“Combined with homelessness, it’s just a nightmare”: A Qualitative Study Exploring How People Experiencing Homelessness Perceive Mental Health and Mental Health Services

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Abstract_ *People experiencing chronic homelessness (PECH) have relatively poor mental health. Whilst trauma and psychologically informed services are becoming more commonplace and demonstrate positive outcomes, they are still underutilised by PECH. Furthermore, little is known about how PECH understand their own mental health. This qualitative study explores PECH’s perceptions of mental health, mental health services, and any perceived barriers or facilitators to access. Eleven PECH participated in semi-structured interviews. Interpretative Phenomenological Analysis was used to make sense of the transcripts, and five overarching group experiential themes were created: ‘Origins of Mental Health’, ‘Understanding of Mental Health Difficulties’, ‘Experiences of Help-Seeking and Services’, ‘Self-help and Self-preservation’, and ‘Perspectives on Mental Health Needs’. Participants understood their mental health in terms of life experiences and expressed a need for interpersonal connection over traditional psychological or psychiatric model-specific interventions, suggesting that attachment-informed support may be beneficial. Whilst policies begin to acknowledge the importance of outreach services and flexible person-centred support, as yet this does not go far enough; participants perceptions of services were based on, often negative, past experiences, with many feeling that the damage was already done. Services need to be proactive in identifying people who need support, taking a non-judgemental stance, and working to rebuild trust.*

Key words_ *mental health; homelessness; service provision; mental health support; intervention*

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Introduction

Heightened rates of poor mental health in people experiencing homelessness (PEH) are well documented and prevalence of mental health diagnoses are higher than in the general population (Barry et al., 2024). In a recent study by Hertzberg and Boobis (2022), 82% of PEH reported having a diagnosed mental health issue, compared to 12% of the general population, and a dual-diagnosis was reported by 25%. The Government report, 'Health Matters, Rough Sleeping' (Public Health England, 2020) acknowledges that common mental health conditions are twice as high for PEH, with psychosis 15 times as prevalent. These heightened rates suggest a level of complexity that public health and local policies need to take into account (Gutwinski et al, 2021) in order to provide adequate levels of mental health support. However, research biases from single-point data captures may skew diagnostic rates, as people who enter-and-exit homelessness briefly and as a one-time event may not have the same mental health complexities as those who have long-term experiences of homelessness (O'Sullivan et al., 2020). Instead, a bi-directional understanding of the link between mental health and homelessness may be helpful (Ridley et al., 2020), acknowledging individual difficulties, the impact of homelessness itself, and the impact of health and social inequalities over the life span.

The mortality rate in PEH is higher (Office for National Statistics [ONS], 2022) and continues to grow each year, with health inequalities widening (Jackson et al., 2024); 44.6% of deaths were related to problematic substance use, whilst 13.5% were due to suicide. Lui and Hwang (2021) discussed the need to understand high mortality rates, not just in terms of the health and environmental challenges that PEH experience, but in the context of the structural barriers and social burdens they face. Despite poorer health outcomes for those who have long-term histories of homelessness, PEH are frequent attendees at Accident & Emergency departments for both physical and mental health crises (British Red Cross, 2021) and it may be that opportunities to offer support are being missed. Omerov et al.'s (2020) systematic review of PEH's experiences of health and social care services reports how PEH experienced difficulties in service access and discrimination, as well as having to prioritise their basic needs; although none of the included literature focused on mental health services, the results may be transferable, but the issue remains that little is known about how PEH experience statutory mental health services and why they may not be being utilised before crisis point.

Causes of homelessness

Despite government policies aimed to reduce homelessness, e.g., the Homelessness Reduction Act 2017 (UK Public General Acts, 2017), homelessness is still on the rise within the United Kingdom, both for street-based sleepers and those in temporary accommodation (Department for Levelling Up, Housing and Communities [DLCH], 2024a; DLCH, 2024b), although these figures may not show the true extent as they miss 'hidden' homelessness, e.g., sofa-surfing. People can initially become homeless for numerous personal reasons, including relationship breakdowns, unemployment and redundancy, and mental health difficulties (Piat et al., 2015), alongside the impact of the recent cost of living crisis (Allard, 2022) and the needs of people who experience homelessness briefly, may be different from those who remain homeless (O'Sullivan et al., 2020). Despite this, Fountain and Howes (2019) report that two thirds of their participants named problematic substance use as the primary catalyst for becoming homeless. Their report considers the complex relationship between homelessness and substance use; becoming homeless may be a direct trigger for substance use, and rates of substance use increase the longer someone remains homeless, both as an individual survival mechanism and through the social influence of peer relationships. Substance use has also been linked to offending behaviours which can result in custodial sentences (Butler et al., 2024), perpetuating cycles of homelessness. Such adversity leads to a sense of marginalisation, stigma, and separation (Sibthorp-Protts et al., 2023), impacting negatively on mental health.

