responding to the invitation email were invited to take part in an interview, which took place either via Microsoft Teams, or in person, depending on participant preference. At the beginning of the interview, participants were asked if they had read the participant information sheet and were given the opportunity to ask questions. Upon completion of the consent form, the researcher started the recording. Online interviews were video recorded and in-person interviews were audio recorded. Interviews ranged from 18 – 77 minutes in length and the recordings were transcribed verbatim. The researcher took notes of their reflections during the interviews to facilitate reflexivity.

2.3.5 Ethical Considerations

Ethical approval for this study was obtained from the University of Southampton Ethics Committee (Submission ID: 73137) and from the Health Research Authority (IRAS ID: 317012) (see Appendix G). To maintain confidentiality, potentially identifying information was removed from the transcripts, transcripts were assigned a unique ID, and pseudonyms were used in the reporting.

2.3.6 Data Analysis

Data analysis was conducted using reflexive thematic analysis (RTA) as outlined by Braun and Clarke (Braun & Clarke, 2006, 2019, 2023). This method provides a flexible and systematic approach to analysing qualitative data, particularly suited to exploring complex, socially situated phenomena such as the barriers to mental health service access for people experiencing homelessness. Reflexive thematic analysis allows for an iterative and recursive process of engaging with data, and the researcher takes an active role in theme development and interpretation.

Braun and Clarke’s (2006) six-phase framework guided the analysis. The first author immersed themselves in the data through the initial conducting of the interviews, reading and re-reading interview transcripts and listening to audio recordings to capture the nuances in participants’ accounts. Initial impressions and patterns were noted in a reflexive journal. The data were coded using NVivo software, employing a combination of semantic (explicit) and latent (interpretive) coding. This approach ensured both surface-level content and deeper, underlying patterns were captured. Codes were organised into broader categories and themes were developed to reflect shared meanings and stories within the data, underpinned by central organising concepts (Braun et al., 2022; Braun & Clarke, 2023; Braun & Clarke, 2019), grounded in participants' experiences and the broader structural context. Themes were reviewed and discussed within the research team and were developed through an iterative and reflective process shown in Appendix I. The themes names were also reviewed, aiming to capture the meaning of the data within. The findings were written up with themes contextualised within the broader literature.

This research used a critical realist epistemological position, which combines a realist ontology – recognising an objective reality – with a constructivist epistemology, acknowledging that this reality is understood and interpreted through human perceptions and social constructions (Fletcher, 2017). Reflexive TA, within this framework, enabled the exploration of both the "real" systemic barriers to mental health services and the socially constructed meanings participants attributed to their experiences. By capturing this duality, the analysis highlights the interplay between individual narratives and the broader structural and cultural contexts in which they are embedded. The first author is a white, middle-class woman with a background in psychology, professional experience in homelessness services and values of social justice and inclusivity. A reflexive journal was kept throughout the research.

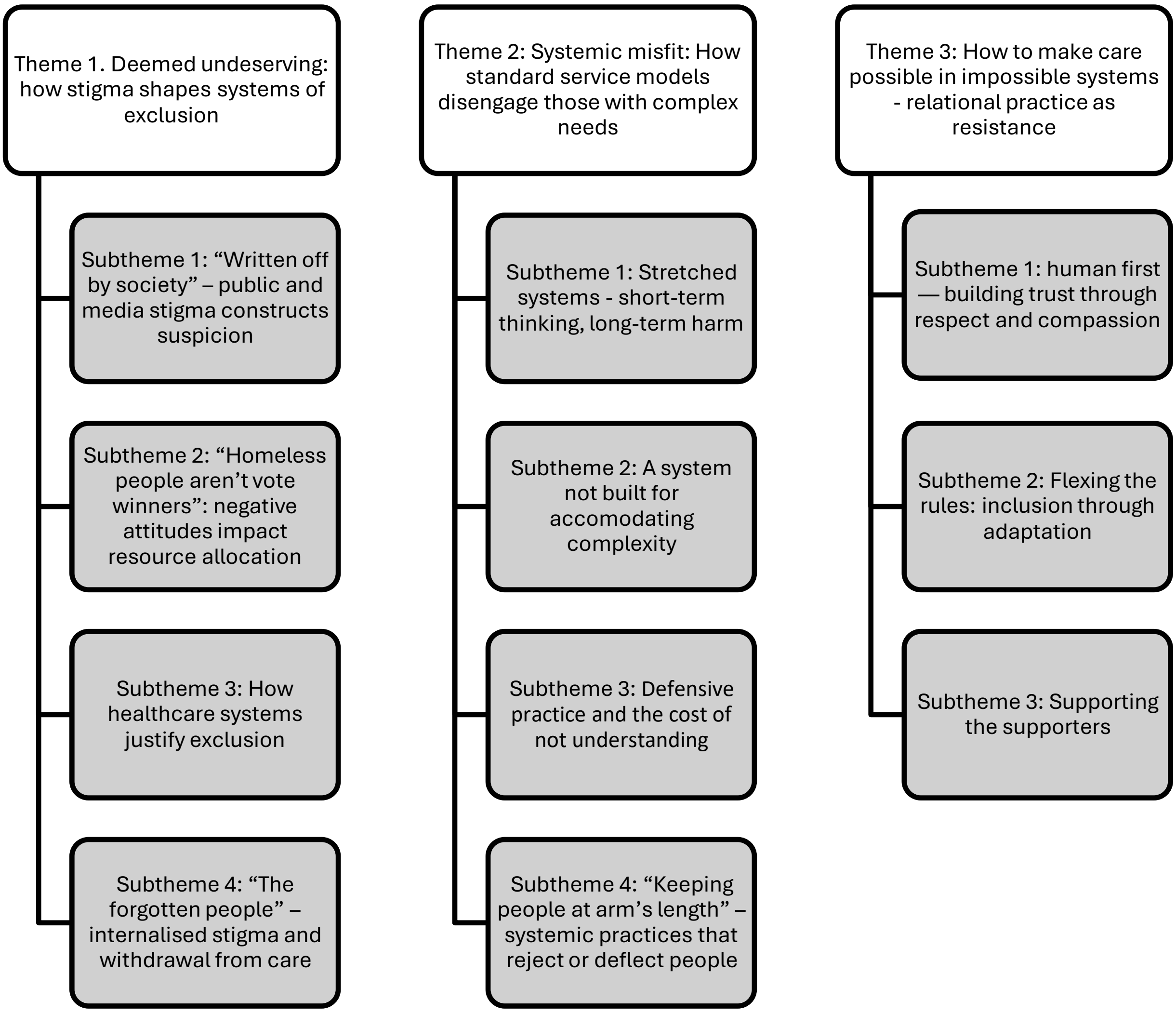
2.4 Results

Analysis of the perceived barriers to accessing mental health care for homeless people generated three key themes: (1) Deemed “undeserving”: How stigma shapes systems of exclusion, (2) Systemic misfit: How standard service models disengage those with complex needs, (3) How to make care possible in impossible systems – relational practice as resistance. Themes are represented as a thematic map in Figure 2.1 and are discussed in the text.

The findings are interpreted, discussed, and contextualised within the available literature, as they are reported in the results section, as recommended by Braun and Clarke (2013) and Byrne (2022), in line with analytical qualitative reporting convention.

Figure 2.1

Thematic Map



2.4.1 Theme 1: Deemed "undeserving": how stigma shapes systems of exclusion

This theme explores how stigma – structural, public, and internalised – shapes access to mental healthcare by influencing who is seen as deserving of care. Stigma is not confined to interpersonal interactions; rather, it is embedded in the policies, and practices of health and social care systems. It manifests in media narratives, political discourse, and public attitudes, producing a system-wide climate of suspicion, moral judgement, and devaluation towards people experiencing homelessness. Participants linked media portrayals of homelessness to societal and political neglect, describing how the image of the "undeserving" homeless person underpins decisions about resource allocation, service design, and referral criteria. Watkins-Hayes and Kovalsky (2016) argue the "deserving vs. undeserving" narrative reinforces exclusion and structural inequality by embedding moral judgments into policies, service design and eligibility. These beliefs and narratives filter into everyday healthcare encounters, where assumptions about danger, non-compliance, or blame, compromise compassion and therapeutic relationships. At the same time, individuals experiencing homelessness internalise these messages, anticipating stigma and often withdrawing from services as a result. The issue of stigma within homelessness and healthcare is well documented and had deleterious effects on the health of people experiencing homelessness (Canham et al., 2022; Mejia-Lancheros et al., 2021; Reilly et al., 2022).

2.4.1.1 Subtheme 1: “Written off by society” – public and media stigma constructs suspicion

Many participants shared the belief that media representations of homelessness fuel negative public perceptions of homeless people and societal stigma. Media often portrays homeless people in a negative light, framing them as dangerous, duplicitous, undeserving of public support, or infers blame and deservingness, perpetuating biases and a culture of suspicion. One participant said, some members of the public may form their entire perception of homelessness based on media narratives, and that their “image is built by, you know, I don't want to say the Daily Mail, but you know…” – (SSP1). Participants shared observations of the everyday interactions homeless people endure, with another participant reflecting on the hostility visible in public spaces and local media:

> “I just find it frustrating that people, that I see on, the [Local Newspaper] the abuse that they get for being homeless and, even more even going into town, like you can see that society has such a negative opinion on people who are homeless.” – (SSP2)

Previous research has linked media discourses to public fears, stigma and suspicion of homeless people (Chapados et al., 2023; Kim et al., 2023). This societal stigma was described as influencing healthcare experiences, where public suspicion follows people into clinical spaces, creating barriers to accessing services: “it is challenging to go and sit in a waiting room and have, you know, endless people looking at you with disapproval.” – (SSP1)

Healthcare professionals themselves may hold negative attitudes and biases towards homeless people. Participants believed that the societal stigma of homelessness permeates healthcare, where assumptions made in place of compassionate curiosity, compromising the ability of professionals to extend respect, unconditional positive regard, empathy, and non-judgement. One participant summarised:

> “The world's so suspicious of [people experiencing homelessness]. So suspicious. So that relationship is already on an unequal footing. You know that whole thing about having a

> positive regard for someone? I think it's challenging when you're always on the back hoof about how suspicious you are.” – (SSP1)

The issue of “suspicion” has been raised in previous studies understanding homeless individuals’ experiences of healthcare, highlighting that this is a recurring barrier (Kneck et al., 2021; O’Carroll & Wainwright, 2019).

2.4.1.2 Subtheme 2: “Homeless people aren’t vote winners”: Negative attitudes impact resource allocation

Participants described how stigma not only shapes attitudes at the interpersonal level, but is embedded within the priorities and decisions of policymakers. Homelessness is consistently framed as politically unpopular and underfunded, not due to a lack of need, but because it is not viewed as an issue that would attract public support or electoral wins. Several participants reflected on the ways politicians, shaped by the same cultural narratives and media portrayals as the general public, adopt a rhetoric that frames homelessness as a lifestyle choice or personal failure. These narratives were seen to influence both direct policy decisions and the broader neglect of homelessness within healthcare planning and funding, which participants linked directly to the challenges the NHS faces in providing mental healthcare to people experiencing homelessness.

> “There's not a great pot of money, and... because it's a group of people, who are sort of castigated, and you get people up higher in government saying, ‘it's a lifestyle choice’ and things like this, that it's not always the most well-funded sector... so you have to battle hard and see what you can find really.” – (SSP3)

Participants described a relationship between the attitudes of the public and policy decisions, suggesting the lack of investment reflects a calculated political decision: “Not great vote winners – people experiencing homelessness – are they?” – (SSP1). This lack of political will has material consequences for services, where underfunding has led to significant staffing issues, limited service availability, and ongoing barriers to access, perpetuating extreme inequality in health. Homelessness is sidelined in health policy choices, despite well-documented health disparities, largely because it lacks political traction (Clifford et al., 2019; Siersbaek et al., 2023).

2.4.1.3 Subtheme 3: How healthcare systems justify exclusion

Participants described how stigma is also embedded in the design, infrastructure, operations, and practices of healthcare systems, which can be hostile, rejecting, and exclusionary towards people experiencing homelessness. Homeless people are frequently labelled as “non-engaging," a term participants viewed as a misrepresentation that deflects responsibility away from services to operate inclusively and instead shifts blame onto marginalised individuals.

> "So, they had this sort of stigma of being 'non-engaging' where actually they was street homeless and struggled to engage because the services weren't really set up in the way to include them." – SSP5

This term reflects language used when working with social exclusion such as "hard to reach" groups or the "inappropriate attendee" (O'Carroll & Wainwright, 2019). There have been calls to reposition such language as it suggests blame or culpability of the individual for deviating from the cultural standard (Fry et al., 2023).

Participants described how referral pathways and rigid service criteria systematically exclude those with overlapping needs, such as homelessness, substance use, and criminal records. These exclusions were described as routine and deeply frustrating. Many participants reflected critically on the culture within mainstream psychiatric services, particularly the exclusion of individuals with co-occurring substance use and mental health problems (dual diagnosis). There is a widespread belief that substance use disqualifies people from accessing mental health care because, "if someone's misusing substances and they're mentally ill, then they're mentally ill because they're misusing substances." – (SSP5). This functions as a justification for dismissal, rejection or discharge, even in cases where substance use is a form of self-medication. Alsuhaibani and colleagues (2021) critically review international guidelines on dual diagnosis, and call for improvements – highlighting they lack inclusivity and poorly address the social dimensions of dual diagnosis such as homelessness.

2.4.1.4 Subtheme 4: "The forgotten people" – internalised stigma and withdrawal from care

Societal stigma is internalised by people experiencing homelessness, influencing how they see themselves and their place within healthcare systems. Participants described how over time, the experience of being ignored, deprioritised, stigmatised, or uncared for contributes to an erosion of homeless people's sense of self-worth and fosters a belief that they are undeserving of help. One participant reflected:

> "I think a lot of people that I work with have had such a hard time because society writes them off. So they're sort of like the forgotten people, the people that no one else cares about, which is really sad. And I guess if you're living like that with everyone looking at you like that, you'll start to believe that about yourself after time as well." – (SSP4)

Participants explained how people experiencing homelessness often anticipate judgement and moral scrutiny before they even walk through the door of a service. The fear of being reprimanded or treated with condescension creates a strong disincentive to seek help: “They're very, very nervous coming into the surgery about how someone's gonna talk to them and how they're gonna treat them, whether they're going to be told off or you know? Talked down to or…” – (SSP7).

Shame, low self-worth, and self-blame also led people to minimise serious health issues or avoid seeking care altogether. Individuals often believe their poor health is an inevitable outcome of their lifestyle (SSP6). One clinician recalled a patient who dismissed vision loss in one eye, believing it to be his fault for injecting drugs and therefore undeserving of treatment (SSP6). In this way, experiences of stigma and exclusion both in public and in healthcare settings leads to avoidance of healthcare until an emergency as a form of self-protection (Bruguera et al., 2025).

2.4.2 Theme 2: Systemic misfit: How standard service models disengage those with complex needs

This theme reflects the incompatibility between mainstream service models and the lived realities of people experiencing homelessness. Services tend to be designed as a one-size-fits-all for the typical needs of the general population and struggle to accommodate instability, poverty, complex trauma, addiction, and complexity. Trauma-informed, relational approaches were viewed as essential but largely absent, with a lack of understanding among healthcare professionals often resulting in exclusionary or defensive practices. These issues are intensified by chronic underfunding and short-term commissioning cycles. Together, these systemic conditions give rise to practices that keep people “at arm’s length” – with exclusion embedded into the design of services. This theme aligns with a realist evaluation that found fragmented health systems often prioritise organisational goals over complex patient needs, excluding marginalised groups and reinforcing cycles of fragmentation and exclusion (Siersbaek et al., 2023).

2.4.2.1 Subtheme 1: Stretched systems – short-term thinking, long-term harm

Funding models driven by the election cycle results in short-term “boom and bust” – (SSP1) commissioning. This destabilises homelessness services, unable to plan for the long-term as they do not have assurances regarding funding. “We thought we were going to get more than one year's funding, but it didn't happen like that” – (SSP5). This impacts morale, the level of investment staff have in building the service, and the quality of care patients receive. Projects that may offer long-term value are frequently shut down before impact can be measured. When it comes to homeless healthcare, participants believe there is a “lack of consistency around a plan” – (SSP1). This inconsistency has harmful effects for service users; participants stressed the human cost of short-term approaches where patients can be “left to fend for themselves” – (SSP8) and emphasised “it costs people's lives.” – (SSP1). Previous research has shown that short-term funding – often influenced by election cycles – destabilises public services, including homelessness provision, and contributes to workforce stress, burnout, fragmented care, and service users being left unsupported between funding cycles (Daly, 2018; Hoddinott et al., 2022).

At a structural level, austerity measures and local government budget cuts were seen to have hollowed out essential services. Participants described a significant reduction in funding for homelessness services: “massive cuts in the last 10 years” – (SSP9). This resulted in the closure of many valuable services including dry hostels, detox/rehab facilities, discharge facilities, and women’s services. The services that do still exist, were described by participants as “woefully” and “chronically” “underfunded and under resourced” – (SSP1, SSP9). Over time, participants have been asked to do more with less, creating barriers for patients: “…our referrals have gone up and our caseloads have gone up, that's become a barrier because for the first time ever, we've sort of had to create a waiting list” – (SSP4). As the NHS becomes more stretched, marginalised groups, including homeless people, meet even greater exclusion from healthcare. Even specialist homeless healthcare services, who are designed to work more flexibly, are facing pressures to focus on shorter, goal-focussed work and to discharge patients sooner than is optimal. This is a “major, major difficulty”, for staff and creates a “squeeze sort of feeling” – (SSP3). The strain extends to inpatient services, which experience pressure to discharge people, often discharging them to the streets, or into short-term accommodation like B&Bs, knowing they would return to street homelessness days later: “It's almost homelessness by arm’s length, I think.” – (SSP1). Participants highlighted the need for increased resources for people experiencing homelessness, which echoes other studies (Crane et al., 2023a; Jackson et al., 2024).

2.4.2.2 Subtheme 2: A system not built for accommodating complexity

A recurring theme in participants’ narratives was the foundational role of trauma, particularly from childhood, and its enduring impact on their patients’ lives. They highlighted the interconnectedness of trauma, neurodiversity, housing instability, addiction, and mental ill health, and how these compound to create complex needs the system is unequipped to meet. One participant said, “An awful lot is trauma. Traumatised people, you know, people who have had horrific, horrific childhoods.” – (SSP4). This trauma often leads to complex mental health challenges, and vulnerability to homelessness: “About 70% of people who are sleeping rough have mental health problems” (SSP4). Substance use is frequently employed as a means of self-medication: “They’re trying to blot out trauma… that’s the case for a lot of our patients” (SSP9). This reflects previous research shows a high prevalence of adverse childhood experiences (ACEs) among homeless populations, with strong associations to mental illness and substance use (Liu et al., 2021).

Managing addiction in healthcare settings poses significant challenges within the current service context. Patients may avoid attending emergency departments to prevent active withdrawal. Self-discharge is another barrier, as patients often leave hospital against medical advice to address their substance use needs. Participants called for collaboration with substance use teams on hospital admissions to overcome such barriers. This phenomenon has been described in a previous study (O’Carroll & Wainwright, 2019) and emphasises the need for systems to improve management of substance use needs within hospital, and develop lines of communication between hospitals and primary care.

Participants consistently linked complex trauma sequalae (e.g. emotion dysregulation, mistrust) to service disengagement and exclusion among people experiencing homelessness. One participant explained: “A lot of our patients… get quite agitated and emotionally aroused in waiting rooms” (SSP7). Such behaviours, often driven by distress, routinely lead to exclusion: “Traditional surgeries… they’re made to say, ‘No, I’m not going to deal with this person. They’re too chaotic’” (SSP3). This rejection is understood in the context of resource rationing and a stretched system: “The NHS is under a lot of pressure at the moment… I think it really struggles to look after chaotic, loud, difficult, abusive people” (SSP6). As one participant summarised: “The bottom line is our standard NHS is not well resourced enough to cope with complex needs” (SSP9). Another added: “We’re always going to treat people as slightly onerous to our service if they are out of the ordinary” (SSP1). The level of complexity was described as challenging for staff to manage: “I think sometimes there can be a degree of compassion fatigue within services… blocks with people not knowing what to do to respond to kind of complex cases” (SSP7).

Recent findings by Pathway and Crisis (Jackson et al., 2024) highlight how capacity pressures disproportionately affect inclusion health groups. As resources shrink, thresholds rise, flexibility decreases, and services become less able to adapt to individual needs – resulting in longer waits, rigid criteria, and exclusion for those who miss appointments or present with behaviours seen as challenging (MEAM, 2022). This highlights the mismatch between the available service provision and the adapted, trauma-informed service required to make healthcare accessible to people experiencing homelessness.

2.4.2.3 Subtheme 3: Defensive practice and the cost of not understanding

A system-wide gap in knowledge, understanding about homelessness and trauma-informed care was understood to influence exclusionary practice and create barriers: “I think sometimes the barriers come down due to a lack of understanding” – (SSP1). For instance, some participants expressed confusion about why people experiencing homelessness might not engage with mental health services (MSP1) or believed housing must precede mental health care, stating “they need to be given a home to fix the mental health” – (MSP2), indicating a limited awareness of the complex psychological and systemic factors that maintain homelessness. This reflects previous research which found understanding and knowledge of homelessness was associated with staff attitudes and the likelihood of perpetuating discrimination (Gunner et al., 2019).

Many participants shared sentiments that colleagues were often reluctant to engage with unfamiliar, uncomfortable, or unpredictable presentations, and in these situations tend to default to rigid rules and protocols as a psychological defence, rather than understanding the context and operating within uncertainty, creating barriers for patients. Practitioner anxiety and the need for certainty and control were seen to drive rigid ways of working such as “blanket policies” (SSP9): “people like to work in certain ways and sort of adapting things around can be very, very disconcerting for people.” – (SSP3). Anxiety and risk aversion from practitioners, especially around prescribing, was also seen as driving barriers to engagement. One participant described situations where practitioners “put the barrier down immediately that that there's not even a sort of meeting of minds or a negotiation” – (SSP1). When operating in a “grey area”, this was seen to stem from an “attitude… around self-preservation” – (SSP1). This culture of rigidity impacts people experiencing homelessness – reinforcing the lack of power, control and agency they experience in their daily lives. One participant summarised this: “I think I think that loss of agency, the fact that they feel they have no control in so many aspects of their life when we when we let that permeate healthcare, we really do a disservice.” – (SSP1).