Media messages that homelessness can happen to anyone are not entirely true, with childhood poverty and experiences such as early drug use, trauma, and time in care, increasing the likelihood (Bramley and Fitzpatrick, 2018), as well as over-representation of ethnic minorities and people with disabilities (ONS, 2023). A recent report in Wales, UK, showed that PEH were more likely to have experienced adverse childhood experiences (Grey and Woodfine, 2019), with 50% of PEH reporting four or more, which is consistent with international figures (Lui et al., 2021). The impact of a difficult early life is more likely to lead to complex homelessness and social exclusion (Fitzpatrick et al., 2013), as well as an increased risk of victimisation or criminal justice involvement (Edalti et al., 2017), problematic substance use, mental health difficulties, and self-directed and interpersonal violence (Hughes et al., 2017). The needs of people who briefly become homeless may be different from those who remain homeless (Johnson and Chamberlain, 2011) and multiple stressful life events, along with problematic substance use and health-related issues, leave people more vulnerable to multiple episodes of homelessness (Roca et al., 2019). Nine in 10 PEH have experienced violence, abuse, or theft on the streets (Sutton-Hamilton and Sanders, 2023), and therefore the duration of homelessness both increases risk and feeds into a pattern of traumatisation across the lifespan.

Mental health and homelessness

The National Institute for Health and Care Excellence [NICE] has produced guidelines to support the access of health and social care services for PEH (NICE, 2022), but the evidence-base is predominantly randomised control trials and studies based in the United States (NICE, 2022), which has different healthcare systems to the UK. A participatory action research study by Rogers and Evans (2023) questioned what practical recommendations could be given to counsellors working with PEH; although also based in the USA, they highlighted the importance of trauma-informed services, relational connection, collaborative working, and understanding both the trauma and sense of agency for PEH. Although the benefit of designing psychologically and trauma-informed services for PEH has been well documented in the UK (Williamson and Taylor, 2015; Phipps et al., 2017), they focus on hostels, rather than statutory services. Conolly (2018) shows the importance of adapted mental health services and there is a growing literature on the benefits of psychological therapies for PEH (e.g., Hyun et al., 2020; Song et al., 2021) but aspects of homelessness, such as lack of sleep (Huynh et al., 2024), may impact the benefit of structured approaches. A recent systematic review highlights the potential benefits of cognitive-behavioural therapy and motivational interviewing interventions (Bodley-Scott et al., 2024), but the domination of medical diagnoses of 'mental illness' narrows the scope of research to targeted interventions designed to reduce symptom levels. Alternative models, such as The Power Threat Meaning Framework (Johnstone et al, 2018), that focus on formulating problems in a social and developmental context remain under-researched, yet may have much to offer to those who have been disadvantaged from childhood.

Many PEH have engaged with mental health services prior to experiencing homelessness (Drife, 2025), but this traditional support does not appear to be a preventative measure. The importance of our early attachment relationships is well established (e.g., Bowlby, 1969), and childhood abuse increases the likelihood of difficulties in relationships later in life (Unger and De Luca, 2014). In a recent systematic review, the majority of PEH had insecure types of attachment (Neves-Horácio et al., 2023), which is often expressed by being mistrustful or fearful of close relationships. Western homeless populations have higher rates of childhood sexual and physical abuse (Sundin and Baguley, 2015), although there are gender and age differences; these abuses inevitably represent a violation of trust in carers and increase the potential for developing PTSD symptoms (Taylor et al., 2022). As a consequence, PEH are likely to have difficulty building the secure relationships they need to support them. This double jeopardy, stemming from early insecure attachment, may impact therapeutic relationships (Bucci et al., 2016; Talia et al., 2019) and the levels of emotional safety PEH seek from those involved in their care

(Sochos, 2023). This inherent difficulty with seeking appropriate help (Rea, 2022), along with the stigma of homelessness, perceived or actual, may subsequently play into health inequalities (Reilly et al., 2022).

PEH's perceptions of healthcare have been explored qualitatively (e.g., Mc Conalogue et al., 2021), but such studies often address general health or focus purely on physical health. In a paper on complex recovery, individuals spoke more about addiction and physical health difficulties than they did about their experience of mental illness (Padget et al., 2016). Similarly, in a narrative study by Williams and Stickley (2011) looking at how homelessness impacted identity and mental health, only two people directly referred to their mental health, with narratives being constructed around drug use, family breakdowns, and stigma. Although Adams et al. (2022) looked at the barriers to accessing mental health support during COVID-19, participants were those who wanted to seek support and the voices of those who may not be accessing services, even when they are designed to meet their needs, are missing from the literature.

Methodology

Despite the heightened rates of mental health difficulties in PEH, often diagnosed by professionals, the important question of 'how do PEH perceive their own mental health?' remains unanswered, as existing research is often diagnostically focused. There is a lack of understanding in the existing literature of how PEH's own perceptions and experiences of mental health may influence the way they engage with services. Therefore, this research paper aims to explore PEH's perceptions of mental health and mental health services and the perceived barriers and facilitators for access to mental health services.

Ethics

Ethical approval for this study was granted by the University of Plymouth 'Faculty of Health Research Ethics and Integrity Committee'. A convenience sampling approach was used in a third-sector organisation that runs a day centre for PEH in Plymouth, UK. Although information sheets were shared within the service, most participants were recruited through word-of-mouth. The researcher spent time in the service building rapport, and staff at the day centre acted as gatekeepers. Participants were read the research information sheet, and a copy was also given, time was provided to answer any questions, and easy-read consent forms were used to overcome any illiteracy barriers. Any participants who were undergoing extreme emotional distress at the time of interview, or under the influence of substances which compromised their capacity to consent, were excluded from the study. Time was provided at the end of the interview for a debrief and to ensure the welfare of participants; the researcher is trained in stabilisation techniques and was able to offer additional support if needed, as were staff at the day-centre. Participants were given a £10 supermarket voucher after interviews were completed.

Methodology

A universal definition of homelessness has been historically elusive, making it difficult to develop transnational policy and comparative statistics (FEANTSA, 2006). FEANTSA therefore developed the European Typology on Homelessness and Housing Exclusion (ETHOS) to define homelessness and housing exclusion. In line with this, the research presented here defines PEH via the ETHOS classifications as those who are 'roofless' or 'houseless'. Additionally, the different pathways through homelessness should be acknowledged. Although McAllister et al. (2011) created a 10-group typology, Kuhn and Culhane's (1998) classification remains in wider use. They categorised PEH into three groups: transitional, episodic, and chronic. Transitional homelessness makes up the majority of PEH and is categorised by people who use a homeless service once and for a short time only, until they are stably housed again. This paper focuses on episodic and chronic homelessness, since people falling into these categories have worse health outcomes and higher rates of problematic substance use (Patterson et al., 2012; Richards et al., 2023). It is, therefore, of particular concern that their needs may not be met by current health services.

Participants were included if they were aged 21+ and fell into the ETHOS categories of 'houseless' or 'roofless'. The focus was on participants who are episodically or long-term homeless, which for the purpose of this research was defined as someone who had been homeless more than once, or for at least a year. As this research explored how PEH understand 'mental health' in general, there was no criteria around having a diagnosis or self-reported mental health difficulties; participants could speak about mental health in terms of resilience and positive mental health, as well as difficulties, if that was their understanding. Participants could be of any gender or ethnicity and basic demographic information was collected.

Data was collected through semi-structured interviews, which were held face-to-face at the day centre. Research design and interview questions (Table 1) were developed with guidance from service-users of the centre and staff in homeless services. Participants were made aware that they did not have to answer any questions they did not want to and could provide as little or as much information as they felt comfortable giving, and that this would not impact their support at the day-centre. Interviews were audio recorded and later manually transcribed. Data was stored in line with the Data Protection Act (UK Public General Acts, 2018) on a password secure laptop.

Table 1. Semi-Structured Interview Schedule

Question	Prompts
What does mental health mean to you?	How would you define it? Could you tell me more?
Could you please tell me about your understanding of your own mental health?	Tell me about your thoughts around your mental health? Family history understandings of mental health? How do you perceive mental health in others? How did you first come to understand your mental health?
Could you tell me your thoughts around mental health services?	Tell me about your understanding of accessing mental health services? Can you give an example of a time you have thought about accessing mental health services? What was your understanding when you chose to, or not, access mental health support? What is your understanding of a psychologist/mental health worker? What would you suggest to someone who you felt was experiencing mental health difficulties?
Is there anything that might make it easier to access mental health services?	Could you tell me about any examples of this? It could be something that's happened to you or someone else that you know who is homeless. How might you design a service?
Is there anything that might make it difficult to access mental health services?	Could you tell me about any examples of this? It could be something that's happened to you or someone else that you know who is homeless.
Could you tell me about how you feel people in mental health services perceive homeless people?	Can you give an example of this? How does this impact your thoughts about mental health services?
Is there anything else you would like to add?	

Interviews were analysed using Interpretative Phenomenological Analysis (IPA). IPA is recommended when exploring people's experiences and how they make sense of their personal and social world (Smith et al., 2022), whilst taking an inductive critical realist approach to faithfully represent participant voices. IPA gives prominence to the participant perspective and allows a holistic view of lived experience, but invites interpretation at a meaningful, rather than surface, level of the data, looking for underlying motivations and contexts to the individual experience.