2.4.2.4 Subtheme 4: “Keeping people at arm’s length” – systemic practices that reject or deflect people

Inflexible systems and narrow eligibility criteria act as structural barriers to care. Standard practices including short appointments, “one appointment, one problem” policies, and restrictive referral thresholds fail to accommodate the complex needs of people experiencing homelessness. One participant summarised how challenging it can be for people to access services: “just getting in through the door, rather than ‘how can I get you registered?’ It's ‘how many barriers can I put up?’… to keep people at arm's length.” – (SSP1).”

The practice of signposting – redirecting individuals to other services, was criticised as a systemic failure and a barrier in disguise: "It's always about 'never here.'" – (SSP1). This participant stressed the emotional toll of signposting "somebody who just managed to pluck up the courage to get over your threshold. Then, you know, you're never in the right place." – (SSP1).

A recurring challenge described by participants is the quandary of being too complex for primary care services but not meeting the threshold for secondary care or crisis interventions. Similarly, the systemic impasse between detox and mental health services exacerbates the issue, as "Mental health services won't see someone while they're actively drinking or intoxicated... but detox services say, 'we can't take them because of their mental health.' So, you're stuck in a chicken-and-egg situation" – (SSP9).

There is a prevailing belief that people who are severely mentally unwell will inevitably be "picked up" by emergency services or detained under legal mechanisms (SSP5). However, this is not always the case; one participant described how colleagues refused to assess a patient outside, claiming it was "against their dignity." – (SSP5). These rigid systemic practices further exclude people experiencing homelessness and these findings together underscore how traditional mental health pathways struggle to accommodate the needs of homeless individuals.

2.4.3 Theme 3: How to make care possible in impossible systems – relational practice as resistance

In the face of structural barriers, many practitioners described how they make care possible by working creatively, flexibly, and relationally within and around the limitations of the system to reach those most often left behind. This theme explores how humanising care through person-centred and psychologically informed practices can act as forms of ethical resistance in systems that are under-resourced, risk-averse, and not built for the needs of people experiencing homelessness. While not always named explicitly, many participants described practices that align closely with trauma-informed care (TIC; Hopper et al., 2010; Huang et al., 2014) and psychologically informed environments (PIEs) (Johnson & Haigh, 2010).

2.4.3.1 Subtheme 1: Human first – building trust through respect and compassion

Building trust was seen as essential and often took time, particularly with individuals who have been repeatedly let down by services. Many participants described how they begin from a place of empathy and unconditional positive regard: seeing each individual as inherently worthy of care and dignity. As one participant shared, "They're people, they're humans, they've got feelings, they've got pride" – (SSP6). This ethos was not just verbalised but enacted through patient, compassionate responses to distress and disruptive behaviours. Respect, non-judgement, active listening, and not imposing predetermined agendas were seen as important factors for engagement. One participant captured this ethos: "We're actually listening. We're not just hearing them. We're listening, you know" – (SSP2). This relational approach often meant offering support even when patients did not immediately engage with treatment goals, and included understanding distress and agitation in the context of trauma. One participant stressed the importance of acknowledging and addressing trauma in every patient interaction, advocating for staff to "always be open to the fact that this person might have shed loads of trauma and treat everybody as if they've got shed loads of trauma" (SSP5). Participants rejected reductive narratives about "non-engagement", instead reframing this: "Don't assume that people are not engaging with you. You know, assume that you're not engaging with them" (SSP5).

These findings align with a review that found interactions that establish trust, safety, respect, and a focus on the therapeutic relationship are key factors to overcoming relational barriers (Magwood et al., 2019). The importance of trust building and trauma-informed therapeutic relationships in engaging people experiencing homelessness is underscored across multiple studies (Barry et al., 2024; McAlpin, 2018; Prestidge, 2014; Weston, 2024).

Practitioners counter dehumanising systems through empathy, active listening, and patience, choosing to meet people where they are and respond to distress with care. This creates more effective therapeutic relationships and can be understood as a form of resistance within systems that often dehumanise – creating agency and dignity in spaces that are typically depersonalised, pathologising, or punitive. Relational resistance, compassion, and everyday acts of dignity, can disrupt dehumanising practices and function as resistance to structural violence and social exclusion (Ettlinger, 2017; Racine, 2021; Toolis & Hammack, 2015).

2.4.3.2 Subtheme 2: Flexing the rules: Inclusion through adaptation

Participants highlighted the strategies they use to overcome barriers to meet the complex needs of their patients. Central to this is an ethos of flexibility and a tailored approach – adapting appointment times, meeting in non-clinical spaces, avoiding punitive policies, and working outside standard referral criteria: "We don't try and work to any particular criteria... it's very much, what can we do for you?" (SSP3). This flexibility also extended to positive risk-taking, particularly around prescribing or co-developing care plans. One noted the importance of collaboration, explaining that engagement was more effective and ethical when "you're moving in the same direction together" and "returning the agency to the individual" (SSP1). Rather than enforcing control, staff described co-creating care plans, supporting harm reduction goals, and enabling patient-led decisions, even when they carried some uncertainty. In place of punitive discharge policies, some services took a more tolerant and relational approach: “We don’t discharge them after three strikes and you’re out… We try and give people time and be patient” (SSP8). In some cases, flexibility was also facilitated through co-location of services which was particularly valuable and reflects recommendations from the literature (Fazel et al., 2008).

This ethos of flexibility values dignity and autonomy and is central to maintaining connection and providing continuity for patients. Similarly, previous research found specialist primary care staff promote engagement in healthcare through flexibility and a focus on building relationships between staff and patients (Mills et al., 2015). Where possible, mainstream services should adopt these practices for marginalised patients, as “missingness” in healthcare has been linked to issues such as absence of flexibility and choice, power imbalance, and poor communication (Lindsay et al., 2024). Services need to be configured and delivered in a way that enables staff to focus on relationship building and allows them to be flexible and person-centred in their practice (Siersbaek et al., 2021).

2.4.3.3 Subtheme 3: Supporting the supporters

Delivering trauma-informed, relational care to people experiencing homelessness requires clinical expertise and emotional resilience. Yet participants repeatedly described the absence of formal training, leaving staff to navigate this complex setting through “on-the-job” learning, informal mentorship, and shared reflection. “No formal training exists anywhere… just a lot of hearsay… it’s almost like a hidden world,” one participant observed (SSP4). While some had received external training in psychologically informed or trauma-informed approaches, these opportunities were often ad hoc and inconsistent. “We don’t really have NHS training specifically related to homelessness,” one practitioner noted (SSP8).

In the absence of comprehensive formal training, teams working in specialist homelessness services have created their own ecosystems of support – reflective spaces, sharing knowledge among peers, formal and informal supervision to navigate emotionally complex work. Participants described how spaces for open dialogue, shared case discussions, a supportive team culture, and mutual validation were crucial for coping with the emotional demands of the work and remaining psychologically informed in their practice. “Proper staff support,” one participant emphasised, means “good supervision, good opportunities to air those feelings” (SSP1). Others spoke to the importance of humility, self-awareness, and the ability to recognise one’s own limits: “If I know that that appointment for me is gonna be challenging, I will then get somebody else to do that” (SSP2). These informal coping strategies were viewed as essential practices of ethical care. Embedding psychological expertise within homeless healthcare teams was seen as beneficial for enabling a reflective, psychologically informed culture, supporting shared formulation and deepening staff understanding of issues such as trauma, risk, and recovery. However, such support structures were precarious and under-resourced.

Although there is growing recognition of the complexities involved in delivering care to this population, homelessness is still largely absent from mainstream clinical education. Participants called for structured, comprehensive training on homelessness to replace the current reliance on ad hoc or “on-the-job” learning. The literature echoes this: Shackshaft (2024) advocates homeless healthcare should be a core component of medical training, with researchers highlighting the need for training within mainstream general practice (Gunner et al., 2019), and hospital settings (McCormack et al., 2022) to upskill clinicians and improve outcomes. Ultimately, delivering psychologically informed, relational care in the context of exclusion, adversity, and under-resourced and emotionally demanding environments, is only sustainable when staff themselves are seen, supported, and valued.

2.5 Discussion

This study illuminates the structural, cultural, organisational, and relational barriers that impede access to mental health care for people experiencing homelessness, from the perspectives of healthcare professionals. Using RTA, three interconnected themes were generated: (1) Deemed “undeserving”: How stigma shapes systems of exclusion, (2) Systemic misfit: How standard service models disengage those with complex needs, (3) How to make care possible in impossible systems – relational practice as resistance. The findings revealed that stigma profoundly influences perceptions of deservingness and serves to drive exclusion at multiple levels. Healthcare systems were described as stretched due to underfunding and short-term funding cycles, resulting in services that are often poorly equipped to accommodate complexity, with rigid, risk-averse practices. At the same time, participants identified ways in which care is made possible through relational, trauma-informed, and adaptive practices that resist systemic norms. However, this work is unsustainable without adequate training, supervision, and investment in staff support.

2.5.1 Implications for policy and practice

The findings of this study highlight a pressing need for policy and service reform to address the structural exclusion of people experiencing homelessness from mental healthcare. The implications below outline changes needed at the levels of service delivery, workforce development, and wider systemic structures to enable more inclusive, effective care.

2.5.1.1 Stigma is systemic and requires system-level reform

Stigma toward people experiencing homelessness is embedded in healthcare systems, shaping infrastructure, language, and funding priorities. To address this, policies should consider revising access criteria, promoting trauma-informed care and reflective practice, and introducing structural accountability measures such as audits of exclusion and discharge data by housing status.

2.5.1.2 Moving beyond short-termism in commissioning

Secure, multi-year funding for homelessness and inclusion health services is essential to address entrenched health inequities. This includes increased investment in dedicated mental health provision for people experiencing homelessness, whose needs are currently unmet in many areas (Giles et al., 2022). Evaluation of commissioned services should include relational and recovery-oriented outcome metrics, not just outputs.

2.5.1.3 Reconfiguring services to meet complexity and embedding relational care in service design

Services must move beyond one-size-fits-all models and adopt trauma-informed and psychologically informed environment (PIE) principles, with a focus on flexibility, person-centred, and relationship-based care. Health services should be configured to enable longer appointments, adapted engagement, and tolerance for missed appointments, creating space for trust and therapeutic alliance to develop. Commissioners are encouraged to incorporate relational quality indicators into service evaluations, acknowledging the value of therapeutic alliance, continuity, and flexibility for improving outcomes for marginalised groups. In hospital settings, better integration and collaboration with substance use services, and primary care is needed to support people with co-occurring health and substance use needs. Bridging the gap between primary and secondary mental health care through more inclusive eligibility criteria, or bespoke pathways would reduce the exclusion of those with complex presentations. Investment in models that integrate health, mental health, housing, and substance use support may help to promote continuity, collaboration, and accessibility and overcome barriers. Placing people with lived experience of homelessness in the centre of service and system redesign will be essential to building more inclusive, compassionate, and effective models of care.

2.5.1.4 Supporting and training the workforce

Delivering trauma-informed care to people experiencing homelessness requires a workforce that is both well-trained and well-supported. Homeless healthcare should be embedded within core clinical training across disciplines – including medicine, nursing, psychology, and allied health – to equip practitioners with the knowledge and skills needed to navigate complexity and structural inequality. Ongoing professional development focused on topics such as homelessness, trauma, relational care, and the social determinants of health for staff, as well as organisational commitments to supervision, reflective spaces, and in-team psychological expertise provide the scaffolding for staff to have the confidence and capacity to engage with complexity and uncertainty, and sustain compassionate, relational practice.

2.5.2 Recommendations for future research

Future research should investigate the long-term impact of psychologically informed and specialist mental health services on mental health and homelessness outcomes for people experiencing homelessness. Realist evaluations would be valuable to explore what works, for whom, in what contexts – particularly for people with overlapping needs (i.e. homelessness, mental illness, and substance use). Alongside this, future research should investigate exclusion in mental health services, by gathering data on discharge and declined referrals by housing status, to understand the scale of systemic bias in care provision. Qualitative studies investigating the views of service leaders and commissioners of mental health, substance use, and homelessness services would provide insight into their contexts and how this impacts decisions around service design, policies, pathways, and eligibility criteria. Future research could gather additional data on mainstream providers views regarding barriers to mental health services for people experiencing homelessness. Additionally, longitudinal studies are needed to understand how factors such as stigma, biases, anxiety, and risk aversion influence decision-making in complex cases, and whether interventions such as trauma-informed training or reflective spaces can shift staff attitudes and improve outcomes. Finally, future research could explore the dynamics and contexts within inclusion health teams to better understand how tolerance of uncertainty and resilience is cultivated within teams.

2.5.3 Reflexivity

My professional experience has cultivated a strong belief in the importance of specialist services to address the complex needs of people experiencing homelessness. I was aware of my inclination to view specialist services as inherently beneficial, which may have shaped my interpretation of participants' accounts. Participants' accounts were understood as both shaped by systemic barriers and reflective of their subjective interpretations and lived experiences. This duality required me to critically balance the "real" structural factors with the socially constructed meanings participants attached to their experiences, ensuring that both were represented in the analysis.

2.5.4 Strengths and limitations

This study provides rich, interpretive, practice-based insight into how systemic exclusion operates within mental health care for people experiencing homelessness. The inclusion of extensive verbatim data provides a grounded and compelling account of experiences of practice in an under researched area. The researcher's position as an "insider" within the field contributed to the gathering of rich data during the interviews, giving the analysis high information power (Malterud et al., 2016b) and generating rich, in-depth themes. Importantly, the development of the interview schedule was informed by individuals with lived experience (EBEs), ensuring that participant narratives addressed topics deemed relevant and significant by service users themselves. Additionally, the themes developed were strongly aligned with existing literature on homelessness, stigma, and health system barriers, enhancing the credibility of the findings.

However, several limitations must be acknowledged. The study focused solely on practitioner perspectives; while these provide valuable insight into how exclusion is enacted and resisted within services, they represent only one side of the service-user interaction. Additionally, although the sample included a range of professional roles, the majority of participants were based in specialist homelessness settings and those who worked in mainstream services had come into contact with at least one person experiencing homelessness in a professional capacity. While specialist staff had previous experience in mainstream services and reflected on both roles, the findings may not be representative of the broader NHS workforce or generalisable to all service contexts. However, as with all qualitative research, the findings are not intended to be statistically generalisable but instead offer transferability to similar contexts. The researcher's positionality as an insider may also have shaped the interpretive lens and influenced participant disclosure. However, reflexive journaling, supervisory discussions, and critical engagement with the data throughout the analytic process was employed throughout to acknowledge positionality.

2.5.5 Conclusion

This study has shown that mental healthcare systems play an active role in reproducing or resisting exclusion for people experiencing homelessness. Through the lens of healthcare professionals in the NHS, it illustrates how stigma, and rigid, risk-averse systems marginalise those with complex needs, while also underscoring the importance of resisting these systems through relational, trauma-informed approaches. As one participant put it, "If you can make a primary care service truly accessible, then we will bring those people in. You know, you just need to keep making sure that door is open" (SSP1). Addressing inequities requires a paradigm shift in how we design, fund, and deliver care – placing compassion, dignity, adaptability, inclusivity, and social justice in both policy, practice, and system design.

Appendix A Search Strategy

A.1 Databases:

MEDLINE, CINAHL, PsycINFO, Scopus, and Web of Science.

The search terms included key words and phrases related to the concepts of “homelessness” (population), “mental health services utilisation” (intervention), “experiences” (outcome), and “qualitative” (study design).

All databases were searched on 25th April 2023 and searches were re-run on 31st October 2024

Cited reference and citing reference search: Forward and backward citation searches of identified studies were performed on 1st November 2024.

A.1.1 MEDLINE, PsycINFO, CINAHL (EBSCOhost)

Searches were filtered to the fields: title, abstract, and subject terms. Expanders: Apply equivalent subjects. No limiters on language or date of publication.

1: “Homeless”

TI OR AB OR SU ((homeless* OR underhouse* OR roofless* OR unhoused OR squat* OR shelter* OR unsheltered OR "no fixed address" OR “no fixed abode” OR "street involved" OR “street attached” OR "sleeping rough" OR "unstable housing" OR "housing instability" OR "precarious housing" OR "precariously housed” OR "rough sleep*" OR "vulnerably housed") OR (homeless OR street OR transient*) N2 (population OR person OR persons OR people* OR individual* OR adult* OR youth* OR men OR man OR women OR woman) OR (temporary or unstabl* or vulnerabl* OR marginal*) N2 (hous* or accommodation* or shelter* or hostel* or dwelling*))

2: “Experience of mental health services”

TI OR AB OR SU ((Experience* OR perspective* OR perception* OR belief* OR attitude* OR opinion* OR thought* OR view* OR reflection*) N3 ((“Mental health” OR psychiatr* OR healthcare OR health OR “primary care” OR “secondary care”) N2 (Services OR care OR provision OR provider OR intervention OR treatment OR Staff OR professional*)))

3: “Utilisation”

TI OR AB OR SU (Use OR using OR utili?ation OR access* OR engag* OR barriers OR facilitators OR enablers OR help-seeking)

4: “Qualitative”

TI OR AB OR SU (Qualitative OR "qualitative research" OR interview* OR "focus group" OR "semi-structured interview" OR “unstructured interview” OR narrative OR "in-depth" OR ethnographic)

Search 1 AND 2 AND 3 AND 4

A.1.2 Scopus

Searches were filtered to title, abstract, and key words. No limiters on language or date of publication.

(TITLE-ABS-KEY (((homeless* OR homelessness OR hostel OR shelter* OR street-involved OR roofless OR unhoused OR "rough sleep*" OR "sleep* rough" OR "no fixed address") OR (precarious* OR vulnerabl* OR unstabl* AND temporar* OR instability) W/2 (hous* OR accomodation OR dwelling) OR (homeless OR street OR transient*) W/2 (population OR person OR persons OR people* OR individual* OR adult* OR youth* OR men OR man OR women OR woman))) AND TITLE-ABS-KEY (((experience* OR perception* OR perspective* OR view* OR attitude* OR belief* OR opinion* OR reflect*) W/5 ("mental health" OR psychiatric OR health OR healthcare OR "primary care" OR "secondary care" OR primary OR secondary OR psycholog*) W/5 (service* OR care OR provider OR intervention OR staff OR professional* OR provision OR treatment))) AND TITLE-ABS-KEY ((utili?ation OR use OR using OR engage* OR access* OR barrier* OR facilitator* OR help-seeking)) AND TITLE-ABS-KEY ((qualitative OR interview* OR ethnographic OR "focus group")))

A.1.3 Web of Science

Searches were filtered by ‘topic’ (title, abstract, author keywords and keywords plus). No limiters on language or date of publication.

((((TS=(((homeless* OR underhouse* OR roofless* OR unhoused OR squat* OR shelter* OR unsheltered OR "no fixed address" OR “no fixed abode” OR "street involved" OR “street attached” OR "sleeping rough" OR "unstable housing" OR "housing instability" OR "precarious housing" OR "precariously housed” OR "rough sleep*" OR "vulnerably housed") OR (homeless OR street OR transient*) NEAR/2 (population OR person OR persons OR people* OR individual* OR adult* OR youth* OR men OR man OR women OR woman) OR (temporary or unstabl* or vulnerabl* OR marginal*) NEAR/2 (hous* or accommodation* or shelter* or hostel* or dwelling*)))) AND TS=(((Experience* OR perspective* OR perception* OR belief* OR attitude* OR opinion* OR thought* OR view* OR reflection*) NEAR/3 ((“Mental health” OR psychiatr* OR healthcare OR health OR “primary care” OR “secondary care”) NEAR/2 (Services OR care OR provision OR provider OR intervention OR treatment OR Staff OR professional*))))) AND TS=((Use OR using OR utili?ation OR access* OR engag* OR barriers OR facilitators OR enablers OR help-seeking))) AND TS=((Qualitative OR "qualitative research" OR interview* OR "focus group" OR "semi-structured interview" OR “unstructured interview” OR narrative OR "in-depth" OR ethnographic)))

A.2 Citation search (cited reference and citing reference)

Reference lists and citations of identified studies were reviewed for potential additional articles.

Forwards and backwards citation searches were conducted with citationchaser:

Haddaway, N. R., Grainger, M. J., Gray, C. T. (2021) citationchaser: An R package and Shiny app for forward and backward citations chasing in academic searching. doi: 10.5281/zenodo.4543513

Appendix B Inclusion and Exclusion Criteria

Table B1

Study Inclusion and Exclusion Criteria

Criteria	Inclusion	Exclusion
Participant: "homelessness"	Currently or formerly homeless individuals Formerly – people with lived experience of homelessness talking about experiences from when they were homeless Currently: Sample includes a majority of homeless people Homelessness defined according to the ETHOS definition of rooflessness or houselessness If they used a sample of mixed respondents e.g. providers and homeless people, only themes pertaining to the perspectives of homeless people were included No restrictions on age and country of origin	Only from perspective of healthcare providers Studies were excluded if they used a mixed sample of various excluded / marginalised groups who were not homeless (e.g. LGBT, travellers) or homeless people were in the minority
Intervention: "mental health services utilisation"	Mental health services Including interventions for mental health with generalisable learning to mental health services Mental health support co-located with accommodation Health care services (including primary care and emergency care) where mental health is mentioned in the themes Health care in this sense referred to statutory / routine clinical care (either state funded or privately funded) If an article's main research area was about a different phenomenon (e.g. stigma, care needs) but had a substantial	Not about healthcare services specifically or minors on healthcare services Not about routine care – experience of specific healthcare phenomenon (e.g. cardiology, palliative care, prenatal care) without substantial generalisable learning to mental health services About a housing service or intervention Experiences of a different intervention without a substantial healthcare component (e.g. volunteer running group) Only about substance use service About prison

Criteria	Inclusion	Exclusion
	section or subtheme on health care services, then that article was included; however, only data from the relevant subtheme were extracted and included in the findings.	
Outcome: “experiences”	Experiences, perceptions of health care / access to healthcare / healthcare utilisation Patients’ reports could refer to either experience of health care services delivery and organisation or their experiences of care by specific health care personnel	No element about experiences or perceptions of health care services Only about perceptions of health needs/values with no mention of experiences/perceptions about health services
Study Design: “qualitative”	Any type of qualitative study Qualitative methods for data gathering and analysis Sufficiently rich qualitative data for synthesis – rich participant quotes Can be as part of mixed methods	No element of qualitative data or qualitative data not significant/rich enough for analysis Unable to separate consumer and provider participant data Systematic review / meta-synthesis A study protocol
Date	No date restrictions – all available studies stored on electronic databases included up until date of search	
Location	Global	No locations excluded
Language	All languages	No languages excluded from search
Types of publication	Published in a peer-reviewed journal	Unpublished/published but not in peer reviewed journal Any other type of publication, including conference papers and thesis

Appendix C Study Characteristics

Table C1

Table of Included Study Characteristics

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
McCabe et al.	2001	USA	17	19-67	Adults	14	3	0	10 White, 3 Black, 2 White Indian, 2 Native American, 2 other	Shelters and soup kitchens in a southeastern US state	Healthcare	In-depth interviews	Phenomenological analysis
French & Reardon	2003	Australia	16	14-21	Youth	0	0	0	Not specified	Mental health service	Mental health service	Interviews	Thematic analysis
Ensign	2004	USA	45	12 to 23	Youth	0	0	0	80% White, 13% African American, 7% mixed race	Street and clinic settings in Seattle, Washington	Health care quality	In-depth interviews, focus groups	Thematic coding
Thompson et al.	2005	USA	60	16-24	Youth	31	28	0	39 Caucasian, 6 African-American, 14 Latino	Shelters and drop-in centres	Healthcare services	Semi-structured interviews	Grounded theory
Darbyshire et al.	2006	Australia	10	16-24	Youth	3	7	0	Not specified	Supported accommodation in Adelaide	Health and social care services	In-depth interviews	Thematic analysis
Wen et al.	2007	USA	17	29–62	Adults	13	4	0	Not specified	Shelters and healthcare facilities	Healthcare encounters in general healthcare services	In-depth interviews	Thematic analysis

Appendix C

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
Leipersberger	2007	USA	25	22-54	Adults	10	15	0	12 African-American, 13 White	Mental health centre	Mental health care	Semi-structured interviews	Constant Comparative Method
Taylor et al.	2007	UK	19	16-23 years	Youth	6	13	0	Not specified	Homeless shelters	Mental health services in shelters	Semi-structured interviews	Thematic analysis
Hudson et al.	2008	USA	54	18-25	Youth	37	17	0	24 African-American, 13 Anglo-Americans, 12 Hispanic-American, 5 other	Shelters in Hollywood and Santa Monica, California	Interpersonal encounters with healthcare providers	Focus groups	Thematic analysis
Sweat et al.	2008	USA	54	18-25	Youth	37	17	0	24 Black, 13 White, 12 Hispanic, 2 Native American, 1 Asian	Shelters and street settings in the USA	Healthcare utilisation	Surveys and interviews	Descriptive and comparative analysis
Christiani et al.	2008	USA	54	18 - 25 years	Youth	37	17	0	44% African American, 24% White, 22% Hispanic, others mixed	Drop-in centres and youth shelters	Quality of healthcare	Focus groups	Thematic analysis
Martins	2008	USA	15	22-75	Adults	6	9	0	6 African-American, 1 Latin American, 1 biracial, 7 Caucasian	Various shelters in the USA	General healthcare system	Interviews	Descriptive phenomenology (Colaizzi's method)
Collins & Barker	2009	UK	16	17-21	Youth	9	7	0	8 Black African, 2 White British, 2 Black British African, 2 Black British Asian, 1	Emergency hostel in Central London	Psychological help	Semi-structured interviews	Thematic analysis

Appendix C

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
									Black British, and 1 Black Caribbean				
Hudson et al.	2010	USA	24	18 - 25 years	Youth	18	6	0	63% White, 21% African American, 13% Hispanic	Drop-in centres	General healthcare access	Focus groups	Descriptive thematic analysis
Whitley	2013	USA	13	20s-70s	Adults	11	2	0	All but one were White Euro-Americans	Rural shelters in New England	General healthcare	Interviews	Thematic analysis
Wise & Phillips	2013	USA	11	21-54	Adults	6	5	0	7 White, 1 Middle-Eastern, 2 Black, 1 German	Shelters	Healthcare services	Narrative interviews	Narrative analysis
Stanhope & Henwood	2014	USA	15	Not specified	Adults	15	0	0	Not specified	Homeless service settings in Los Angeles	General healthcare engagement	Semi-structured interviews	Thematic analysis
Archard & Murphy	2015	UK	4	45-58	Adults	4	0	0	Service users White British	Supported housing, trauma service	Social support work in a psychological trauma service	Narrative interviews	Thematic analysis
Rae & Rees	2015	UK	14	29-53	Adults	12	2	0	1 Irish, 1 Mixed British, 5 White British, 2 Asian, 4 Afro-Caribbean	Hostels and day centres in the UK	Healthcare experiences	Semi-structured interviews	Colaizzi's phenomenological method
Nicholas et al.	2016	Canada	48	15-26	Youth	27	12	0	Not specified	Emergency departments and community agencies	Emergency department services	Focus groups and individual interviews	Grounded theory analysis
Woith et al.	2016	USA	15	Not specified	Adult	10	5	0	10 White, 5 Black (African American)	Drop in church ministry providing meals, concerts,	General nursing interactions	Semi-structured interviews	Thematic analysis

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
										study groups, and church services,			
Chaturvedi	2016	UK	6	16-25	Youth	2	4	0	Not specified	Hostels in the UK	Counselling services	Semi-structured interviews	Thematic analysis
Narendorf et al.	2017	USA	54	18-25	Youth	30	24	0	28% African-American, 26% White, 20% Hispanic, 6% other	Psychiatric emergency unit	Psychiatric emergency services	Mixed methods (interviews, diagnostic data)	Qualitative thematic analysis and quantitative analysis
Strange et al.	2018	Australia	27	23-84	Adults	20	7	0	5 Indigenous, 22 Non-Indigenous	General practice street health service in Sydney, Australia	General practice street health service	Semi-structured interviews	Thematic analysis
Black et al.	2018	Australia	10	17-23	Youth	2	8	0	Not specified	Various services in Australia	Mental health services and homelessness support	Semi-structured interviews	Thematic analysis
Parsell et al.	2018	Australia	20	Not specified	Adults	2	18	0	Not specified	Supportive housing in Brisbane, Australia	Integrated health care and supportive housing	Mixed methods: surveys and qualitative interviews	Thematic analysis
Purkey & MacKenzie	2019	Canada	31	Not specified	Adults	0	0	0	Not specified	Hospital-based services in Ontario, Canada	Hospital services	Focus groups, in-depth interviews, surveys	Directed content analysis
Ramsay et al.	2019	Canada	16	18 - 65+	Adults	13	3	0	Not specified	Urban shelters and streets in Canada	Healthcare access	In-depth interviews	Framework analysis

Appendix C

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
Gunner et al.	2019	UK	22	24-70	Adults	15	5	0	14 White, 2 Asian, 2 Black, 1 Mixed, 3 unknown	Homeless shelters, specialist primary healthcare centre (SPHCPH)	Primary healthcare and specialist primary care	Semi-structured interviews	Thematic framework analysis
McConalogue et al.	2019	UK	28	Not specified	Adults	20	8	0	71% white	Homeless shelters and streets in Gloucestershire, UK	Health services in general	Semi-structured interviews	Thematic analysis
O'Carroll et al.	2019	Ireland	61	Not specified	Adult	31	16	0	Mostly Irish	Multiple sites including streets, drop-in centres, and hospitals.	Health service utilisation	Ethnographic observations and interviews	Critical realist approach
Kerman et al.	2019	Canada	52	Mean age 48 years	Adults	22	30	0	Not specified	Mental health services in Ottawa	Mental health services	In-depth interviews	Thematic analysis
King et al.	2020	USA	38	Mean age 49 years	Adults	28	0	0	78.9% white	Community-based organizations in Portland, Oregon	Recommendations for healthcare systems and medical students	Semi-structured interviews	Thematic analysis
Clark et al.	2020	UK	11	21-62 (mean 36)	Adults	9	2	0	Not specified	Specialist primary care service	Specialist primary care	Semi-structured interviews	Not specified
Varley et al.	2020	USA	36	Mean age 48 years	Adults	28	8	0	12 White, 22 African-American	Primary care clinics	Primary care	Semi structured interviews	Template analysis
Moore-Nadler et al.	2020	USA	13	Mean age 48 years	Adults	10	3	0	67% Caucasian, 33% African American	Homeless day shelter in Mobile, Alabama	Healthcare services	Interviews	Hermeneutic philosophical approach

Appendix C

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
Gilmer & Buccieri	2020	Canada	53	17 - 66	Mixed	32	21	0	All Canadian born, 24% with Indigenous ancestry	Hospitals and primary care settings	Mental health and addiction care	Narrative interviews	Narrative inquiry
Voisard et al.	2021	Canada	20	19-65	Adults	20	0	0	Not specified	Shelter-based mental health program	Mental health services	In-depth interviews	Grounded theory
Hirst & Cuthill	2021	UK	22	19 - 60	Adults	15	7	0	15 UK, 3 EU, 2 refused asylum seekers	GP outreach in hostels, streets, and day centres	GP outreach services	Interviews and focus groups	Framework analysis
Perez Jolles et al.	2021	USA	61	54 (average age)	Adults	22	39	0	66% racial and ethnic minorities, 31% White	Three PSH agencies in Southern California	Health services access	Mixed methods: survey and interviews	NVivo coding
Kneck et al.	2021	Sweden	26	Median age 46 years	Adults	0	26	0	Not specified	Primary healthcare centre in Stockholm, Sweden	Healthcare services	Interviews	Content analysis
Nichols & Malenfant	2022	Canada	38	16-29	Youth	19	11	7	65% White, 13% Mixed, 7% Black, 7% Brown, 5% Indigenous	Community organisations	Health services	Participatory research interviews	Institutional ethnography and thematic analysis
Thorndike et al.	2022	USA	23	20-69	Adults	5	6	2	9 Mexican, 3 White, 4 Black, 2 Mixed, 1 Asian, 3 Indigenous	Shelters and encampments in Mission District, San Francisco	General healthcare access	Interviews	Thematic analysis
McCormick et al.	2022	USA	21	18-25	Youth	4	16	1	5 Black, 3 Hispanic, 6 Hispanic White, 3	Virtual interviews	Mental health services	Interviews	Modified grounded theory analysis

Appendix C

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
									Multi-racial, 4 non-Hispanic White				
Austin et al.	2022	USA	40	32-45	Adults	13	26	1	47% non-white	Community organizations in Seattle, Washington	Health care for people who inject drugs	Semi-structured interviews	
Henderson et al.	2022	USA	16	Not specified	Adults	16	0	0	9 Black, 6 White, 1 unknown	Emergency homeless shelter in Philadelphia	Access to healthcare services	Focus groups	Content analysis
Paradis-Gagne et al.	2022	Canada	12	30-70	Adults	10	2	0	10 White, 2 Indigenous.	Mobile health clinics in Quebec, Canada	Mobile outreach health services	Interviews and focus groups	Critical ethnography and thematic analysis
Christian et al.	2022	USA	27	Average age 58	Adults	21	6	0	Not specified	Permanent housing community in Texas	General healthcare	Group and one-on-one interviews	Inductive thematic analysis
Ramirez et al.	2022	USA	31	35-65	Adults	24	7	0	18 White, 11 African-American, 2 Hispanic	Non-traditional clinic settings in Houston, Texas	Primary care and specialist primary care services	In-depth interviews	Thematic analysis
Younas et al.	2022	Canada	23	30-70	Adults	15	8	0	Not specified	Hospitals and clinics	Nursing care	Interviews	Thematic analysis
MacKinnon et al.	2022	Canada	30	34-74	Adults	16	12	0	17 White, 13 Racialised	Permanent supportive housing in Vancouver, Canada	Primary care embedded within supportive housing	Semi-structured interviews	Thematic analysis
Meehan et al.	2023	USA	25 + 43	18+	Adults	40	18	6	Diverse; included historically marginalised ethnic groups.	Six shelters in Seattle, Washington.	Primary and emergency care perceptions	Semi-structured interviews, focus groups	Thematic analysis

Appendix C

Study authors	Year	Country	n	Age of sample	Age group	M	F	T, NB	Ethnicity	Study setting	Type of healthcare	Data collection method	Data analysis method
Paradis-Gagne et al.	2023	Canada	12	30-70	Adults	10	2	0	White	Mobile clinic in community settings	Nurse-led mobile clinic	Semi-structured interviews, observation	Thematic analysis
Carmichael et al.	2023	Austria, Greece, Spain, UK	35	25-71 years	Adult	22	13	0	Diverse	Various community and health service settings across 4 countries.	Healthcare access	Semi-structured interviews	Thematic analysis
Anastasiya et al.	2024	Canada	171	26-45	Adult	98	63	6	47% White, 13% Indigenous, 6% Other, 2% Black, 29% Missing	Emergency departments and urgent care centres in Kingston.	Emergency care services	Narrative-based interviews	Thematic analysis
McDaniel et al.	2024	USA	20	38 - 52 years	Adult	15	5	0	35% Black, 10% White, 20% Hispanic, 5% Asian, 30% unreported	Public spaces and follow-up settings	Mobile crisis teams	Semi-structured interviews	Thematic analysis
Ingram et al.	2024	Ireland	38	Not specified	Adult	38	36	0	Diverse, included migrants.	Primary care and addiction services in Dublin	Primary care and harm reduction services	Ethnographic observation and informal interviews	Thematic analysis

Note. M = Male, F = Female, T, NB = Trans, Non-binary, Non-cisgender

Appendix D Conceptual Categories Iterations

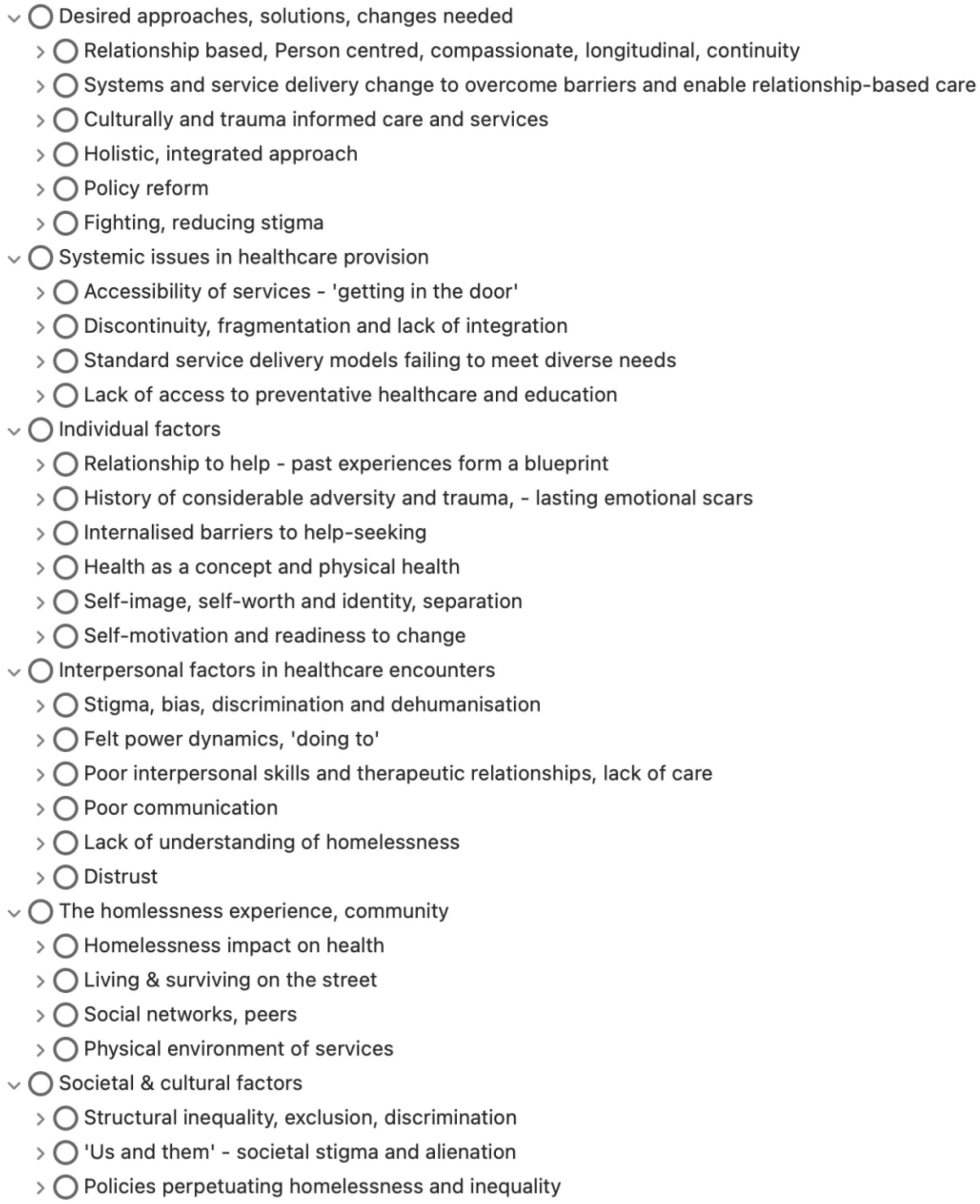
Figure A1

Earlier Conceptual Piles

- ○ Systemic issues in healthcare provision
  - ○ Accessibility of services - 'getting in the door'
  - ○ Holistic, compassionate, and culturally informed care
  - ○ Standard service delivery models failing to meet diverse needs
  - ○ Discontinuity, fragmentation and lack of integration
  - ○ Insufficient staff training, inconsistency, lack of homeless cultural competence
  - ○ Lack of access to preventative healthcare and education
- ○ Interpersonal factors in healthcare encounters
  - ○ Stigma and discrimination
  - ○ Longitudinal, relationship-based, compassionate care
  - ○ Interpersonal skills
  - ○ Felt power dynamics, 'doing to'
  - ○ Homelessness cultural competence and understanding
  - ○ Communication
  - ○ Trust, distrust
- ○ Individual factors
  - ○ Internalised barriers to therapy, help
  - ○ Physical health
  - ○ Becoming homeless
  - ○ Mental health, substance issues
  - ○ Motivation
  - ○ Self-image, self-worth and identity
  - ○ Social power(lessness), (in)justice, and self-advocacy
- ○ The homlessness experience, community
  - ○ Homelessness impact on health
  - ○ Living on the street
  - ○ Competing priorities
  - ○ Homelessness on sense of self - marginalisation and separation
  - ○ Social networks
  - ○ Shelter living
- ○ Society & cultural factors
  - ○ Policies and policy reform
  - ○ 'Us and them' - societal stigma and alienation
  - ○ Structural inequality, exclusion, discrimination

Figure A2

Final Conceptual Piles



- ○ Desired approaches, solutions, changes needed
  - ○ Relationship based, Person centred, compassionate, longitudinal, continuity
  - ○ Systems and service delivery change to overcome barriers and enable relationship-based care
  - ○ Culturally and trauma informed care and services
  - ○ Holistic, integrated approach
  - ○ Policy reform
  - ○ Fighting, reducing stigma
- ○ Systemic issues in healthcare provision
  - ○ Accessibility of services - 'getting in the door'
  - ○ Discontinuity, fragmentation and lack of integration
  - ○ Standard service delivery models failing to meet diverse needs
  - ○ Lack of access to preventative healthcare and education
- ○ Individual factors
  - ○ Relationship to help - past experiences form a blueprint
  - ○ History of considerable adversity and trauma, - lasting emotional scars
  - ○ Internalised barriers to help-seeking
  - ○ Health as a concept and physical health
  - ○ Self-image, self-worth and identity, separation
  - ○ Self-motivation and readiness to change
- ○ Interpersonal factors in healthcare encounters
  - ○ Stigma, bias, discrimination and dehumanisation
  - ○ Felt power dynamics, 'doing to'
  - ○ Poor interpersonal skills and therapeutic relationships, lack of care
  - ○ Poor communication
  - ○ Lack of understanding of homelessness
  - ○ Distrust
- ○ The homlessness experience, community
  - ○ Homelessness impact on health
  - ○ Living & surviving on the street
  - ○ Social networks, peers
  - ○ Physical environment of services
- ○ Societal & cultural factors
  - ○ Structural inequality, exclusion, discrimination
  - ○ 'Us and them' - societal stigma and alienation
  - ○ Policies perpetuating homelessness and inequality

Appendix E Translation Table

Table E1

Translation Table Including Contextual Level, Key Metaphors, Third Order Constructs, and Citations