Smith et al.'s (2022) seven stages of IPA analysis were followed. The researcher familiarised themself with each interview, before making initial notes at a surface and interpretive level, which then developed into personal experiential themes (PETS) for the participant. Once each interview had been analysed, the 109 PETS were combined and the five group experiential themes (GETS) accounting for shared or divergent experiences emerged through the interpretative process. Themes were cross-checked with an experienced researcher and an 'IPA Consultative Peer Group'. Additionally, member validation was completed for both PETS and GETS with one participant.

Researcher position

IPA encourages researcher reflexivity in a double hermeneutic cycle; therefore the researcher position was considered throughout. The researcher has experience of working in homeless services and felt frustrated when service-users struggled to access mental health support due to services not meeting their needs, alongside the emotional impact of the death of a service-user that had felt avoidable. This was important to acknowledge to maintain a level of objectivity whilst recognising the subjective nature of the analysis. A presuppositional interview (Barret-Rodger et al., 2022) was completed prior to data collection, bracketing interviews were used, and a reflective journal was kept, mitigating bias.

Findings

Participants

Smith et al. (2022) recommend 10 participants for an IPA study, and 11 interviews were completed (Table 1); the average interview length was 28 minutes.

Table 2. Table of participants[1]

Name	Gender	Age	Ethnicity	Homelessness history	Substance Use
James	M	37	White British	6 months, 2nd time	Occasional alcohol/cannabis
Liam	M	46	White British	2/3 years; long history of homelessness	Poly-drug use
Ben	M	31	White British	2½ years; long history of homelessness	Poly-drug use
Sofia	F	21	White British	2½ years	Poly-drug use
Chris	M	52	White British	7 months; 2nd time	None reported
Oliver	M	49	British-Indian	One year	Occasional alcohol
Rosie	F	37	White British	4 months; long history of homelessness	Poly-drug use
John	M	50	White British	Eight months; 2nd time	None reported
Amelia	F	23	White British	One year	Poly-drug use
Lucas	M	37	White British	2½ years; 10 years of homelessness	Poly-drug use
Isabella	F	36	White British	7 weeks; 8-9 episodes of homelessness	Poly-drug use

In total seven men and four women were interviewed, and ages ranged from 21 to 52 (mean age: 38) and all, but one, participants described themselves as White-British. Length of homelessness and substance use were self-reported. Although no other demographic data was specifically collected, four of the participants shared that they were care leavers and five disclosed that they have previous experience with the criminal justice system. Whilst it was not an inclusion criterion, all

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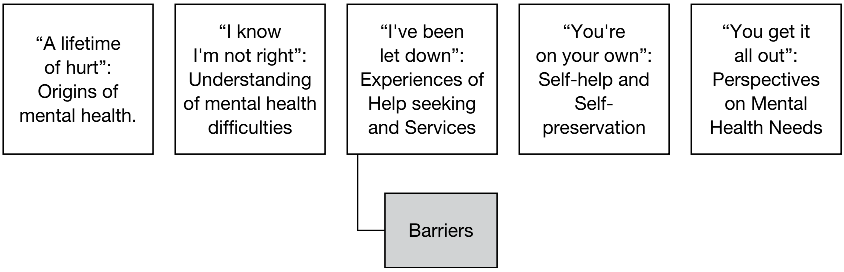
[1] Pseudonyms used

participants alluded to having mental health difficulties, even if not formally diagnosed and described how being homeless exacerbated this, particularly for those participants who had been homeless for longer periods of time.

Themes

Following the analysis, five GETS, and one subtheme emerged (see Figure 1) and will be described in detail.

Figure 1. Overview of themes



"A lifetime of hurt": Origins of mental health

An important feature of how participants understood their own mental health was the sense that it was impacted by lifetime events. For many, mental health difficulties were the result of hardships from across their lifespan. Lucas said:

> I've got a lifetime of…hurt and abuse, I guess, stress and bullshit and… some of the stories I could tell you and that.

For many participants, their mental health difficulties started in childhood. John described how he started developing his own coping methods from a young age due to his early experiences:

> I was physically abused by my father. I was used as a punch bag. Then my mum…an alcoholic, every time I had a problem, she would hit the bottle. So I didn't have either parent. And I've just been left to my own devices. So I've done what I know how to survive.

However, the impact of this was that John ended up in the care system:

> And… at age 11, I was put in foster care. I left to my own devices, hence I went stealing and the car crime, everything just spiralled out of control.

John was not the only participant who was placed in care at a young age and Lucas talked about how “that fucked my head right up […] you just feel sorta worthless” after his grandmother placed him in care after his grandad died. Although no participant talked in depth about their experience of care, there was a sense that it continued to impact their low self-esteem and self-identity. Lucas said:

> ADHD was thought to be just a naughty kid, you know […] I was bit of a problem child… even in the care system I was passed from one family to the next […] I suppose I was a naughty kid, to be fair.