Contextual level to frame synthesis	Key metaphor	Key concepts (second order constructs)	Definition of concept / third order constructs (translated first and second order constructs)	Papers that include the concept
Individual factors – history, beliefs, and psychology	*Lasting psychological scars*	Interdependence of compound trauma, mental health, and substance use	Interconnected nature of poverty, childhood trauma, mental health, substance use, and behavioural problems, and pathways into homelessness. Abuse, neglect, family instability, or loss during childhood, left "lasting psychological scars". Substances used as a coping mechanism, providing short-term relief, but exacerbating instability, homelessness, loneliness, isolation, and mental health problems in the long-term. The trauma of homelessness itself – exposure to violence, victimisation, and stigmatisation – compounds these struggles. Mental health and substance use problems are a barrier as they impact ability and motivation to manage health. Although these issues are interconnected, the tendency for services to address these issues in isolation often rendered support inadequate.	(Archard & Murphy, 2015; Carmichael et al., 2023; Christiani et al., 2008; Clark et al., 2020; Collins & Barker, 2009; Gunner et al., 2019; Hudson et al., 2010; Ingram et al., 2024; King et al., 2020; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Mc Conalogue et al., 2021; McCormick, 2022; McDaniel, 2024; Moore-Nadler et al., 2020; Narendorf, 2017; O'Carroll & Wainwright, 2019; Perez Jolles et al., 2021; Rae & Rees, 2015; Stanhope & Henwood, 2014; Strange et al., 2018; Thorndike et al., 2022; Whitley, 2013)21/06/2025 16:50:00
		Breakdown of support systems – 'set up to fail'	Sense of being let down and "set up to fail" by familial, personal, community, and governmental support systems, leaving them with no options, feelings of abandonment, and disappointment and mistrust of others and systems. Unstable formative environments characterised by poverty, conflict, domestic violence, neglect, and parental substance misuse, often led to family breakdowns, estrangement, or placement into foster care. This exacerbated feelings of abandonment, rejection, and displacement, and systemic failure meant they were	(Clark et al., 2020; Collins & Barker, 2009; Ensign, 2004; Leipersberger, 2007; Mc Conalogue et al., 2021; Moore-Nadler et al., 2020; Narendorf, 2017; Nichols & Malenfant, 2022; O'Carroll & Wainwright,

Contextual level to frame synthesis	Key metaphor	Key concepts (second order constructs)	Definition of concept / third order constructs (translated first and second order constructs)	Papers that include the concept
			left in unsafe or unsuitable housing situations. Lack of guidance, life skills, secure attachments, or a safety net meant they felt unprepared for living independently – "set up to fail". Unmet expectations of housing assistance. Reliance on informal support systems (friends or extended family), was a temporary solution that often failed – "burned all bridges".	2019; Purkey & MacKenzie, 2019; Rae & Rees, 2015)
Individual factors – history, beliefs, and psychology	*Past experiences form a blueprint (of how I will be treated)*	Past negative healthcare experiences lead to fear/distrust and avoidance	Past negative experiences with healthcare services deterred people from seeking care again and created distrust and apprehension towards healthcare systems and professionals. Examples include being treated disrespectfully, receiving inadequate care, feeling unwelcome, or experiencing stigma related to homelessness or drug use. There is a deep distrust and scepticism about the system's ability or willingness to meet their needs. For some this is cultural/generational distrust of formal support systems. These experiences lead to care avoidance, denial, minimization of problems, and postponement of help-seeking – only seeking care in a crisis or emergency. Fear of authority figures, linked to historical and systemic abuses of power contributes to avoidance. This distrust is particularly strong in those who have experienced homelessness-related discrimination or marginalisation within healthcare settings.	(Austin et al., 2021; Chaturvedi, 2016; Collins & Barker, 2009; French et al., 2003; Gunner et al., 2019; Henderson et al., 2022; Kneck et al., 2021; Leipersberger, 2007; MacKinnon et al., 2022; Meehan et al., 2023; Moore-Nadler et al., 2020; Nicholas et al., 2016; Nichols & Malenfant, 2022; O'Carroll & Wainwright, 2019; Paradis-Gagné et al., 2022, 2023; Perez Jolles et al., 2021; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Stanhope & Henwood, 2014; Thompson et al., 2006; Thorndike et al., 2022; Wen et al., 2007; Whitley, 2013; Wise & Phillips, 2013; Woith, 2016)21/06/2025 16:50:00
		Relationship to help	Past experiences of abuse, betrayal, abandonment, breaches of trust, and being let down (by family, friends, systems) shape the attitudes people have towards 'help'. Reluctance to seek help. Difficult to build trust given experiences of traumatic relationships. Self-reliance and independence valued due to experiences – it's safer to rely on yourself to avoid disappointment and being hurt. "Don't be beholden to anyone". "Look after your own problems". "Suspicious of "help" – desire to protect themselves emotionally, led to avoidance of seeking help. The emphasis on self-sufficiency serves as both a coping mechanism and a barrier to accessing care.	(Chaturvedi, 2016; Collins & Barker, 2009; Darbyshire et al., 2006; Ensign, 2004)

Contextual level to frame synthesis	Key metaphor	Key concepts (second order constructs)	Definition of concept / third order constructs (translated first and second order constructs)	Papers that include the concept
		Alertness to negative behaviours of professionals	Peoples' experiences of past trauma, discrimination, marginalisation, and internalised stigma means they may be more sensitive/alert to the negative behaviours and attitudes of healthcare professionals. Subtle indicators gleaned through non-verbal communication and attitudes of healthcare professionals can signal unwelcomeness and judgement. Feelings of low self-esteem, self-worth, inferiority, stigmatisation and alienation means they may be more likely to feel judged or "looked down on" in healthcare settings.	(Mc Conalogue et al., 2021; Wen et al., 2007; Younas et al., 2022)
Individual factors – history, beliefs, and psychology	*It's a gamble I'm not willing to take – Internalised barriers to help-seeking*	Stigma around seeking help for mental health issues	Societal and internalised stigma regarding mental health conditions create barriers to help-seeking. Worries about what others might think of them if they accessed mental health support and shame and embarrassment about their reasons for seeking help. Concerns of being labelled or perceived as "crazy" or "different". Being seen as having mental health difficulties adds an extra layer of stigma on top of already being part of a marginalised group (homeless). This double identity-threat is particularly impactful for young people who are "trying to construct identities based on normality".	(Chaturvedi, 2016; Darbyshire et al., 2006; French et al., 2003; Gunner et al., 2019; Nicholas et al., 2016; Stanhope & Henwood, 2014; Thorndike et al., 2022)
		Fear of vulnerability and exposure	Discomfort and hesitation about opening up to others, especially healthcare professionals. Sharing personal stories or discussing struggles feels risky, as it exposes their inner lives to potential judgment or misunderstanding. The fear of being emotionally overwhelmed during these interactions also contributes to this barrier, as does the belief that healthcare professionals might not be equipped to handle the depth or complexity of their issues.	(Carmichael et al., 2023; Chaturvedi, 2016; Collins & Barker, 2009; French et al., 2003; McCormick, 2022; Rae & Rees, 2015; Stanhope & Henwood, 2014)
		Concerns around communication and assertiveness	Shyness, nervousness, or anxiety in social interactions, especially with unfamiliar health professionals can be a barrier to effective care. Difficulties in communicating personal needs or asserting oneself due to low self-esteem or not having learnt assertiveness skills. This can impact the care received, feel disempowering, and, in some cases, lead to unmanaged mental health symptoms. Others may expect to be rejected and feel a sense of anger or injustice, and use aggression to assert themselves, which can lead to exclusion from services due to "challenging behaviour".	(Carmichael et al., 2023; McCormick, 2022; O'Carroll & Wainwright, 2019)

Contextual level to frame synthesis	Key metaphor	Key concepts (second order constructs)	Definition of concept / third order constructs (translated first and second order constructs)	Papers that include the concept
		Stigma, internalised stigma, and fear of discrimination (due to homelessness / substance use)	In society, homeless people are stigmatised and stereotyped, treated as "bums" or looked at like a "low-life". Internalised societal narratives that homelessness or poor mental health is a personal failing = self-blame. The carrying of shame and internalised stigma about their homelessness and/or substance use into healthcare settings. Negative, discriminatory, stigmatising experiences with healthcare staff then reinforce this internalised stigma and shame. An extra layer of fear of discrimination for people with racialised identities. Experiences of poor treatment, stigma, and discrimination in healthcare mean people anticipate being judged in future encounters and are driven to avoid seeking help. In this context of stigmatisation, avoidance may be driven by a desire to preserve a semblance of pride and dignity.	(Austin et al., 2021; Carmichael et al., 2023; Christian et al., 2022; Christiani et al., 2008; Leipersberger, 2007; Martins, 2008; O'Carroll & Wainwright, 2019; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Varley et al., 2020; Woith, 2016)
		Fear of the unknown	Anxiety and apprehension when encountering unfamiliar aspects of healthcare, such as therapy or counselling. These services seem mysterious or intimidating, with unclear processes or expectations. Misconceptions about therapy, influenced by cultural narratives or media portrayals, add to the hesitancy. Worries about being "put on the spot," being asked probing questions they can't answer, or that therapy might be "posh" or too formal for them.	(Chaturvedi, 2016; French et al., 2003)
		Hopelessness – seeking help is futile	Belief that seeking help is futile. The systemic and personal challenges of homelessness led to feelings of powerlessness and being trapped. A sense of hopelessness, where repeated disappointments left people feeling stuck in their circumstances. Trying to improve their situation felt like "getting hit in the face." Fatalistic cognitions, such as the expectation of an early death or the belief that their situation is beyond improvement, lead to disengagement from care. These beliefs create a sense of resignation, where seeking help feels pointless	(Moore-Nadler et al., 2020; O'Carroll & Wainwright, 2019)
		Fear and scepticism of bio-chemical explanations of mental health and medication	Fears, mistrust, ambivalence and scepticism around medical and psychiatric interventions to treat mental health problems. Anxiety about medications, fearing side effects, dependency, or the implications of taking something that alters their mental state, or they believe medications to be harmful or ineffective based on past experience. Sense that healthcare professionals are "pill pushers". Scepticism	(French et al., 2003; Gilmer, 2020; Leipersberger, 2007; Parsell et al., 2018; Voisard et al., 2021; Whitley, 2013)

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			about biological explanations for mental health issues in the context of homelessness and social problems.	
		Self-motivation and readiness to change	People need to reach a point of personal readiness before they can engage meaningfully with services. Feeling ready to access support was perceived as extremely personal. Participants valued autonomy in decision-making and often resisted being told what to do, preferring to make choices on their own terms.	(Clark et al., 2020; Collins & Barker, 2009; French et al., 2003; Ingram et al., 2024; Mc Conalogue et al., 2021; Narendorf, 2017; Rae & Rees, 2015; Thompson et al., 2006)
Individual factors – history, beliefs, and psychology	*Healthcare is not for me – the impact of marginalisation*	Homelessness impacts self-esteem and self-worth	Homelessness leads to low self-esteem and a diminished sense of self-worth, which prevents people from asking for help due to feeling undeserving or inferior. People feel worthless, inferior and alienated, like "a sorry excuse for a person", "dirt", or "very small within yourself". This may be particularly felt in healthcare where social comparison/power differential is more notable – people feel "less of a life form" than the doctors.	(Archard & Murphy, 2015; Kneck et al., 2021; O'Carroll & Wainwright, 2019; Rae & Rees, 2015; Stanhope & Henwood, 2014)
		Loss of self and personhood (invisibility and dehumanization) Not a priority / not counting	Homelessness as a "big black hole," stripping away personhood, identity, and rendering them invisible. Sense of alienation, separateness, and disconnection from society and past selves – a sense of "not counting" like the rest of the population. In healthcare, they felt like an "intrusive visitor", dehumanised, and reduced to their homelessness status. They linked this to discriminatory treatment, including being ignored, dismissed, deprioritised, denied care, and forgotten about – left "on the back burner". Belief that their lives were not valued by the systems meant to support them – some felt healthcare staff wouldn't care if they died, reinforcing feelings of worthlessness, and a sense of dehumanisation. Being ignored or feeling invisible in healthcare settings also reinforces that they are separate/alienated from the rest of society, that they are an "anomaly" and "do not fit in" – further undermining self-worth and putting people off seeking care.	(Archard & Murphy, 2015; Kneck et al., 2021; Martins, 2008; McCabe et al., 2001; Parsell et al., 2018; Rae & Rees, 2015; Thompson et al., 2006; Wise & Phillips, 2013)
Individual factors – history, beliefs, and psychology	*Health as survival, not perfection*	High levels of chronic disease, complexity and comorbidity	Multiple comorbid health conditions – high levels of chronic conditions (hepatitis C, diabetes, cardiac issues, asthma, chronic pain), mental health issues, and substance use disorders. Complex and overlapping health conditions make healthcare challenging, both for individuals and healthcare providers. The burden of managing multiple health conditions overwhelmed people, and made self-care	(Carmichael et al., 2023; Christiani et al., 2008; Gunner et al., 2019; Henderson et al., 2022; Hudson et al., 2010; Ingram et al., 2024; Kneck et al., 2021; Leipersberger, 2007; Mc

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			tricky. This complexity is challenging for healthcare providers to manage as multiple chronic conditions require multidisciplinary support, which is often fragmented or inaccessible to those experiencing homelessness, leading to further deterioration of health. Health problems are worsened by social disaffiliation (a severing of ties between people and public services), the lack of resources to manage health, and the influence of stereotypes on treatment (e.g. "I had a stroke, but they thought it was narcotics").	Conalogue et al., 2021; McDaniel, 2024; Moore-Nadler et al., 2020; Paradis-Gagné et al., 2023; Perez Jolles et al., 2021; Thompson et al., 2006; Voisard et al., 2021; Whitley, 2013)
		Health conditions as a barrier	Physical, mental, or cognitive conditions affecting mobility, ability to socialise, and/or remember appointments impacted people's ability to manage health and attend appointments. Often then excluded from healthcare for missing appointments.	(Henderson et al., 2022; Moore-Nadler et al., 2020; Parsell et al., 2018; Perez Jolles et al., 2021; Ramirez et al., 2022; Thorndike et al., 2022)
		'Health' as a concept	View of 'health' is broader and more holistic than the absence of physical disease – falls outside traditional biomedical model – important link between the mind and the body. Wellbeing, dignity, and self-regard important aspects of health. Health is defined by functionality, freedom, respect and dignity, and a sense of control and mastery over their environment, addiction, and mental health. Prioritised over physical health as without this, cannot be fully healthy. Health as a means to support daily survival, maintain a sense of autonomy, and exit homelessness. Achieving basic needs such as stable housing, nutrition, and hygiene prioritised over health, seeing these as prerequisites to being able to focus on improving their health and wellbeing. Impact of how they are treated by others on their overall health – need to be respected by others to be fully healthy. Importance of health education but felt they lacked understanding of healthcare processes and managing their health.	(Ensign, 2004; Gunner et al., 2019; Ingram et al., 2024; Leipersberger, 2007; Mc Conalogue et al., 2021; McCabe et al., 2001; Paradis-Gagné et al., 2023; Perez Jolles et al., 2021)
Interpersonal factors in healthcare encounters	*Seen as less, treated as less*	Bias, prejudice, and discrimination in healthcare = poorer treatment	Healthcare staff may hold implicit biases that homeless people are "sub-human", "lazy", "intellectually inferior", "criminals", assume they have mental illness, are "junkies and drunks looking out for a fix", and that they just want a bed for the night. Belief they are treated as "lesser than" because of their homelessness, substance use, or appearance, resulting in inadequate or dismissive care, leading to emotional distress. Disclosure of their homeless status or substance use influences how they are treated – they notice a physical change in the staff demeanour upon the	(Anastasiya et al., 2024; Austin et al., 2021; Carmichael et al., 2023; Christian et al., 2022; Gilmer, 2020; Gunner et al., 2019; Henderson et al., 2022; Hudson et al., 2008, 2010; King et al., 2020; Kneck et al., 2021; Martins, 2008; Meehan et al.,

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			discovery of this information. Interactions were characterised by disrespect, being spoken down to, not being taken seriously, and a lack of empathy. "Anytime you have 'homeless' put on your records, your care goes down almost immediately... it's everything, it's attitude". This label followed them through healthcare interactions, as though they had been "flagged", shaping staff attitudes, overshadowing participants' health needs, and reducing the quality of care received. "Drug-seeking behaviour" often assumed, and an extra layer of stigma and discriminatory treatment applied such as being denied medication or treatment. This bias and discrimination forms poor perceptions of healthcare and leads to feelings of devaluation and alienation, reducing participants' willingness to seek care.	2023; Moore-Nadler et al., 2020; Nicholas et al., 2016; Nichols & Malenfant, 2022; O'Carroll & Wainwright, 2019; Paradis-Gagné et al., 2023; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Ramsay et al., 2019; Sweat J et al., 2008; Varley et al., 2020; Wise & Phillips, 2013; Younas et al., 2022)
		Dehumanisation	People experiencing homelessness felt dehumanised by healthcare staff and treated as "less than human" or "invisible". Encounters were impersonal or mechanistic, with treatment likened to "processing a piece of meat" or "meatball triage". Interactions left them feeling like "just a number", "cattle", or "a statistic" – undervalued, objectified, and worthless. Healthcare staff conveyed a lack of empathy, dismissive or indifferent attitudes, and a sense that they did not have the time or inclination to make them "feel like a human being", reinforcing feelings of worthlessness. This lack of personal connection was compounded by a sense of power imbalance, where participants felt they were treated as "sub-human". Dehumanisation in healthcare discouraged participants from seeking care.	(Anastasiya et al., 2024; Austin et al., 2021; Black et al., 2018; Gunner et al., 2019; Leipersberger, 2007; Martins, 2008; Moore-Nadler et al., 2020; Rae & Rees, 2015; Wen et al., 2007; Woith, 2016)
		Disrespected, dismissed	Feelings of being disrespected, devalued, and dismissed in their interactions with healthcare staff. Disrespect conveyed through being ignored, belittled, or spoken to in a condescending manner, left people feeling unwelcome and unworthy of care. They felt their concerns were dismissed or minimised, especially in emergency settings or around treatment for pain. Metaphors of being "treated like dirt" or placed "on the back burner" encapsulated the feelings of being looked down upon and deprioritised. These experiences of disrespect and dismissal contributed to a profound sense of worthlessness, disconnection from healthcare systems, and marginalisation which deterred them from seeking care.	(Austin et al., 2021; Hudson et al., 2008; Kerman et al., 2019; King et al., 2020; Martins, 2008; McCormick, 2022; Moore-Nadler et al., 2020; Nicholas et al., 2016; O'Carroll & Wainwright, 2019; Purkey & MacKenzie, 2019; Ramsay et al., 2019; Sweat J et al., 2008; Thompson et al., 2006; Whitley, 2013; Younas et al., 2022)
		Judged and scrutinized	People felt judged and scrutinised in healthcare settings, encountering overt and covert judgmental attitudes from staff. Judgemental attitudes centred on their	(Darbyshire et al., 2006; Mc Conalogue et al., 2021; Nicholas

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			homelessness, substance use, or perceived lifestyle choices, and made people feel judged, misunderstood and unfairly categorised. Judgemental attitudes may be linked to the concept of the “inappropriate attendee” – the view that homeless people overuse emergency services and are “wasting” hospital resources. Such judgmental attitudes often alienated participants from healthcare services, making them feel like "outcasts" or undeserving of care. Judgment and scrutiny create barriers to trust and care, perpetuating cycles of marginalisation and poor health outcomes.	et al., 2016; O’Carroll & Wainwright, 2019; Ramsay et al., 2019; Woith, 2016; Younas et al., 2022)
		Unwelcomeness	Sense of “unwelcomeness” in healthcare linked to stigmatising encounters where people felt ignored, treated rudely, or dismissed. Ranged from overt dismissiveness to subtle, non-verbal cues such as rushed interactions or indifferent attitudes. Led to feeling devalued and excluded. Past experiences of discrimination make this more likely, leading to strong emotional responses, such as anger, frustration, or despair. “I’d rather sit here and fuckin’ die on a bench than go over there.” Unwelcomeness also from members of the public - “regular people” in the waiting room become “annoyed”, “scared”, and “angry” in their presence. Links made to hygiene issues. These experiences are founded in stigma and discrimination and perpetuate cycles of exclusion and mistrust, discouraging people from seeking care.	(Darbyshire et al., 2006; Kneck et al., 2021; Martins, 2008; Strange et al., 2018; Wen et al., 2007)
Interpersonal factors in healthcare encounters	*Stripped of voice, stripped of power*	‘Doing to’	Disempowerment experienced in healthcare settings through not being listened to, heard, or feeling as though their perspective is not valued. Sense of being stripped of their voice and autonomy, with decisions made for them rather than with them. Coercive, controlling, restrictive approach, where people felt forced to comply with treatment. This, combined with a lack of transparency or explanation created a sense of being controlled rather than supported. The lack of meaningful engagement where personal strengths, insights and concerns were disregarded led to mistrust and disengagement from services, creating future barriers.	(Austin et al., 2021; Christian et al., 2022; Clark et al., 2020; Darbyshire et al., 2006; Henderson et al., 2022; Hudson et al., 2008; Ingram et al., 2024; Kneck et al., 2021; McCormick, 2022; Nicholas et al., 2016; Paradis-Gagné et al., 2023; Rae & Rees, 2015; Ramirez et al., 2022; Sweat J et al., 2008; Thompson et al., 2006; Woith, 2016; Younas et al., 2022)
		Abuse of power, unethical behaviour	Perceived lack of professionalism from healthcare staff, where they exhibited unethical behaviour or failed to act in the best interest of patients. This creates a	(Kerman et al., 2019; Kneck et al., 2021; Moore-Nadler et al., 2020; Younas et al., 2022)