Although Lucas recognised that his ADHD diagnosis was not understood, he still described himself as naughty, suggesting that the early narrative has stuck with him into adulthood and shaped his view of his early life.

Rosie spoke about mental health across generations and a sense of inevitability that was shaped by family narratives:

> My whole family’s got it, my mum’s got it, and her mum had it, it obviously goes round in the genes innit, like I hope I haven’t caught something […] we all suffered from quite a lot of trauma with men and unhealthiness and shit, and then going on to destroy ourselves with drugs and stuff.

Rosie described mental health as something catchable, even though she understood there were also patterns of trauma and destructive coping mechanisms. However, rather than something genetic as Rosie described, Ben talked about the generational impact in terms of repeated behaviours:

> The reason why a lot of people are the way they are, is because they’re reflecting off their parents […] 9 times out of 10, right, if a man is beating a woman and the kid sees it, what’s that kid gunna do when they’re older?

Ben recognised that patterns of violence repeat themselves but leaves a small chance that intergenerational patterns can be changed.

Although most participants talked about the origins of their mental health difficulties stemming from childhood, Isabella pinpoints a single event as an adult as the trigger:

> I don’t think I’ve really had problems with mental health until everything that happened to me […] Since I got sliced and that.

"I know I'm not right": Understanding of mental health difficulties

However, for John it was not just about negative events, but how they were understood that mattered when thinking about mental health difficulties:

> We all have hurt, we all love, we all hate. We all have good times, we all have bad times. It's the perception of how you deal with it, that determines the outcome of where you're gunna go.

There is a sense of emotions and events, including negative ones, being universal and that bad times are inevitable. This is shared by Chris:

> You're okay for a while, um, but then something else in life might happen, you never know what's gonna happen tomorrow.

Chris described a sense of transience and unpredictability with his mental health, and a belief that you can be knocked back again even when things feel stable. Being able to understand personal experiences was considered important across participants and Liam described how his mental health can feel unknowable:

> I don't know half of the shit that's going on with me. But I know, I know it's definitely something not, not right you know, I know I'm not right.

He described a sense that something is not right with him, and continued, saying he would want support to help him understand himself more:

> I would love to have them come and help me, and maybe like, tell me what was going on with me, you know what I'm saying? So I'll know exactly what's what.

He shared that when he was younger, he experienced anger, but this was not necessarily the real problem:

> I didn't understand it, I didn't know what depression was. So I yeah, I would get angry, I would smash doors and walls and things and smashed my hands up and, yeah, and it was depression.

Mental health was understood in terms of experiences, rather than being diagnostically led but a doctor was the main mental health support for most participants. Many felt that medication was the only support offered. There was a frustration due to medical professionals being quick to prescribe, rather than taking time to understand the problem. James described his feelings on this:

> They're quick to put stuff down as, like you know, oh we'll just medicate and medicate and medicate. And a year later and nothing's changed and it's not actually got to the root cause at all.

Oliver also talked about ending up like a "walking pharmacy" when all he wanted was to understand what was going on for him.

“I’ve been let down”: Experiences of help-seeking and services

An experience that came up with every participant was at least one, if not several, past experiences of services being rejecting, inconsistent, and feeling let down. For some, this was due to their early experiences, as John shared:

> As a child I had a psychiatrist in a different country. And… they locked me up.

This sense of not getting suitable support stemmed into adulthood:

> I’ve been let down, I’ve trusted somebody to help and they’ve passed me from pillar to post, post to pillar, that’s a confusing situation for anybody to be in.

This experience of being passed around across the lifespan was shared by many participants, as Sofia says:

> Help started when I was nine with more therapists than you could shake a stick at, but that kind of makes it all worse [because] you’ve gotta re-tell it.

Although Sofia hoped to access mental health support in the future, for Amelia, feeling let down led to her not wanting to access mental health services again:

> I wouldn’t even access it, cause they’re crap, they’re absolutely crap. They don’t, they don’t help you with what you need help with.

Amelia’s experience of mental health was tied in with social service requirements and assessments and “they use that against you”. Not only did Amelia describe mental health being used against her, but for her support came too late:

> Because I didn’t have a diagnosis, they took my little boy off of me. […] then I got the ADHD diagnosis but that don’t help because my son’s been adopted.

A lack of trust did not just come from mental health services, and Oliver described an incident where he experienced racial prejudice from his local police force:

> I did lose faith in the police. And then when you lose, you know, you think yourself you lose faith in the police, you know nothing will protect you like.

He went on to describe how reputations matched his experience:

> … they were both sexist and racist from what I heard, like, and kind of when you read things like that, I kind of think, well, yeah, no wonder I had no help from them.