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			sense of frustration, disempowerment, and lack of safety in healthcare, especially for women.	
Interpersonal factors in healthcare encounters	*Seen, but not cared for*	Poor interpersonal skills and ineffective relationships put people off seeking care	Poor interpersonal skills of healthcare staff – characterised by a lack of empathy, not being listened to, inattentiveness, insensitivity, a lack of compassion, and rudeness – left individuals feeling undervalued and uncared for. This gave people a sense that staff were "in it for the paycheck" rather than because they genuinely care. Interactions felt transactional and impersonal, where staff focused on completing tasks rather than engaging with patients as individuals. This lack of focus on the relationship, trust building, and building rapport – for instance, through taking the time to understand patients' needs, and connecting on a personal level (mutuality, reciprocity, self-disclosure), hindered effective care and put people off seeking care.	(Austin et al., 2021; Collins & Barker, 2009; Hudson et al., 2008; Kerman et al., 2019; Leipersberger, 2007; McCormick, 2022; Nicholas et al., 2016; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Ramsay et al., 2019; Varley et al., 2020; Wen et al., 2007; Whitley, 2013; Woith, 2016; Younas et al., 2022)
Interpersonal factors in healthcare encounters	*Out of touch*	Lack of homelessness cultural competency	Healthcare staff convey a lack of understanding of the causes and lived realities of homelessness, the impact of trauma/adversity, SDoH, and cultural competency. A common sentiment was "they have no idea", and staff did not show compassionate curiosity about what they did not know or understand. For example, they expressed intolerance and judgement of behaviours, language style, presentation / appearance, hygiene, and lacked knowledge around harm reduction approaches to substance use. This lack of understanding perpetuated feelings of exclusion.	(Henderson et al., 2022; King et al., 2020; Moore-Nadler et al., 2020; Nicholas et al., 2016; Purkey & MacKenzie, 2019)
		Lack of relatability	Importance of relatability, empathy, understanding, and shared life experiences or attitudes in fostering trust and effective therapeutic relationships. Mismatches in age, gender, race, or socioeconomic background often made it harder to relate and created barriers to trust. This was especially true for people from African American backgrounds in the US who felt mental healthcare workers were personally inexperienced and unwilling or unable to relate to their them on a personal level. Young people especially felt dismissed or misunderstood when staff failed to acknowledge their maturity or lived experiences, e.g. one person described being "downgraded" to a child. However, although shared identities can help, an approach characterised by empathy, respect, openness, understanding and sensitivity to difference can also help bridge the divide and foster trust.	(Archard & Murphy, 2015; French et al., 2003; Leipersberger, 2007; McCormick, 2022)

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Interpersonal factors in healthcare encounters	*Left out of the conversation*	Poor communication	Poor communication is a barrier to therapeutic relationships and leads to disengagement, particularly for vulnerable populations. Participants disliked the authoritative or "lecturing" tone and communication style of healthcare providers. Poor or absent communication and lack of amenability or rudeness when answering questions left patients feeling "snubbed", unwelcome, and frustrated. Conversations were one-way and not mutually engaging – there was little room for patient input. Unclear or absent explanations regarding their treatment, and the use of complex medical jargon left them feeling confused and excluded from understanding their care. This increased people's feelings of vulnerability and fear, and in some cases anger and "stroppiness" in response to what was considered "purposefully antagonistic behaviour".	(Anastasiya et al., 2024; Christian et al., 2022; Darbyshire et al., 2006; Ensign, 2004; Hudson et al., 2008; McCormick, 2022; Meehan et al., 2023; Perez Jolles et al., 2021; Varley et al., 2020; Wen et al., 2007; Younas et al., 2022)
Interpersonal factors in healthcare encounters	*I don't trust them*	Distrust as a consequence of negative healthcare encounters	Mistrust in healthcare systems is maintained by poor interpersonal encounters such as through poor communication, unwelcomeness, not being listened to, fear of harm, stigmatisation, judgemental attitudes, a lack of safety, and feeling healthcare professionals do not have their best interests in mind. The impact of mistrust is particularly severe for people experiencing homelessness, as their limited access to care makes each interaction significant, and a lack of trust leads to avoidance of and disengagement with healthcare.	(Christian et al., 2022; Kerman et al., 2019; McCormick, 2022; Purkey & MacKenzie, 2019; Thorndike et al., 2022; Wen et al., 2007)
Systemic issues in healthcare provision	*Getting in the door*	Inflexible systems and gatekeeping	Rigid, exclusionary criteria and systemic gatekeeping perpetuates barriers to access. The systemic prioritisation of rules, procedures, efficiency, and conformity/compliance over adaptability and equitable access to care fails to recognise the complex and intersectional needs of marginalised populations and leaves people feeling abandoned and unsupported with no alternatives for meeting their health needs, perpetuating exclusion. Normative assumptions about having a fixed address, valid identification, a permanent phone number, access to the internet, the "office hour norm" for appointments, and being able to remember advance appointments exclude those most in need. This is compounded by "overwhelming" bureaucratic hurdles such as excessive paperwork and navigating complex systems. Healthcare systems/providers serve as gatekeepers, limiting/controlling access to services based on requirements such as sobriety, housing/risk stability, or compliance with	(Anastasiya et al., 2024; Austin et al., 2021; Carmichael et al., 2023; Christiani et al., 2008; Clark et al., 2020; French et al., 2003; Gunner et al., 2019; Henderson et al., 2022; Ingram et al., 2024; Kerman et al., 2019; King et al., 2020; Kneck et al., 2021; Leipersberger, 2007; MacKinnon et al., 2022; Martins, 2008; Mc Conalogue et al., 2021; Moore-Nadler et al., 2020; Nichols & Malenfant, 2022; O'Carroll & Wainwright, 2019; Paradis-Gagné et al., 2022;

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			rules – excluding people who are homeless or using substances. People with "dual-diagnosis" (of mental health and substance use) are denied mental health support until they address their substance use, despite this being perceived as interrelated, trapping them in cycles of unmet needs or being "coerced into sobriety". The lack of flexibility in care delivery, such as standardised protocols designed for the general population, do not accommodate the realities of homelessness. For example, missed appointments result in patients being discharged and having to start the process again. A lack of personalisation meant participants received instructions like "rest at home" or "elevate your leg," which are unfeasible without stable housing.	Parsell et al., 2018; Purkey & MacKenzie, 2019; Ramirez et al., 2022; Ramsay et al., 2019; Thompson et al., 2006; Wise & Phillips, 2013)
		Financial and logistical barriers	Tangible barriers related to finances and transport impact access. Public transport systems were often unreliable, inaccessible, or non-existent. Walking long distances to healthcare facilities was time-consuming and often physically exhausting, particularly for people with chronic pain or disabilities. People often missed appointments due to these logistical challenges. In the US, financial barriers were common. Even when people had insurance, gaps in coverage or high out-of-pocket costs for medications and treatments meant healthcare was unaffordable. When people did not have insurance, they were denied care without upfront payment, and forced to go without prescriptions. Many were afraid of debt and bankruptcy from medical bills. Belief healthcare systems prioritise profit over patient wellbeing. In countries with universal healthcare, financial barriers related to paying for transport to attend appointments (UK, Canada), or to services not covered by provincial insurance (e.g. private counselling, prescriptions)(Canada). Systemic inequity embedded in healthcare systems – assumes access to resources that many marginalised people do not have.	(Carmichael et al., 2023; Christian et al., 2022; Christiani et al., 2008; Gunner et al., 2019; Henderson et al., 2022; Hudson et al., 2008; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Meehan et al., 2023; Moore-Nadler et al., 2020; Narendorf, 2017; Nicholas et al., 2016; Paradis-Gagné et al., 2023; Ramsay et al., 2019; Stanhope & Henwood, 2014; Sweat J et al., 2008; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Wise & Phillips, 2013; Woith, 2016)
		Impact of systemic resource limitations	The healthcare system is strained by limited resources and characterised by long wait times and inadequate service provision. Long waiting lists, particularly for mental health / psychiatry services, with some waiting years to access services. Lack of availability of services, particularly mental health / psychiatry services (especially for unhoused people). Long wait times in hospitals and drop-in clinics. In the UK, the "one appointment, one problem" policy made them feel rushed and	(Carmichael et al., 2023; Christian et al., 2022; Christiani et al., 2008; Gunner et al., 2019; Henderson et al., 2022; Hudson et al., 2010; Ingram et al., 2024; King et al., 2020; Mc Conalogue et al., 2021; Moore-Nadler et al.,

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			lacked the opportunity to discuss their multiple health issues. For some, long wait times at A&E were a barrier and led to the non-use of any/all healthcare services.	2020; Nicholas et al., 2016; Nichols & Malenfant, 2022; Paradis-Gagné et al., 2022, 2023; Perez Jolles et al., 2021; Ramsay et al., 2019; Sweat J et al., 2008; Thorndike et al., 2022; Varley et al., 2020)
		Lack of awareness and poor information dissemination	A systemic lack of awareness about available support services and how to access them among people experiencing homelessness. Perceived inadequacy of service promotion and outreach and frustration at the lack of visible and accessible information about available services. Particularly difficult to access information without internet or stable accommodation. Information about resources is spread is through informal channels, such as through word-of-mouth, though peers in hostels/shelters, or by chance, bridging the gap. Poor dissemination of information means people may remain disconnected from useful services.	(Collins & Barker, 2009; Darbyshire et al., 2006; French et al., 2003; Gunner et al., 2019; Leipersberger, 2007; Paradis-Gagné et al., 2022; Perez Jolles et al., 2021; Thorndike et al., 2022; Varley et al., 2020)
Systemic issues in healthcare provision	*The non-care system* *Standard delivery models failing to meet diverse needs*	Inadequacy of the medical/psychiatric model	Limitations of the medical/psychiatric model in addressing the mental health needs of people experiencing homelessness. Perceived overreliance on medication and lack of holistic, person-centred care that considers the context of mental health (impact of social circumstances, housing insecurity). Many felt reduced to a set of symptoms rather than being treated as an individual, and felt labels and diagnoses overshadowed their broader needs and circumstances. View of: “the quicker we label them, the quicker we can get them on medication, the quicker we can get them out of here.” Rushed, “drive-by” assessments and prescribing medication without a meaningful discussion about concerns or preferences, felt impersonal and dismissive. Scepticism of medications, due to side effects and the failure to address “root causes”. Patients expressed preference for non-pharmacological treatment options, but such options are not thought to be accessible. The protocols of psychiatric care, such as isolation during treatment, were felt to be counterproductive and contributed to the view that psychiatric hospitals are "inhospitable", “institutionalising” and like prisons. Desire to avoid.	(Darbyshire et al., 2006; Gilmer, 2020; Kneck et al., 2021; Leipersberger, 2007; Moore-Nadler et al., 2020; O’Carroll & Wainwright, 2019; Parsell et al., 2018; Ramsay et al., 2019; Voisard et al., 2021; Whitley, 2013)

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		Broken medical system designed for financial gain	In studies from the US, there was a cynicism about the healthcare system – that it only exists to make money and prioritises profit over patient care. There was a lack of trust in the medical establishment, and questions around the system's moral compass in relation to the ethical duty of "do no harm", as they felt an inability to pay could lead to neglect, harm, and even fatal outcomes. Some believed healthcare providers often recommended unnecessary treatments or medications purely for financial gain. The high cost of healthcare services was a significant barrier, leading to lack of medical attention, worsening health outcomes, and deepening mistrust in the system.	(Christian et al., 2022; Ramsay et al., 2019; Stanhope & Henwood, 2014; Sweat J et al., 2008)
		Hospitals as exclusionary spaces	Hospitals perceived as exclusionary, stigmatising, and "uninviting places" that made them feel unwelcome, marginalised and like "intrusive visitors" – outsiders rather than patients deserving of care. Hospitals were not perceived as safe and supportive, but "confrontative and threatening" environments, that heightened their vulnerability, "stripped [them] of their dignity" and reinforced social inequities. Belief that staff in emergency departments were not equipped in managing crisis, people "high" on drugs, disorderly behaviour, and using de-escalation techniques. Instead, security staff were involved and were viewed as trying to "provoke" patients, and ended up "escalating" situations, mirroring their experiences with the police. Lengthy wait times, failure to meet need, an incongruence or "collision" of cultures, and the absence of accommodations for people with complex needs highlights that hospitals are "non-inclusive" and poorly designed for marginalised populations and actively contribute to their sense of exclusion and dehumanisation.	(Archard & Murphy, 2015; Ensign, 2004; Kerman et al., 2019; Kneck et al., 2021; Martins, 2008; Nicholas et al., 2016; Nichols & Malenfant, 2022; O'Carroll & Wainwright, 2019; Paradis-Gagné et al., 2022; Purkey & MacKenzie, 2019; Strange et al., 2018; Wen et al., 2007; Wise & Phillips, 2013; Younas et al., 2022)
Systemic issues in healthcare provision	*Patchwork services*	Discontinuity, fragmented services, lack of care-coordination and integration	Fragmented services, poor care coordination, communication and collaboration between services create significant barriers to effective care – both tangible and emotional. Services often operated in silos, with patients having to navigate disconnected systems with little collaboration and poor communication between healthcare, mental health, substance use, and social services. Fragmentation resulted in missed referrals, inadequate follow-up, conflicting advice, and care plans that did not address their interconnected needs. This fragmentation had an emotional impact – people felt bounced between services, abandoned, emotionally drained from "having to tell [their] story over and over again", and were unable to form trusting relationships with healthcare professionals. High staff turnover	(Anastasiya et al., 2024; Archard & Murphy, 2015; Black et al., 2018; Carmichael et al., 2023; Christian et al., 2022; Darbyshire et al., 2006; Gunner et al., 2019; Henderson et al., 2022; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Mc Conalogue et al., 2021; Meehan et al., 2023; Moore-Nadler et al., 2020; Narendorf, 2017; Nicholas et al.,

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			disrupted the development of trust and consistency and led to frustration and disengagement, “You build a relationship, and then they’re gone. You’re back to square one.” Given high levels of past relational trauma, abandonment, losses and estrangements in the population, high staff turnover may emphasise feelings of being unwanted or rejected. Poor or premature discharge planning from hospitals did not consider social care/housing needs and people were often discharged to the street without the necessary conditions to recover: “They knew full well I didn’t have anywhere to go once they discharged me but they discharged me anyways.” A system riddled with gaps, where a lack of continuity, integration and collaboration perpetuates cycles of being let down, poor health, and disengagement.	2016; Nichols & Malenfant, 2022; O’Carroll & Wainwright, 2019; Paradis-Gagné et al., 2023; Perez Jolles et al., 2021; Rae & Rees, 2015; Ramsay et al., 2019; Stanhope & Henwood, 2014; Strange et al., 2018; Thorndike et al., 2022; Varley et al., 2020)
Systemic issues in healthcare provision	*A system that waits for crisis*	Lack of access to preventative healthcare	The lack of access to preventative healthcare forces people into a crisis-driven approach to managing their health where they delay seeking care until health issues become critical/emergencies and can no longer be ignored/neglected. They “endure” their health problems and illnesses and seek care as a “last resort”. Emergency services are often the primary means of addressing health issues. This results in what is described as “inappropriate use” of emergency care, but rather, it should be viewed it as a necessary response to the failings in access to preventative care. Barriers lead to an “endless cycle” of avoidable crisis, where without access to effective preventative care, mental and physical health deteriorates, putting people at risk of involuntary admissions. Long-term issues remain unaddressed, and housing/social instability worsens, further undermining access. Reliance on “underground resourcefulness” (self-medication), to manage health. Systemic barriers (e.g. administrative, attitudinal, logistical) force people to rely on crisis care rather than preventative healthcare, exacerbating health disparities.	(Carmichael et al., 2023; Clark et al., 2020; Darbyshire et al., 2006; Gunner et al., 2019; Henderson et al., 2022; Hudson et al., 2010; Kerman et al., 2019; Martins, 2008; Nichols & Malenfant, 2022; O’Carroll & Wainwright, 2019; Paradis-Gagné et al., 2023; Sweat J et al., 2008; Wise & Phillips, 2013; Woith, 2016)
The homeless experience and community	*Homelessness weathers you physically and emotionally*	Homelessness as a lived event is unhealthy	Homelessness has damaging physical, emotional and psychological effects, leaving both visible and invisible scars. Living on the streets exposes people to constant dangers, trauma, violence, harsh weather, social isolation, and leaves them without basic necessities and hygiene facilities. The unpredictability of where they will sleep, what they will eat, and being vigilant for danger means people operate in survival mode – a state of stress and emotional exhaustion. “You’re constantly outside… the cold, the heat, it wears you down. It makes you crazy.” This way of living directly and indirectly lead to a decline in mental and physical health. I.e. directly through	(Archard & Murphy, 2015; Austin et al., 2021; Carmichael et al., 2023; Clark et al., 2020; Gunner et al., 2019; Hudson et al., 2010; Ingram et al., 2024; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Mc Conalogue et al., 2021; McCabe et al., 2001;

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			exposure, injury, loneliness/isolation, stress and trauma, and indirectly as living on the street made it impossible for them to prioritise health, self-manage health, and increased harmful substance use. Women experience compounded vulnerabilities due to lack of safety, trauma related to gender-based violence, and unmet female health needs. Those in hostels or supported housing felt they had more control over their health but struggled with sleep deprivation, high levels of substance use, and arguments/violence. They acknowledged a ‘‘comfort level’’ in “confining your thoughts and energies to immediate needs” and adapting their mindset to focus on longer-term needs took time.	Narendorf, 2017; Nichols & Malenfant, 2022; O’Carroll & Wainwright, 2019; Parsell et al., 2018; Rae & Rees, 2015; Stanhope & Henwood, 2014; Strange et al., 2018; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Voisard et al., 2021; Whitley, 2013; Wise & Phillips, 2013; Younas et al., 2022)
The homeless experience and community	*Living and surviving on the street* *"Surviving on their own terms"*	Living and surviving on the street: competing priorities	Survival is the main priority for people experiencing homelessness, taking precedence over managing health. Their efforts are spent on meeting basic needs of shelter, food, safety, and income generation. People experience a constant sense of uncertainty and lack of control over their lives. The “chaotic” nature of homelessness, where people have “competing priorities” that force them to make impossible choices, means health-related concerns are consistently pushed to the “bottom of their priority list”. Substance use / addiction compounds this “chaos” and negatively impacts healthcare engagement.	(Austin et al., 2021; Carmichael et al., 2023; Christian et al., 2022; Clark et al., 2020; Gunner et al., 2019; Leipersberger, 2007; MacKinnon et al., 2022; Narendorf, 2017; Nicholas et al., 2016; O’Carroll & Wainwright, 2019; Rae & Rees, 2015; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Voisard et al., 2021; Whitley, 2013; Wise & Phillips, 2013)
		Strengths and values fostered through homelessness	Surviving homelessness forms strengths and values such as resourcefulness, independence, autonomy, ingenuity, resilience, freedom, and the ability to "figure it out" on their own. Living on the streets requires ingenuity and resourcefulness – finding creative ways to meet basic needs, such as sharing medications, over-the-counter remedies, practicing “white lies” (telling providers what they believe they want to hear to get their needs met), being a support resource for one another within social networks, and sharing of information. A sense of freedom in managing their own lives without external constraints. Sense of pride in their independence, self-sufficiency, and resilience to be able to survive. However, these strengths and values may act as barriers to support and healthcare services. For example, the value placed on self-sufficiency means admitting need or asking for help might feel	(Christiani et al., 2008; Hudson et al., 2010; Martins, 2008; McCabe et al., 2001; O’Carroll & Wainwright, 2019; Thompson et al., 2006; Woith, 2016)

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			like a failure in maintaining autonomy or resilience. This is particularly impactful if healthcare staff do not respect their strengths and values. “Paternalistic” or “condescending” staff that try to “do everything for you” were viewed as disregarding of autonomy and independence and leading to frustration and trust issues.	
The homeless experience and community	*Social networks* *“Fragile connections”*	Companionship and looking out for one another	Through being excluded from housed communities, homeless people tend to connect with one another – others who are socially isolated. All struggling “to be” a part of society and accepted as “being-in-the-world.” A sense of solidarity and connection with others who had similar backgrounds, traits, and experiences. Recognition of the impact of mental and physical health issues in their community and people looked out for one another, took care of one another, and provided one another with companionship and mutual support. “[name of other resident] pops up now and again for a chat like, which I like, because me and him go back a long time”. They also share information about available support services through word-of-mouth. These acts of kindness are a buffer against the isolation of homelessness.	(Archard & Murphy, 2015; Christiani et al., 2008; Hudson et al., 2010; Kerman et al., 2019; Moore-Nadler et al., 2020; Perez Jolles et al., 2021; Purkey & MacKenzie, 2019)
		Lack of social support and trust in peers	A lack of trust in social networks – survival meant being cautious and vigilant of others’ intentions so as not to be exploited or taken advantage of. They maintained a “low profile” around peers, and watched what they said in the presence of certain peers. Conflict among peers (bullying, arguments, physical fights, theft) made people feel unsafe. Peer/social groups were not experienced as a source of support and participants did not believe they could depend on friends or other members of the homeless community during tough times. Participants felt they had lost social skills as part of experiencing mental health difficulties. Those who were in recovery from substance use tended to isolate themselves, distancing themselves from peers who were currently using substances to avoid the risk of partaking. The lack of strong social support contributes to social isolation and is linked to worse health outcomes.	(Archard & Murphy, 2015; Kerman et al., 2019; Leipersberger, 2007; Mc Conalogue et al., 2021; Perez Jolles et al., 2021; Thompson et al., 2006; Woith, 2016)
		Perceiving themselves as different from other service users	Perceiving themselves as different/dissimilar from other people experiencing homelessness, based on behaviour, mental health issues, substance use, age, appearance, hygiene and immigration status. This "us vs them" mindset created a sense of division within the homeless community, mirrored the “us vs them”	(Christiani et al., 2008; Ensign, 2004; Hudson et al., 2010; Ingram et al., 2024; Kerman et al., 2019; O’Carroll &

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			separation they experienced from wider society, and created "stigma among the stigmatized". Feel uncomfortable/intimidated around others described as "crazies", "junkies", "out of control", and "wing nuts" – desire to distance themselves from them. This put people off using essential services such as emergency shelters and homeless clinics: "I don't want to be in the same room as the 'crazies'...the people there are just out of control" and "There are tons of people you don't want to deal with there . . . a lot of 'wing-nuts' . . . I don't want to sit in there." Also disapprove and seek separation from those who have a "negative attitude" or seem unmotivated in improving themselves – they view this as hindering their own progress toward stability. Such distinctions were made to maintain a sense of identity and avoid behaviours they did not want to be associated with.	Wainwright, 2019; Thompson et al., 2006)
The homeless experience and community	*Homeless at home*	The physical environment of services as a barrier to safety, comfort, and access	Health, wellbeing, and engagement is affected by the physical environment of homelessness and health services. Shelters viewed as unsafe, chaotic, and unhygienic, and a lack of privacy and being around strangers created feelings of paranoia and vulnerability, leading to avoidance of these spaces. Some people in temporary accommodation had issues with bed bugs, cockroaches, used syringes, and general neglect of the space, which led to a diminished sense of self-worth. "There is still cockroaches everywhere. Nobody says anything, we don't matter." The atmosphere of services also impacted mental health: chaotic, noisy environments disrupted sleep and heightened anxiety and stress. Essential services located in unsafe environments ("back alleys") were avoided due to fear of encountering aggression or violence. Services out of the way so "normal people" would not have to be "exposed" homeless people. Living in hostels/temporary accommodation linked to feeling "homeless at home" and feelings of being disconnected/estranged from others.	(Archard & Murphy, 2015; Ensign, 2004; Hudson et al., 2010; Kerman et al., 2019; Leipersberger, 2007; Mc Conalogue et al., 2021; McDaniel, 2024; O'Carroll & Wainwright, 2019; Thompson et al., 2006; Voisard et al., 2021)
Societal and cultural factors	*Us and Them*	Societal stigma and alienation	Living on the streets is considered an "aberration by societal norms" and homelessness, using drugs, or mental illness are not "value-neutral states". Considered a stigmatising lifestyle – very aware of society's pejorative view of them of "drug abusers", "bad people", "bums". "junkies", "wasters", "psychos". Hyperawareness of other people. Judgements of others expressed through "the gaze" – the relentless stares/glares of the public, or pitying looks from professionals. Interactions with the public sparked feelings of shame, rejection, and alienation.	(Archard & Murphy, 2015; Austin et al., 2021; Darbyshire et al., 2006; Gunner et al., 2019; Hudson et al., 2008, 2010; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Nicholas et al., 2016;

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			View themselves and other homeless people as distinctly "separate" / "different" from society, and "less than" / "second class citizens" – a sense of "us and them". Feel unwanted in wider society and that power structures try to make them invisible. Sense of protest in retaliation to stigma and exclusion in society drives a "go-against attitude". Healthcare structures and interactions were consistent with societal marginalisation. Stories of segregated waiting rooms for those who were visibly homeless or drug users, where they were "ushered" out of sight, reinforcing the stigma and sense of being "less than", and "us versus them". Observed "social triage" where ranking of need/priority is driven by social rather than medical determinants. Belief people of higher social status receive a "different reception" to them (more welcoming). Additional layers of stigma for those with intersecting marginalised identities, including racial discrimination, stigma toward LGBTQ+ individuals, and the stigma of having a criminal record. In mainstream healthcare settings, stigma and exclusion (from professionals are other service users) can prompt "poor behaviour" that leads to banning from services. Societal stigma is internalised, leading to low self-worth and feeling "undeserving", which deters people from seeking care. Further harm through institutionalised discrimination in healthcare. "I hope that before the day that I die, I'll see the homeless being treated [as] more than a second-class citizen. I really do. In the health care system we're treated worse than dirt, and I hope it changes."	Nichols & Malenfant, 2022; Purkey & MacKenzie, 2019; Strange et al., 2018; Thompson et al., 2006; Wen et al., 2007; Wise & Phillips, 2013)
Societal and cultural factors	*Built to exclude*	Structural inequality, exclusion, and discrimination	Social vulnerabilities and structural inequality impact the health experiences and outcomes of people experiencing homelessness. Homelessness as "the tip of the iceberg called poverty". Growing up in deprivation and the stress of poverty exposes people to a higher likelihood of "dysfunctional familial backgrounds" (domestic violence, parental substance use, abuse), foster care, and substance use, increasing a person's vulnerability to homelessness and health problems. Additionally, there is resource inequality between communities, with poorer access to services in poorer areas. However, in healthcare there is little acknowledgment of the SDoH or the need for societal-level change. Structural inequality is reflected in the design and delivery of healthcare services. A "classist", "two-tier" system, "designed by middle class	(Darbyshire et al., 2006; Hudson et al., 2008; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Meehan et al., 2023; Moore-Nadler et al., 2020; Nicholas et al., 2016; Nichols & Malenfant, 2022; O'Carroll & Wainwright, 2019; Parsell et al., 2018; Purkey & MacKenzie, 2019; Ramirez et al., 2022; Stanhope & Henwood, 2014; Sweat J et al., 2008; Whitley, 2013; Wise & Phillips, 2013)

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			people for middle class clients". Experience that people of higher social status are treated better in healthcare and people who can afford to pay receive higher quality care, while those in poverty (especially people experiencing homelessness) receive inadequate and dismissive treatment and have little social power to advocate for themselves. Healthcare systems fail to address the needs of women and racialised communities, and "strip them of dignity". Without structural changes, marginalisation, barriers, and health disparities will remain.	
Societal and cultural factors	*The system is rigged against us*	Policies that perpetuate inequality	Current policies fail to adequately address the underlying causes of homelessness, and the realities of homelessness are not considered, resulting in exclusion and inadequate support. Housing-first approaches are beneficial but are not sufficient on their own; barriers to healthcare and other services often persist even after housing needs are met. Services that address basic needs, while needed, lack mechanisms to address long-term exclusion. Policies that promote the criminalisation of homelessness perpetuate marginalisation and stigmatisation and the "revolving door". Interactions with police viewed as "harassment". "Being homeless is illegal, you get a ticket for just standing on the street...you have cops chasing you...and are very mean...you sit down, they think you are camping out, and they give you a ticket...they find every way to aggravate you to send you to jail." Prison release often leaves people vulnerable to homelessness. Policy decisions around resource allocation for people experiencing homelessness, and current systems (interagency competition for limited resources and resource "gatekeeping") cannot create infrastructure capable of assuring equitable care. Means efficiency is prioritised which excludes people with social vulnerabilities who deviate from the norm.	(Austin et al., 2021; Carmichael et al., 2023; Christian et al., 2022; Henderson et al., 2022; Hudson et al., 2010; Ingram et al., 2024; Leipersberger, 2007; Meehan et al., 2023; Moore-Nadler et al., 2020; Nichols & Malenfant, 2022; Parsell et al., 2018; Rae & Rees, 2015)
Desired solutions to reduce homeless health inequality	*Care that works / Pebbles in the pond*	"I felt like I mattered" (Relationship-based, person-centred, compassionate, longitudinal care)	An approach of relationship-based care where providers foster trust and psychological safety through interactions that embody respect, empathy, genuineness, understanding, reliability, active listening, good communication, compassion, and are non-judgemental, allows patients to feel seen, heard, and valued – "I felt like I mattered". This forms the foundation for engagement. Support with addressing basic needs builds trust and engagement. A therapeutic alliance, that is based on mutual respect, respects patient autonomy through shared decision making, and a tailored approach is valued and can empower people to take	(Anastasiya et al., 2024; Archard & Murphy, 2015; Austin et al., 2021; Black et al., 2018; Carmichael et al., 2023; Chaturvedi, 2016; Christian et al., 2022; Christiani et al., 2008; Clark et al., 2020; Collins & Barker, 2009; Darbyshire et al.,

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			an active role in managing their health. Longitudinal care where there is consistency in healthcare providers, reduces the burden of repeatedly telling their story and facilitates the building of a working alliance.	2006; Ensign, 2004; French et al., 2003; Gunner et al., 2019; Henderson et al., 2022; Hirst & Cuthill, 2021; Hudson et al., 2008; Kerman et al., 2019; King et al., 2020; Kneck et al., 2021; Leipersberger, 2007; MacKinnon et al., 2022; Martins, 2008; McCabe et al., 2001; McCormick, 2022; McDaniel, 2024; Meehan et al., 2023; Moore-Nadler et al., 2020; Nicholas et al., 2016; Paradis-Gagné et al., 2022, 2023; Perez Jolles et al., 2021; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Ramirez et al., 2022; Ramsay et al., 2019; Stanhope & Henwood, 2014; Strange et al., 2018; Taylor et al., 2007; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Voisard et al., 2021; Wen et al., 2007; Whitley, 2013; Wise & Phillips, 2013; Woith, 2016; Younas et al., 2022)
		Systems and service delivery changes to overcome barriers	Service delivery models must be redesigned to effectively meet the needs of people experiencing homelessness. Effective systems must address exclusionary factors such as practical barriers, inflexible time constraints on staff and patients, bureaucracy, fragmentation, and inflexible, high threshold eligibility requirements. Services that address these barriers directly – such as mobile/street clinics, integrating services (e.g., 'one stop shop', co-located care for mental health, substance use, and physical health), on-site clinics within hostels/shelters, and community-based clinics – improve access and help to meet need. Services can be more inclusive, flexible, responsive, and accessible / accommodating to the	(Anastasiya et al., 2024; Archard & Murphy, 2015; Austin et al., 2021; Black et al., 2018; Carmichael et al., 2023; Christian et al., 2022, 2022; Christiani et al., 2008; Clark et al., 2020; Darbyshire et al., 2006; Ensign, 2004; French et al., 2003; Gilmer, 2020; Gunner et al., 2019; Henderson et al., 2022; Hirst & Cuthill, 2021;

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			realities of homelessness by offering flexible or drop-in appointments, informal approaches, and culturally competent practice. Involving peer approaches in service delivery can support this. Inter-service collaboration and communication across organisations (e.g. health, housing, social care) is key and involves coordinating care, sharing information, and ensuring smooth transitions between services to prevent patients from falling through the gaps. Service design to facilitate continuity of care and personalised, longitudinal, relationship-based care is important and may require a philosophical shift from protocols, targets, and system requirements, to focusing on authentic working alliance.	Hudson et al., 2008; Ingram et al., 2024; Kerman et al., 2019; Kneck et al., 2021; Leipersberger, 2007; MacKinnon et al., 2022; McDaniel, 2024; Meehan et al., 2023; Moore-Nadler et al., 2020; Narendorf, 2017; Nicholas et al., 2016; Nichols & Malenfant, 2022; O'Carroll & Wainwright, 2019; Paradis-Gagné et al., 2022, 2023; Parsell et al., 2018; Perez Jolles et al., 2021; Purkey & MacKenzie, 2019; Rae & Rees, 2015; Ramirez et al., 2022; Ramsay et al., 2019; Stanhope & Henwood, 2014; Strange et al., 2018; Sweat J et al., 2008; Taylor et al., 2007; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Voisard et al., 2021; Whitley, 2013)
		Culturally and trauma-informed care and services	Effective care requires healthcare professionals to be understanding and knowledgeable of homelessness issues, culture, trauma, substance use, and SDoH that shape the lives, mental health, and behaviours of people experiencing homelessness. They should work to reduce inequitable power relations, racism, discrimination, and effects of historical and current inequities within healthcare encounters. Training is needed for healthcare professionals and should include inter- and intra-personal skills to address biases and stigma, engage compassionately and effectively, and may be developed during educational training, ongoing professional development and through reflective practice. Service users value feeling understood by people who have been through similar challenges. Employing people with lived experience of homelessness or substance use as staff or peer workers is useful to build understanding, cultural competence, engagement, and trust. Approaches to engagement should be informal, proactive, consistent, and	(Archard & Murphy, 2015; Austin et al., 2021; Carmichael et al., 2023; Chaturvedi, 2016; Clark et al., 2020; Collins & Barker, 2009; Ensign, 2004; French et al., 2003; Gunner et al., 2019; Henderson et al., 2022; Hirst & Cuthill, 2021; Hudson et al., 2008; Ingram et al., 2024; Kerman et al., 2019; King et al., 2020; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Mc Conalogue et al., 2021; McCabe et al., 2001; McCormick, 2022; McDaniel,

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			patient – “not giving up”. Physical and organisational environments impact engagement – thoughtful design, compassionate policies, and trauma-informed practices can help environments to feel inclusive, welcoming and facilitate a sense of safety, comfort, respect and relaxation and encourage engagement. Services that recognise the impact of trauma on emotions/behaviours and are understanding and tolerant to behaviours (e.g. within waiting rooms) can reduce rejection and exclusion.	2024; Moore-Nadler et al., 2020; Nicholas et al., 2016; Paradis-Gagné et al., 2022; Perez Jolles et al., 2021; Purkey & MacKenzie, 2019; Ramsay et al., 2019; Strange et al., 2018; Sweat J et al., 2008; Taylor et al., 2007; Thompson et al., 2006; Varley et al., 2020; Voisard et al., 2021; Wen et al., 2007; Whitley, 2013; Wise & Phillips, 2013; Woith, 2016; Younas et al., 2022)
		Holistic, integrated approach	A holistic approach recognises that health is not just the absence of illness but a state of overall wellbeing, encompassing physical, mental, emotional, and social dimensions. Value of holistic, multidisciplinary, integrated care models that address interconnected issues such as mental health, substance use, housing, nutrition, hygiene and shelter to improve access and engagement. Starting by meeting basic needs first (e.g. housing, food, hygiene) and personalised needs helps to build trust and engagement. Incorporating health education into healthcare provision helps people manage their health, builds self-efficacy, empowerment, engagement and improves health outcomes. “Just having that knowledge makes so much of a difference… you’re more aware to comply and participate with the nurses and the doctor.” Alternative/complementary therapies (e.g. acupuncture) are valued and seen as less intimidating than traditional/western medicine. Incorporating these approaches co-located into services may bridge the gap to services and improve engagement.	(Archard & Murphy, 2015; Chaturvedi, 2016; Christian et al., 2022; Clark et al., 2020; Ensign, 2004; Henderson et al., 2022; Kerman et al., 2019; Kneck et al., 2021; Mc Conalogue et al., 2021; McCormick, 2022; McDaniel, 2024; Moore-Nadler et al., 2020; Nichols & Malenfant, 2022; Paradis-Gagné et al., 2022, 2023; Parsell et al., 2018; Perez Jolles et al., 2021; Ramirez et al., 2022; Strange et al., 2018; Taylor et al., 2007; Thompson et al., 2006; Thorndike et al., 2022; Varley et al., 2020; Voisard et al., 2021; Whitley, 2013; Younas et al., 2022)
		Policy reform	Structural changes in political will, economic resources, and public health policies are needed to address the systemic inequities that perpetuate health disparities for people experiencing homelessness.	(Austin et al., 2021; Carmichael et al., 2023; Christian et al., 2022; Henderson et al., 2022; King et al., 2020; Leipersberger, 2007; MacKinnon et al., 2022;

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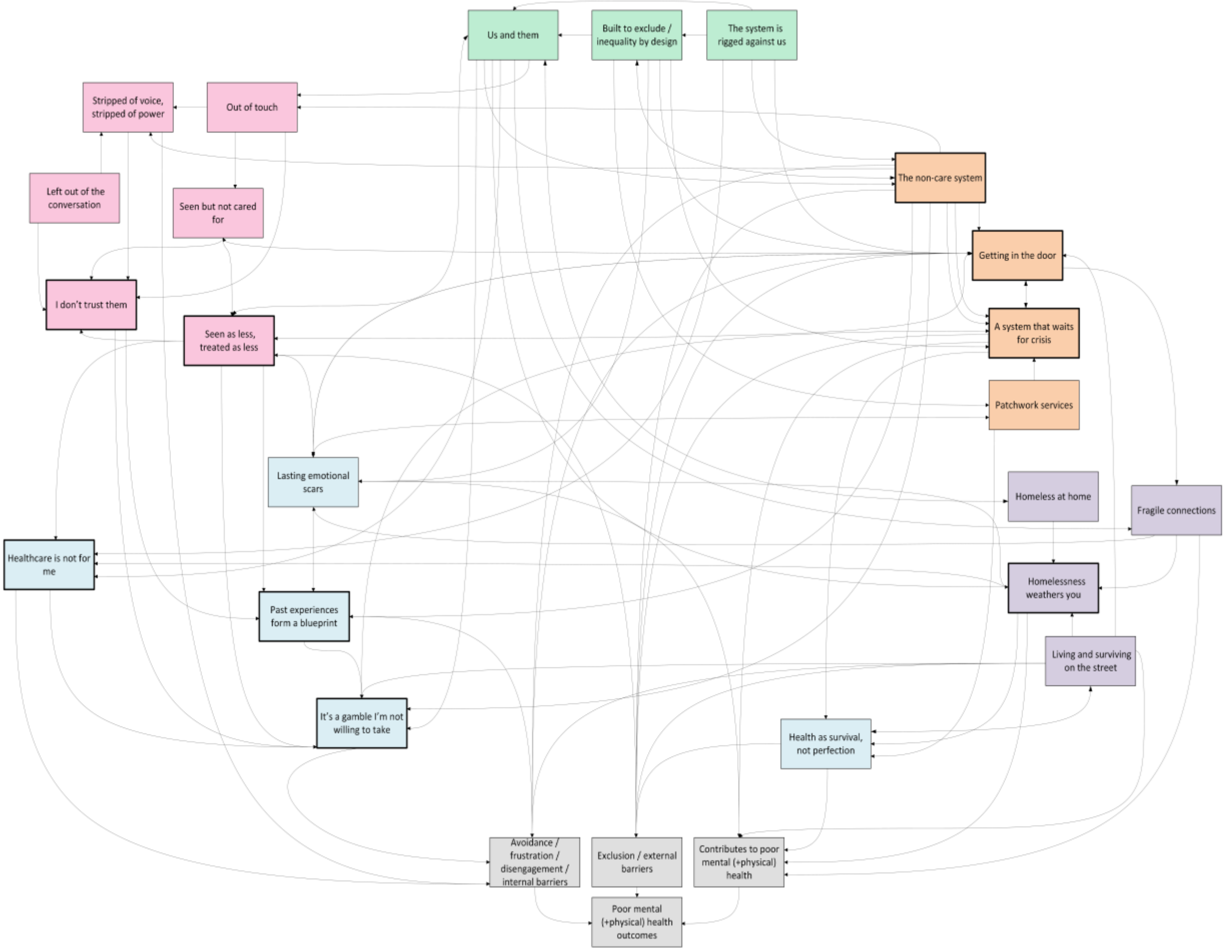
			• Housing is central for stability and to health and wellbeing. Addressing homelessness is an important form of healthcare. Policies that embed healthcare services within supportive housing provide a sustainable model to address both health and housing needs. • There needs to be a shift from punitive to supportive, evidence-based policies to reduce harm and support recovery. This includes removal of policies that create exclusionary barriers, such as sobriety requirements or DNA policies. Plus, decriminalisation and compassionate care such as safe injection sites, crisis response teams, and harm-reduction models. “[We need] safe spots to shoot up.”, “Addicts should get prescriptions from a doctor and go to safe using sites and use. Addiction is an illness” • Policies should address systemic barriers and ensure healthcare is accessible and inclusive for marginalised groups of people. This includes addressing SDoH and in the US this means funding for comprehensive free medical care. • Policies should target risk factors for homelessness such as ACEs, poverty, and systemic racism to prevent homelessness and improve long-term health outcomes. • Policies should also support training for healthcare staff and systems to practice trauma-informed, culturally competent care to help to break the cycle of rejection, exclusion, and traumatisation. • Healthcare institutions and professionals should use their power and influence to lobby for equitable access to care and systemic changes.	Martins, 2008; Mc Conalogue et al., 2021; McCormick, 2022; McDaniel, 2024; Nicholas et al., 2016; O’Carroll & Wainwright, 2019; Parsell et al., 2018; Ramsay et al., 2019; Stanhope & Henwood, 2014; Sweat J et al., 2008)
		Fighting and reducing stigma	Stigma shapes identities, healthcare experiences, and outcomes for people experiencing homelessness. • A culture where there is parity between mental and physical health would help to reduce stigma around seeking help for mental health problems and help to shift public attitudes. Policies that promote institutional	(Chaturvedi, 2016; French et al., 2003; King et al., 2020; Kneck et al., 2021; Leipersberger, 2007; Martins, 2008; Stanhope & Henwood, 2014)

Contextual level to frame synthesis	Key metaphor	Key concepts (second order constructs)	Definition of concept / third order constructs (translated first and second order constructs)	Papers that include the concept
			stigmatisation of mental illness (e.g. benefit award decisions or health insurance decisions) should be reviewed. • Addressing societal stigma of mental illness and homelessness through normalisation and public awareness/education may help to reduce stigma around these issues. • Healthcare professionals should advocate for people experiencing homelessness to receive respectful, dignified care, and challenge/confront discriminatory behaviours among their peers and within systems • Interventions and opportunities for people experiencing homelessness to develop identities outside of homelessness/mental illness/addiction may help to deconstruct stigmatised identities. They may also help the public to see people experiencing homelessness as more than their stigmatised identities. (e.g. engaging in/disseminating creative pursuits).	