Oliver continued to say how this lack of trust now applied universally to services, including mental health who “brainwash you”, which is why he had not accessed support. He elaborated:

> So many promises and lies in all different systems, and you just, you’re thinking I’m fed up of hearing this and hearing that, and then it don’t happen.

There was a general understanding across participants that mental health services were stretched and underfunded. Some spoke about how changes needed to happen at a government level. Chris said:

> It's very, very strained. Urm, possibly it needs to go as high as the government […] I know they're suffering.

Chris described a duality that services are suffering alongside the people who access them. Funding cuts impacting helpful services was also raised by Liam, who spoke about a positive experience in a rehabilitation centre:

> The funding, well it ran out and nobody would refund it. And then that was that. Generally that's what happens.

Sofia went on to explicitly name mental health and homelessness as things that desperately need funding:

> Look at the services which don't even have enough funding to keep it going. […] the amount of homeless people who, if they were given the chance to speak to like to a mental health service, would jump at it. We just can't because there is no-one. It's heart-breaking.

Barriers

Every participant spoke about barriers they faced around service access. For many the difficulties came before they even got into a service. Amelia described that often people do not know how, or where, to go:

> It's all done by Internet and not a lot of homeless people have phones, so they would have to go to the library or speak to someone at an agency that would be able to help them. Then it's finding that cause you don't even have to Google Maps.

However, Sofia described how it goes beyond information sharing, due to the impact of illiteracy in homeless populations:

> A lot of people out here can't even read and write […] the doctor will go, yeah, just sign all this paperwork, and they sit and sit there looking at it like 'err?, how am I gunna read that?'

Other participants knew how to access support, but felt like barriers were put in their way. Chris described how:

> I've had to relive what I've been through three times in one day, by the time I got to [service], I was, I was going mad. I was kicking off. I did apologise afterwards because, erm, you know that's not really me.

Services for Chris made him act in a way that he did not like; even when he finally got support he worried that it was not adequate:

> Am I going to be better in 2 1/2 months or am I going to get to the end of that and still be suffering from stress. Where do I turn then?

There was something important about being met where you are at, when you need the support, rather than being referred on. Lucas says:

> Oh yeah we'll refer you on, you'll be put on a waiting list, hah, 12 months down the line when you've lost all motivation to work, work with the people who want to work on your mental health, you get a phone call and it's like, fuck off mate.

He noted that even if you are motivated to get help, asking for it not always easy:

> People sometimes don't have the self-worth or courage to get up and go to them and say that I need help.

Services need to do more than just reduce barriers, and instead should be proactive in finding the people that need them. Liam suggested:

> I think they should go out and search more for people rather than wait for them to come to them […] Trouble is some of these places they're so busy that and understaffed you just get forgotten about.

For him there was a feeling that you can get lost in the system and the environment of having combined support makes these harder as difficult interpersonal relationships mean "some people probably won't come".

Chris was unique in that he was currently accessing mental health support, but even with support he struggled:

> I try to do the breathing exercises […] you might be trying to do that, and there might be an argument going off behind you.

"You're on your own": Self-help and self-preservation

Some participants felt that the only way they could get support was to go to extreme measures. Sofia talked openly about a suicide attempt:

> Two days later I had social services knocking on the door. And I'm like so you wrote me off when I was 8 or 9, and now you're wanting to come back on to the scene after doing fuck all for the last god knows how many years of my life.

Sofia felt like she needed support from services from a young age, but due to a lack of it, suicide felt like it became her only option. There was an anger that this was when services finally offered the support she wanted. Oliver had a similar experience, but rather than support he received a prison sentence:

> I had a breakdown […] tried to blow my head off, it just didn't work, and because of what I done, obviously it's a danger to other people and that's how I got a criminal record for it.

However, despite his criminal record Oliver shared his surprise that it got him the help that he needed*.* Prison was seen as the best way of getting support for several participants, and Isabella noted the unfairness of this:

> You shouldn't have to go and crime just to get help.

For others, like James, there was a feeling that unless you go to extreme measures you do not get support.

> I don't meet a threshold for like mental health issues […] and it's almost like, see you later. You're on your own. If I wasn't trying to see my children, I would have no problem just saying like you know what, I think I'm going to kill myself, if it's just going to get me off the street, even if it's true or not.

John talked about how talking meant having to face reality "and it's not a nice place. And so everyone escapes, whether it be drugs, alcohol, or what". The use of illegal drugs or alcohol as a coping mechanism was talked about by most participants. Lucas described how services need to understand that people use drugs for a reason, and it should not be a barrier to access:

> It's still 'well you're taking mind altering substances'. Well, hang on here. I'm taking that for a fucking reason. Get real. It's common sense.

This is reflective of the acknowledgement that substances both offer relief from mental health difficulties, but also exacerbate other factors; it is not an easy place to be. Whilst problematic substance use for coping was discussed by the majority, it was not true of everyone. John's form of escapism was driving ("I tend to drive a lot rather than think a lot") and for others it was about being able to reframe their situation. Oliver described how:

> I play a game of like what you call reverse psychology. You know something's really getting to you, just think of it as part of something to help you.

"You get it all out": Perspectives on mental health needs

All participants spoke about the importance of having someone to talk to. John talked about the impact of loneliness:

> When you got no one to talk to, that's when you start to feel the loneliness of everything and loneliest is the most common killer to any generation.

Amelia noted the importance of building connections with professionals in order to be open, and recognised that this takes time and effort, and Liam noted the importance of professionals just spending time with people:

> … just go around these places to generally talk to people really because you'll find all that out just by doing that, just by sitting down and having a cup of tea.

There was a sense that support needed to feel more casual than clinical. Sofia describes an ideal environment as "a chilled out area with someone who looks friendly but has that knowledge of what to do" and in this space: "you scream, you rant, you rage, you cry… but you get it all out. And then you can go back next week if you need to."

For Sofia support was more than talking, it was about letting out emotions in a safe way. Some participants had places where they had this support, from probation workers ("I just need to vent and she just listened to me" – Liam), to doctors, to hostel staff; it mattered less about who offered the support, but simply that it was there. John described his social-prescriber:

> [She] doesn't judge me […] you talk about what matters to you and they sort of introduce it in a way that isn't mental health, mental health, mental health.

Although Sofia talked about the importance of being able to talk to friends, as well as professionals, she also recognised the emotional impact it has, particularly when they have similar experiences.

> If you do lose a friend or a family member out here, you blame yourself. […] if we had a little thing where we had people sit and listen to homeless people, it could, it could extend their lives slightly, because they feel like they've actually got someone to talk to who cares.

Whilst acknowledging peer support as important, she recognised that this is often not enough and professional help is needed. Whilst having someone to talk to was seen as integral for most participants, for Ben, good support did not need to involve words:

> Animals are a good thing for mental health people to have, because emotional support is better than anything in life […] they don't argue, they don't talk back to you [laughs] all they can do is just show love.

Whilst talking may help, having a connection with a living being was ultimately the most important thing, but services need to be aware of the homeless context when offering support as a number of difficulties of being homeless were given. For some, like Liam, it was the routine of being homeless ("you're always on the move

[…] the world is going too fast for me") and it is unclear whether his sense of fastness was the result of or cause of homelessness; for Amelia, homelessness was very much the cause of her problems:

> Homelessness causes mental health because you don't know where you're gonna sleep, don't know where you're gonna eat, […] I'm constantly on edge, having glass bottles thrown at my tent and that, with a baby inside of me […] I've got really, really bad anxiety. And I've been crying quite a lot lately.

Amelia talked about the impact of violence, which is made harder with pregnancy due to an increased sense of vulnerability. Feeling exposed was shared across participants, but was particularly prominent for females. Isabella described herself as "more vulnerable" when homeless and said:

> You gotta be awake, you gotta be alert. I can't even put my hood up when I go out.

Despite this, some men also spoke of the impact of street violence, as Liam shared:

> Even though I'm a grown-arse man, I'm still scared.

This sense of vulnerability was also explored by several participants who note the increased mortality within the homeless population. Isabella noted "it's not good out here, for nobody" and grief and loss was spoken about. Sofia noted how services need to be responsive to bereavements:

> I know four that have died in the last month, all cause they've been trying to use things as blockers and there's bad batches going around. It's… heartbreaking. But then that leads more people to need more help from mental health services because they just lost close friends, close family. It's an endless circle.

Although the majority off participants spoke of how homelessness worsened their mental health, Ben spoke of how he found his mental health had improved:

> When I live in a house my mental health goes really bad but living on the street, my mental health goes fine because I'm free in my head. I don't have no restrictions […] you can back yourself away from everyone.

However, although Ben talked about the benefits for him, he acknowledged:

> No one should feel like that, better off on the street, you know what I mean? And it's cause I've been on the street for 2 1/2 years. It's just normal to me now.

Ben recognised the impact of normalisation of his experiences on the streets, and that if things had been changed in the past maybe he would feel differently now.

Discussion

This IPA study explored PEH's perceptions of mental health, mental health services, and any perceived barriers or facilitators to access. Five GETS emerged:

Origins of mental health, understanding of mental health difficulties, experiences of help-seeking and services, self-help and self-preservation and, perspectives on mental health needs.