Appendix F Line of Argument Synthesis

Figure F1

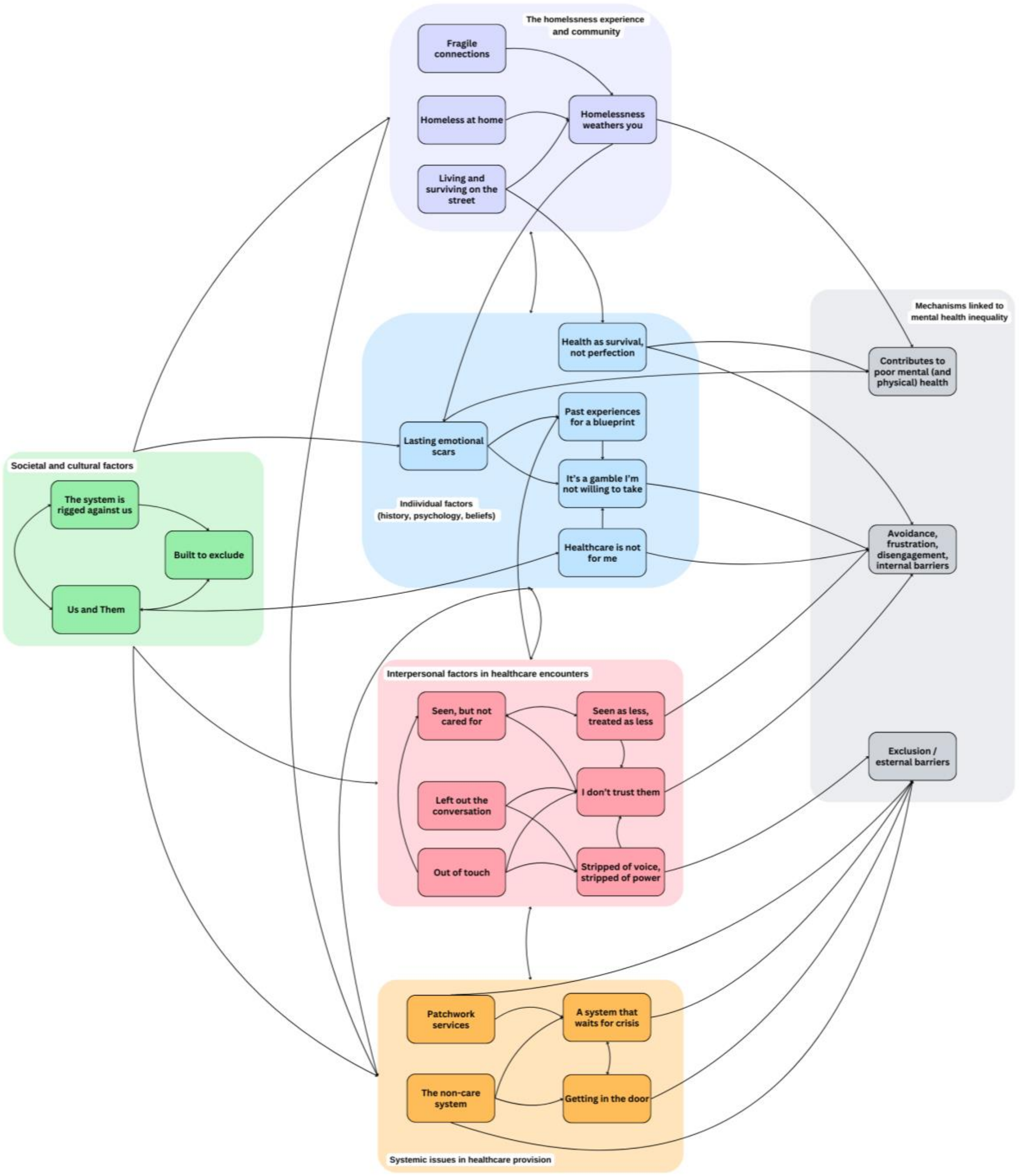
Model Development – Iteration 1



Note. Relationships between key concepts and links to the mechanisms maintaining mental health inequality. The different colours represent the different contextual groups.

Figure F2

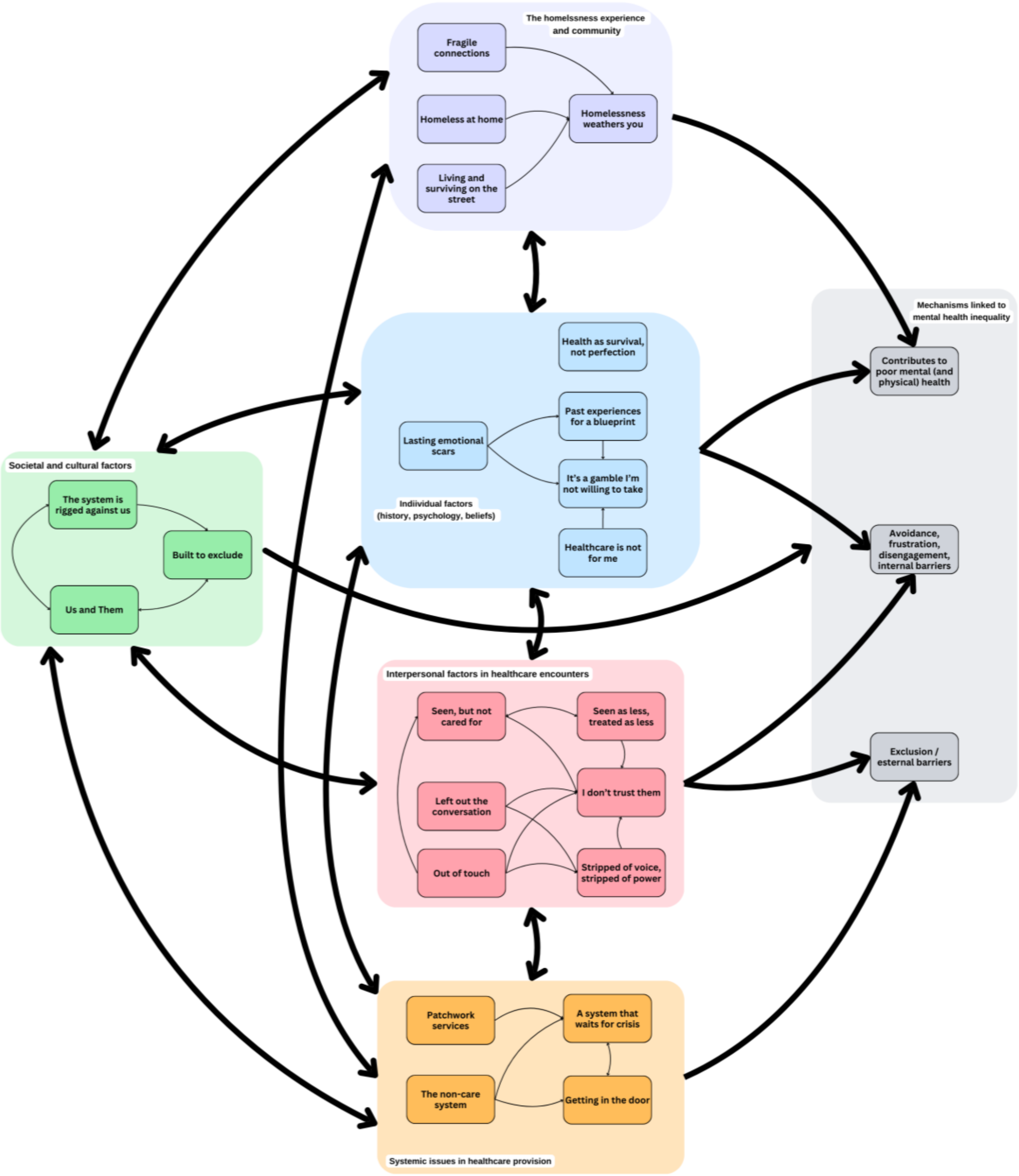
Model Development – Iteration 2



Note. Simplified relationship diagram showing the key relationships between concepts and their contextual groups and the links to the mechanisms maintaining mental health inequality.

Figure F3

Model Development – Iteration 3



Note. Further simplified diagram showing the direction of the relationships between concepts groups and the mechanims, with a particular focus on the direction of the relationships.

Figure F4

Initial Development of the 'Cog' Model

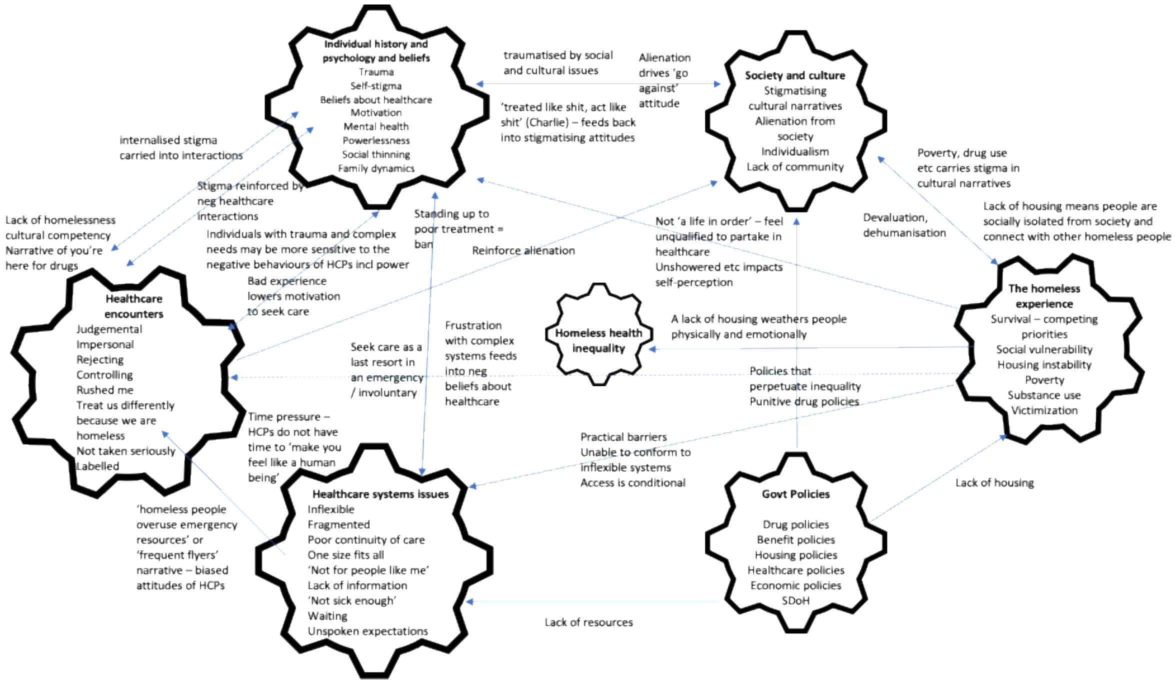


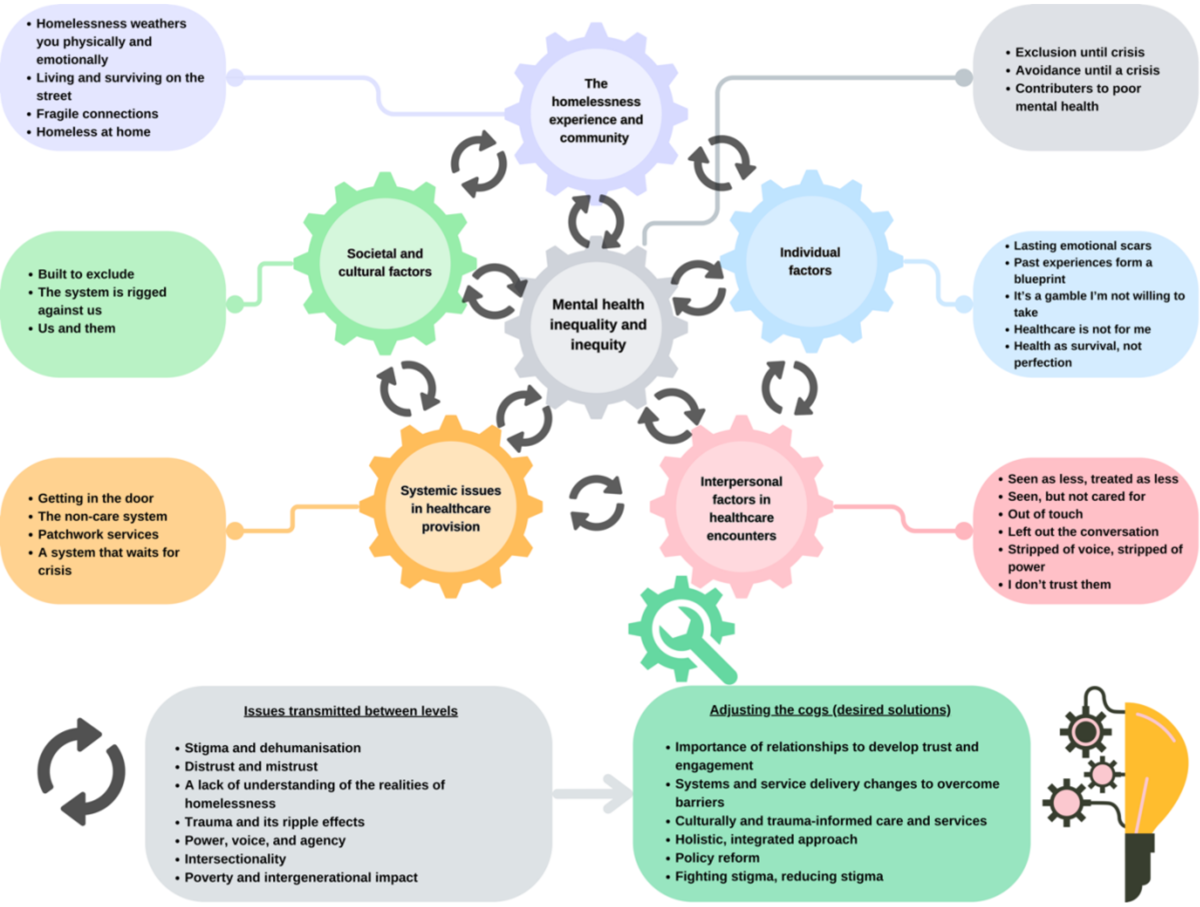
Figure F5

Model Development - Iteration 5

Note. Interlinking cogs for each of the concept groups represent the bi-directional relationships and how they interact to maintain mental health disparities. Labels show the key concepts.

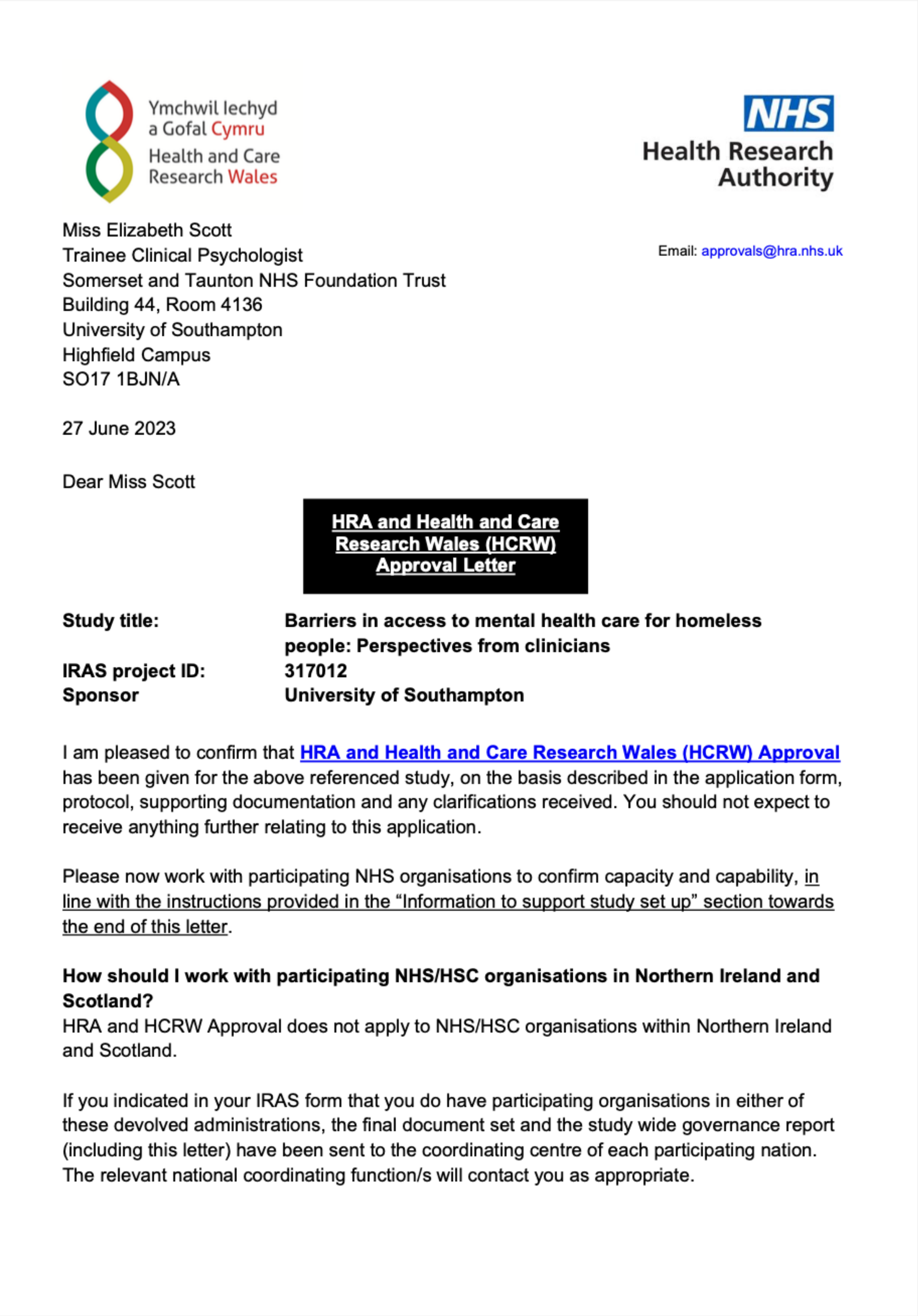
Figure F6

Model Development - Iteration 6



Note. Interlinking cogs for each of the concept groups represent the bi-directional relationships and how they interact to maintain mental health disparities. Labels show the key concepts.

Appendix G Ethics Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Miss Elizabeth Scott
Trainee Clinical Psychologist
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Building 44, Room 4136
University of Southampton
Highfield Campus
SO17 1BJN/A

Email: approvals@hra.nhs.uk

27 June 2023

Dear Miss Scott

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Barriers in access to mental health care for homeless people: Perspectives from clinicians**
IRAS project ID:	**317012**
Sponsor	**University of Southampton**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

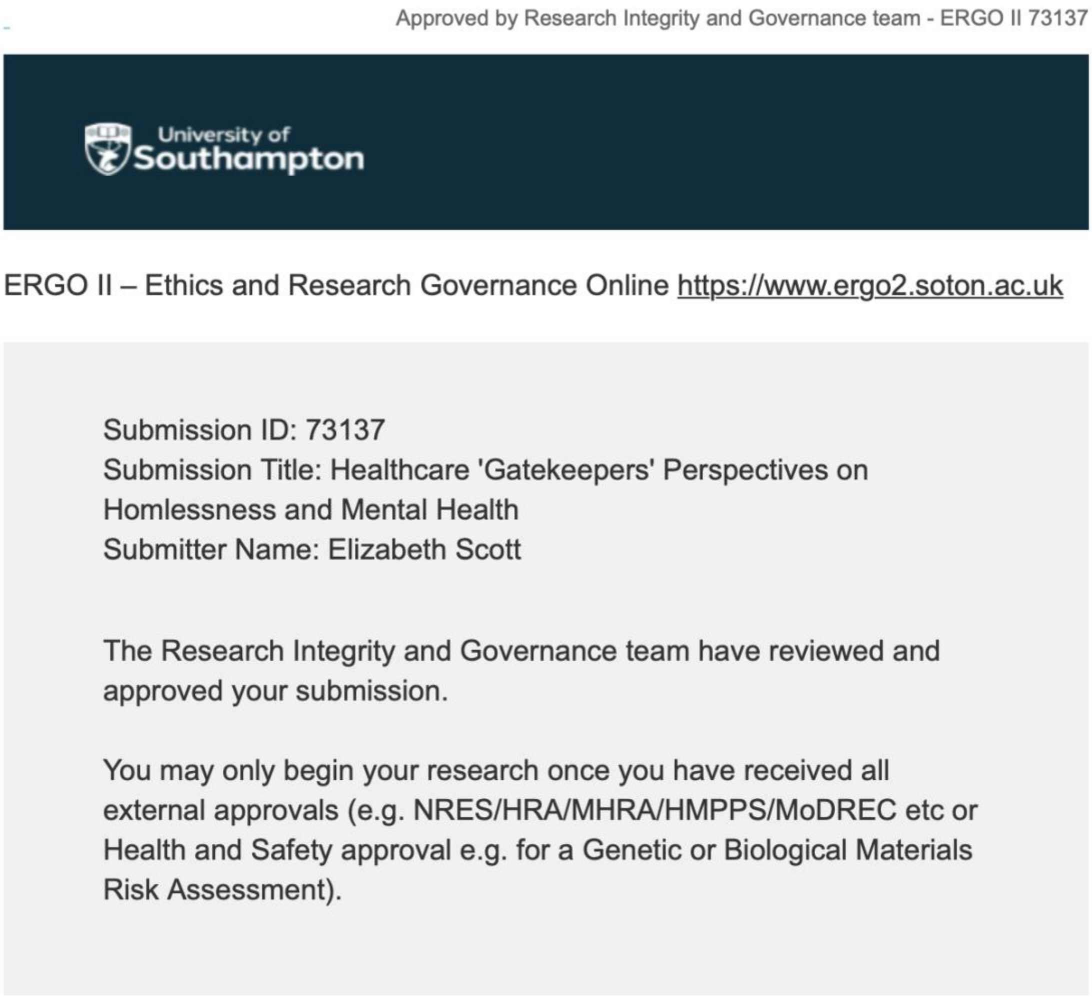
Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix G



Approved by Research Integrity and Governance team - ERGO II 73137

University of Southampton

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 73137
Submission Title: Healthcare 'Gatekeepers' Perspectives on Homlessness and Mental Health
Submitter Name: Elizabeth Scott

The Research Integrity and Governance team have reviewed and approved your submission.

You may only begin your research once you have received all external approvals (e.g. NRES/HRA/MHRA/HMPPS/MoDREC etc or Health and Safety approval e.g. for a Genetic or Biological Materials Risk Assessment).

Appendix H Interview Topic Guide

Interview schedule

Barriers in access to mental health care for homeless people: Perspectives from clinicians

1. Experience of working with people experiencing homelessness

What is your experience of working with homeless people?

- How regularly do homeless people present to your service?
- Do you have examples of how homeless people present in your service?

What training, (if any), have you had about homelessness?

2. Perspectives about homelessness

What do you think the causes of, or contributing factors to homelessness are?

- What do you think keeps some people 'stuck' in homelessness?

What are some of the challenges you've faced when working with homeless people within your service?

- How have these experiences influenced your views about homelessness?

How do your perspectives about homelessness influence your practice?

3. Role of NHS mental health services in supporting people who are homeless

What do you think about the relationship between homelessness and mental health?

- What influences your view on this?

What role do you think mental health services play in supporting homeless people?

- What influences your view on this?

What role do you think the NHS has in supporting homeless people?

- What influences your view on this?

4. Views on barriers to accessing mental health services for homeless people

What do you think are some of the challenges the NHS faces in providing care for homeless people?

Why do you think some homeless people are not able to access/engage with mental health services?

- What influences your view on this?

What do you believe some of the systemic barriers are that homeless individuals face in accessing mental health services?

- How do you think these barriers impact the provision of care to homeless people?

As a clinician, what are some of the systemic barriers you face when working with homeless people?

- [Do you] / [are you able to] / [how do you] make adaptations for people's needs? (E.g. around choice/control/ flexibility?)

5. Thoughts around potential solutions / recommendations

What would help you to feel more effective in your work with homeless people?

In your experience, what has helped (or what would help) with reducing barriers to access/engagement?
How could services be improved to accommodate the needs of people experiencing homelessness?
What systemic changes or policy recommendations would help improve the provision of mental health services for homeless individuals?

6. Closing

Anything else that would be helpful to add?
Any questions for me?

Appendix I Theme Development

Figure I1

Process of Developing Themes

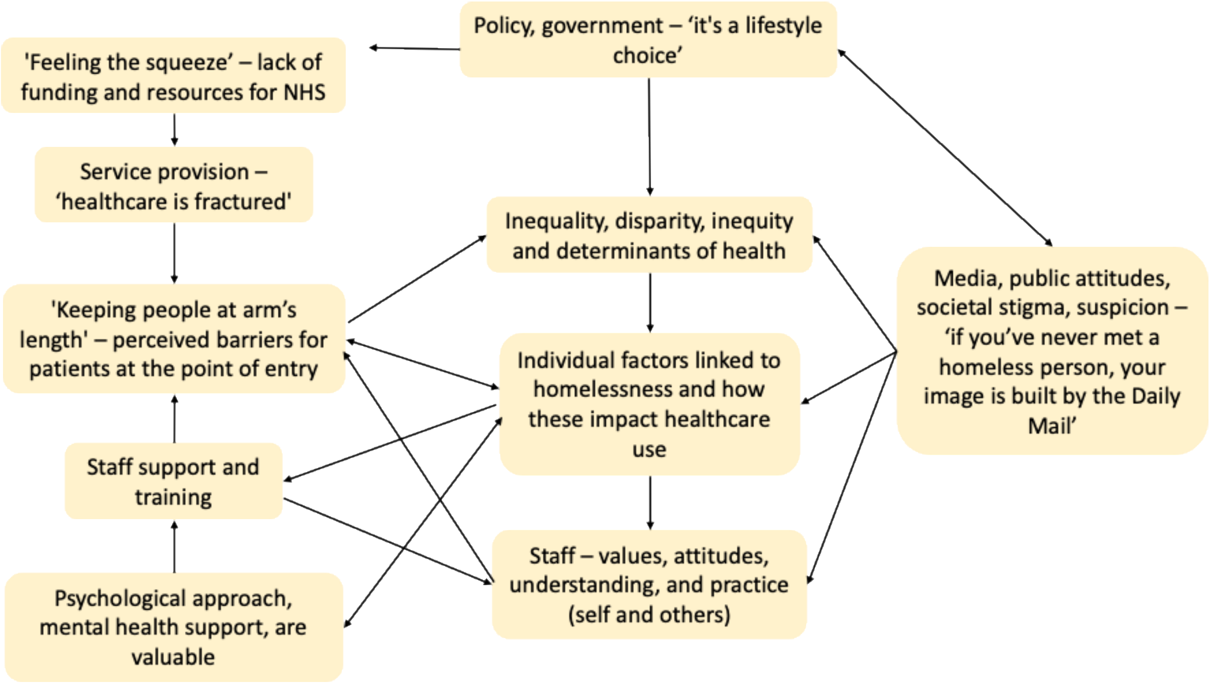


Figure I2

Process of Developing Themes

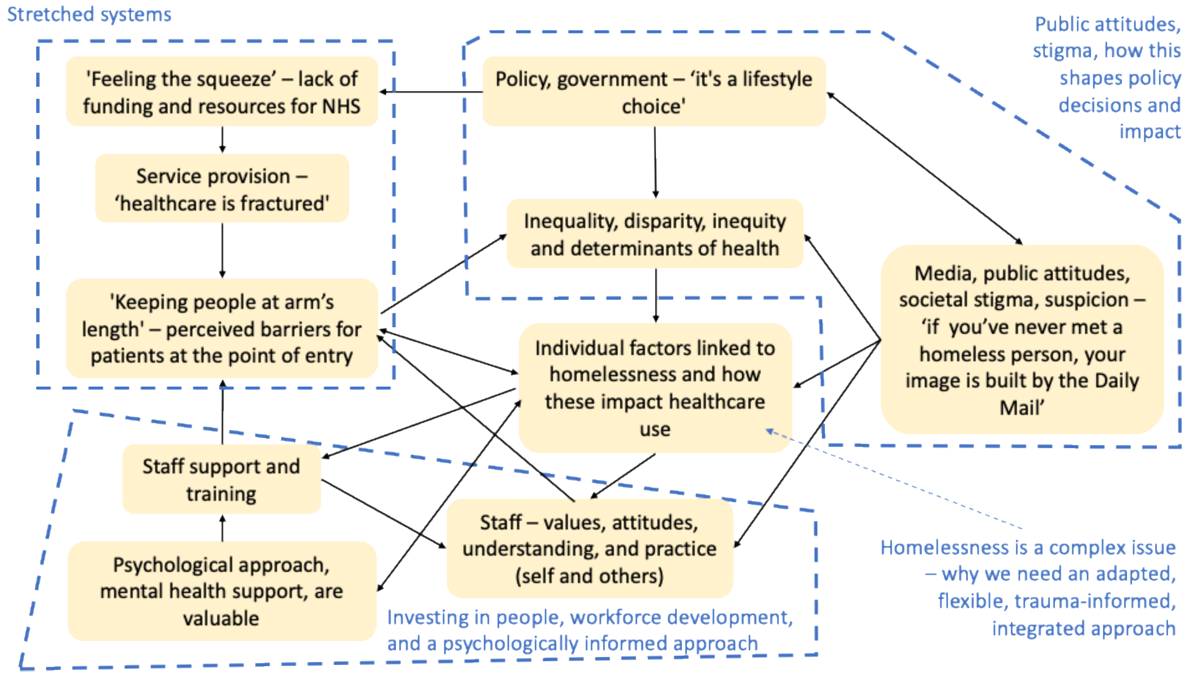


Figure I3

Process of Developing Themes

Figure I4

Process of Developing Themes

Figure I5

Process of Developing Themes

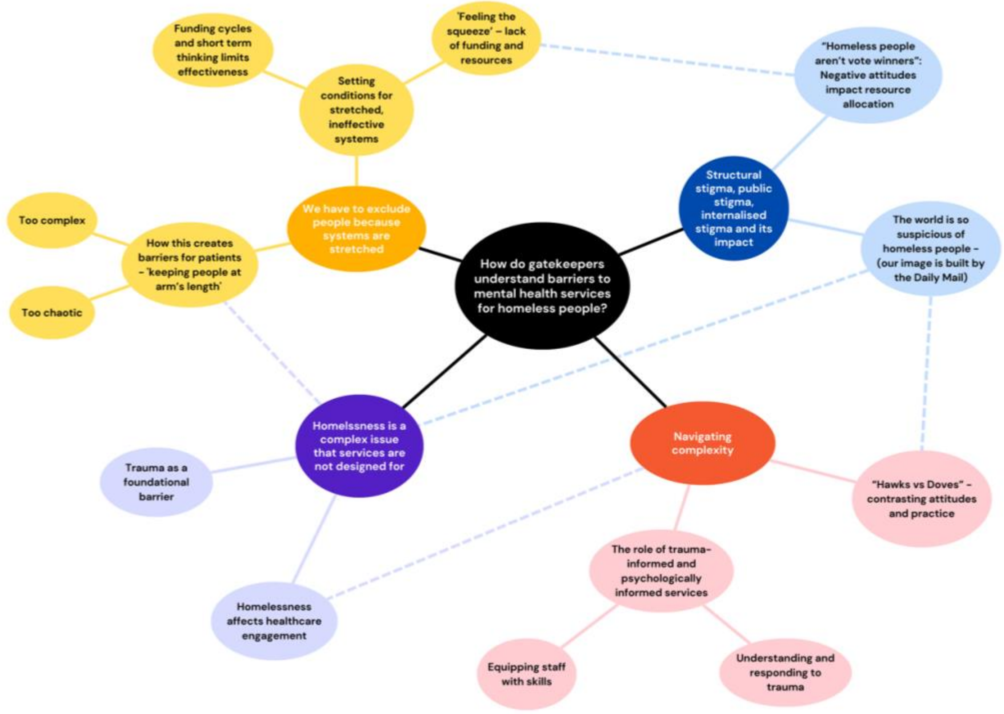


Figure I6

Process of Developing Themes

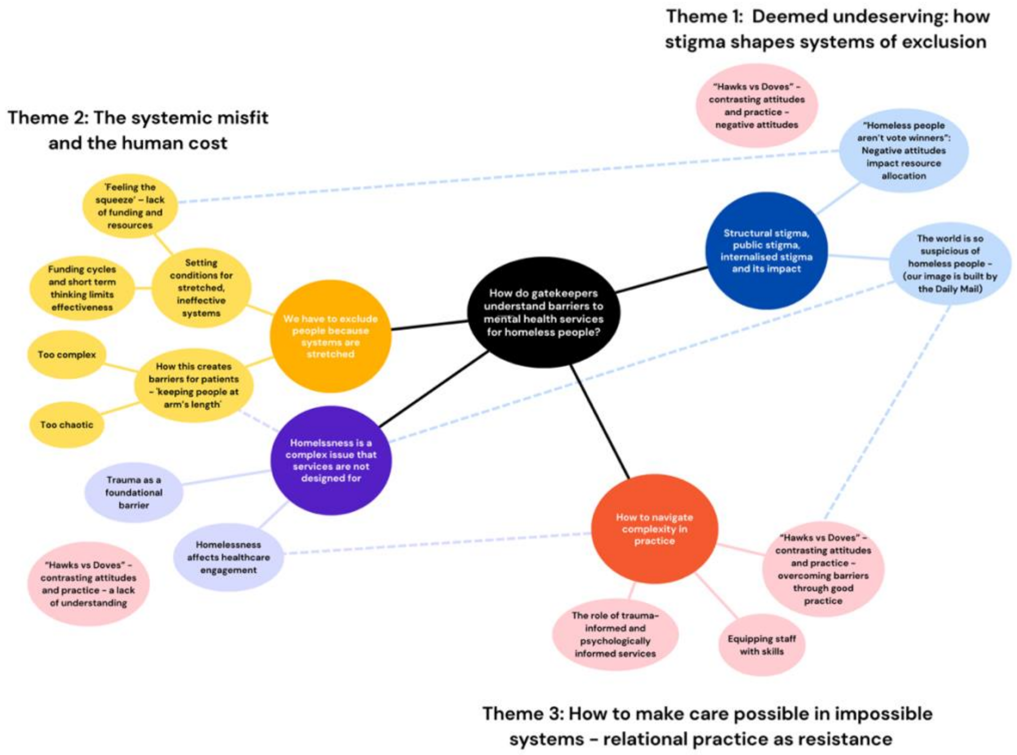
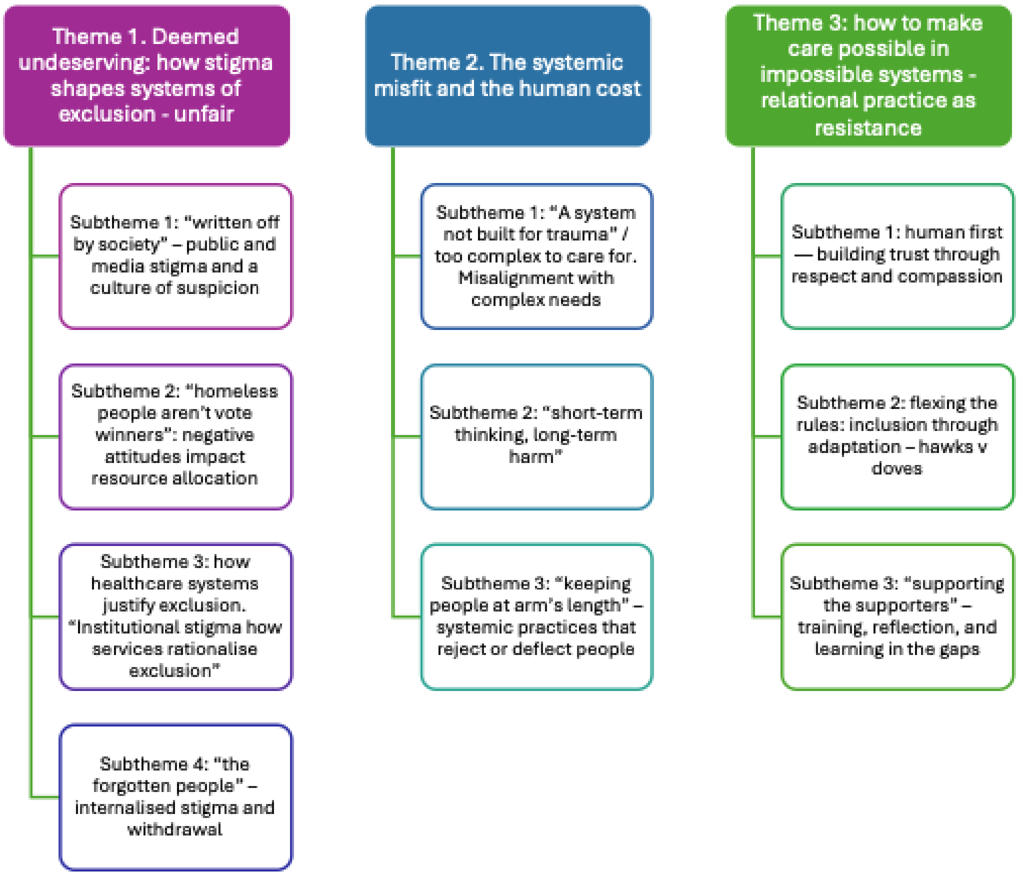


Figure I7

Process of Developing Themes



Appendix J Author Guidelines for Chosen Journals

J.1 Chapter 1 – International Journal of Qualitative Studies on Health and Well-being

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

We offer a range of editing, manuscript preparation and post publication services to assist you in preparing your manuscript for submission, increase your chance of acceptance, or broaden the readership of your article. General guidance on every stage of the publication process is available at our Author Services website.

About the Journal

International Journal of Qualitative Studies on Health and Well-being is an Open Access international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Open Access means you can publish your research so it is free to access online as soon as it is published, meaning anyone can read (and cite) your work. Please see our guide to Open Access for more information. Many funders mandate publishing your research open access; you can check open access funder policies and mandates here.

Please note that this journal only publishes manuscripts in English.

International Journal of Qualitative Studies on Health and Well-being accepts the following types of articles:

- Research Article
- Review Article
- Letter to the Editor
- Editorial

- Methods
- Data Notes

CRediT

ZQHW has adopted the CRediT taxonomy and authors are now required to complete the CRediT taxonomy.

ZQHW has adopted the CRediT taxonomy and authors are now required to complete the CRediT taxonomy when providing author contributions for all submissions. Should you have any queries, please visit our Author Services website or contact us here. Alternatively, you can contact the Editorial Office at: QQHW-peerreview@journals.taylorandfrancis.com.

Preparing Your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

ZQHW publishes Research Article, Review Article, Letter to the Editor, Editorial, Methods and Data Notes.

Format-Free Submission

Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), PDF, or LaTeX files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

- There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, and references. Further details may be requested upon acceptance.
- References can be in any style or format, so long as a consistent scholarly citation format is applied. For manuscripts submitted in LaTeX format a .bib reference file must be included. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.

- The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.
- Spelling can be US or UK English so long as usage is consistent.

Note that, regardless of the file format of the original submission, an editable version of the article must be supplied at the revision stage.

Checklist: What to Include

1. **Author details.** Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) requirements for authorship is included as an author of your paper. Please ensure all listed authors meet the Taylor & Francis authorship criteria. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. **CRediT Roles.** From February 2025, this journal collects CRediT roles as part of the submission process and includes them on published articles when supplied by the authors. You may be required to provide CRediT roles (contributor details) for yourself and your co-authors. For more information about CRediT visit Author Services.
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4. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming. Taylor & Francis Editing Services provides a video abstract creation service for a fee.

5. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
   For single agency grants
   This work was supported by the [Funding Agency] under Grant [number xxxx].
   For multiple agency grants
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

6. **Disclosure statement.** This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. Further guidance on what is a conflict of interest and how to disclose it.

7. **Author Contributions statement.** Please provide an author contributions statement at the end of your article, before the references, that outlines which author(s) were involved in the conception and design, or analysis and interpretation of the data; the drafting of the paper, revising it critically for intellectual content; and the final approval of the version to be published; and that all authors agree to be accountable for all aspects of the work.

8. **Biographical note.** Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g. no more than 200 words).

9. **Data availability statement.** Authors are required to provide a data availability statement, detailing where data associated with a paper can be found and how it can be accessed. If data cannot be made open, authors should state why in the data availability statement. The DAS should include the hyperlink, DOI or other persistent identifier associated with the data set(s), or information on how the data can be requested from the authors. Templates are also available to support authors.

10. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

11. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. Articles with

extenders, such as infographics or video summaries, are up to 108% more likely to be downloaded (based on data in May 2024 from Plain Language Summary of Publication and Clinical Trial Protocol articles published in Future Oncology in 2023). We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article. Taylor & Francis Editing Services can help you create research promotion materials, including infographics, video abstracts, lay summaries and graphical abstracts, to support your article's impact. For more information, including pricing, visit this website.

12. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

13. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

14. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

15. **Units.** Please use SI units (non-italicized).

Disclosure Statement

Please include a disclosure statement, using the subheading "Disclosure of interest." If you have no interests to declare, please state this (suggested wording: *The authors report there are no competing interests to declare*). For all NIH/Welcome-funded papers, the grant number(s) must be included in the declaration of interest statement. Read more on declaring conflicts of interest.

J.2 Chapter 2 – Journal of Community and Applied Social Psychology

MANUSCRIPT CATEGORIES AND REQUIREMENTS

JCASP publishes articles in a range of formats, including:

- **Research papers** which report quantitative, qualitative and mixed methods studies.
- **Meta-analyses and review articles** which survey theoretical developments or topics of major interest.
- **Commentaries** on new ideas, initiatives, or interventions, and commentaries on social, environmental, legal, medical, educational or administrative developments from a community and applied social psychology perspective.
- **Book reviews** (see Book Review Submission section)

Debates and commentaries arising from the research and review articles are warmly welcomed and published as part of that section of the Journal.

Submissions should be as concise as is consistent with clear exposition of the subject matter. Manuscripts should not exceed **10,000 words.** The word count includes abstract, references and tables. The word limit is 10,000 words for meta-analyses and review articles as well.

Short Papers of no more than 2,000 words in length are encouraged. Research papers, Innovations in practice and Commentaries are all welcome in the Short Paper section. Submissions will be reviewed as is standard practice, but it is anticipated that the reviewing and publication process will be of shorter than average duration than for longer papers.

Free Format submission

The Journal of Community and Applied Social Psychology now offers Free Format submission for a simplified and streamlined submission process. Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.

- An ORCID ID, freely available at https://orcid.org.
- The title page of the manuscript, including:
    - Your co-author details, including affiliation and email address.
    - Statements relating to our ethics and integrity policies, which may include any of the following
        - data availability statement
        - funding statement
        - conflict of interest disclosure
        - ethics approval statement
        - patient consent statement
        - permission to reproduce material from other sources
        - clinical trial registration

Important: the journal operates a double-anonymized peer review policy. Please anonymise your manuscript and supply a separate title page file.

REVISED SUBMISSION REQUIREMENTS

Parts of the Manuscript

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

Title Page

The title page should contain:

The full title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);

A short running title of less than 40 characters;

Data Availability Statement;

The full names of the authors;

The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

Conflict of Interest statement;

Acknowledgments. (Sponsor(s) of the research, if any, and grant number(s) should be included here.) Acknowledgements should be placed on the title page rather than in the main text.

Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page. The title page is not sent to reviewers.

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

Authorship

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

Acknowledgments

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

Main Text File

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

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx).

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations

- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments;
- Abstract structured (intro/methods/results/conclusion) or unstructured
- Up to seven keywords;
- Main body
- References;
- Tables (each table complete with title and footnotes);
- Figures: Figure legends must be added beneath each individual image during upload AND as a complete list in the text.

Abstract

An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. Please provide an abstract of no more than 200 words for a full-length article, or around 50 words for a short paper. No abstract is needed for a book review.

Keywords

Please provide up to ten keywords (see Wiley's best practice SEO tips).

References

References in published papers are formatted according to the Publication Manual of the *American Psychological Association* (6th edition) and this is the preferred reference style. However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Footnotes

Footnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep footnotes brief; they should contain only short comments tangential to the main argument of the paper and should not include references.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

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

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Data Sharing and Data Accessibility

This journal expects data sharing. Review Wiley's Data Sharing policy where you will be able to see and select the data availability statement that is right for your submission.

Data Citation

In recognition of the significance of data as an output of research effort, Wiley has endorsed the FORCE11 Data Citation Principles and is implementing a mandatory data citation policy. Wiley journals require data to be cited in the same way as article, book, and web citations and authors are required to include data citations as part of their reference list.

Data citation is appropriate for data held within institutional, subject focused, or more general data repositories. It is not intended to take the place of community standards such as in-line citation of GenBank accession codes.

When citing or making claims based on data, authors must refer to the data at the relevant place in the manuscript text and in addition provide a formal citation in the reference list. We recommend the format proposed by the Joint Declaration of Data Citation Principles:

[dataset] Authors; Year; Dataset title; Data repository or archive; Version (if any); Persistent identifier (e.g. DOI)

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

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

General Style Points

The following points provide general advice on formatting and style.

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement**: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Numbers**: numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names**: Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name,

mentioning the proprietary name and the name and location of the manufacturer in parentheses.

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List of References

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