'Origins of mental health' represented how participants understood the cause of their mental health difficulties, with most stemming from traumatic events that were linked to childhood and family narratives. *'Understanding of mental health'* represented how participants want to better understand themselves and the causes of their behaviours and coping mechanisms. '*Experiences of help seeking and services'* highlighted how services have let participants down over the years, either through individual or systemic failures, including racism, over-prescribing, and funding cuts. *'Self-help and self-preservation'* incorporated what participants found protective for their mental health, the extreme measures people have needed to go to get support, and the need for an acceptance and understanding of their survival mechanisms*. 'Perspectives on mental health needs'* focused on building meaningful connections, reducing stigma, how being homeless directly impacts mental health experiences, and getting the right support is vital.

Despite the only mental health input for many participants being their GP, participants did not give a bio-medical understanding of mental health. Instead, they spoke of it in terms of life events, understandings, and family influence. Psychiatric definitions are important, as they hold relevance for policy makers and are helpful for monitoring and outcomes; indeed this is how we know that prevalence of mental health problems is so high for people experiencing chronic and episodic homelessness. However, when supporting PEH, diagnosing and prescribing medication may be pathologising of their coping mechanisms. People with mental health issues risk epistemic injustice (Crichton et al., 2017) and have their interpretations discounted in lieu of professional knowledge, which along with the stigma participants reported feeling, may add to a sense of not being understood and increase stigma around mental health and coping mechanisms. Similarly, despite many acknowledging using drugs or alcohol as their way of coping, participants rejected the over-prescribing of medication for mental health, with many feeling it does not help them understand the true cause of their issues.

Whilst not dismissing biological underpinnings of mental health, the 'Power Threat Meaning Framework' [PTMF] by Johnstone et al (2018) offers a different perspective focusing on both seeing people as individuals, whilst understanding limiting factors within society: the focus becomes 'what's happened to you?' rather than 'what's wrong with you?'. The PTMF focuses on how power and threats impact on someone's life and how people understand and respond to these. Participants spoke of power and threat across their life: from childhood trauma, to government and service level barriers, to violence on the streets and the impact of stigma. Although there is a growing evidence base for the efficacy of psychological intervention (e.g., Bodley-Scott et al., 2024) collaborative understandings are important (Ness et al., 2014) and the PTMF is person-centred, validates individual experiences, and is contextually sensitive, which would support discussions around the impact of homelessness itself. Participants spoke of wanting to get to 'the core', and there is a need to continue to develop evidence for affective interventions that align with PEH needs and contribute to best practice guidance, e.g., NICE.

Stigma may be a bigger barrier than previously thought. Whilst the stigma of being homeless is a known barrier to accessing healthcare (Mejia-Lancheros et al., 2020; Reilly et al., 2022), participants spoke about how this interacts with both male identity and the stigma of having mental health difficulties. Whilst male identity and mental health stigma has been raised previously (Chatmon, 2020), a greater understanding is needed about how this may worsen health outcomes when combined with homelessness in order to find solutions. Additionally, both the stigma of being homeless and the impact of homelessness itself were described as exacerbating mental health difficulties. Housing First is an internationally used approach that provides people with complex needs a stable home alongside person-centred support (Homeless Link, 2024). Although it has shown positive results internationally for housing stability (Tsemberis and Eisenberg, 2000), health (Peng et al., 2020), and other holistic outcomes (Homeless Link, 2024), it is still only a small proportion of people in the UK who are able to receive this service (Homeless Link, 2020). There is a need to grow this approach and despite the clear benefits of the approach, there is mixed evidence on the impact of Housing First on social and clinical outcomes (Tsai, 2020), relational difficulties (Cole, 2023), and multidisciplinary working, including mental health, within communities are needed alongside to ensure holistic support is offered.

Whilst IPA facilitates an understanding of shared experiences of a population, it is important to note differences too. Whilst all participants were adults experiencing homelessness, they differed in age, gender, and ethnicity, and these characteristics may result in different experiences. For example, relational violence is more likely to be experienced and cause homelessness for women (Magnusson and Davidge, 2020), and an awareness of gendered differences is important (e.g., Radcliffe et al., 2024). Ethnic groups, other than white, are over-represented in homeless data across England, but it is particularly marked in the Southwest (Finney, 2022), where this data was collected. Notably, Oliver was the only non-white participant, which may say something about how, where, and if PEH from ethnic minorities are accessing support. Oliver talked about how police contact and imprisonment had impacted his views of services. There is an overrepresentation of ethnic minorities in the criminal justice system (Ministry of Justice, 2022) and inpatient units (Barnett et al., 2019), which may play into a lack of trust that contributes to the health inequalities minoritised others face (Kapadia, 2022) and services may need to do more to reach them. Whilst statistical data helps highlight this difference, more research is needed to understand sub-groups' experiences of homelessness and service access to see if additional or varying support is needed, beyond what this paper and others suggest. Whilst a growing number of services offer trauma-informed policies (Office for Health Improvement and Disparities, 2022), offering additional support to wider services (e.g., police, social services) around dual-diagnosis, psychological understandings, etc,. may aid in ensuring PEH get their needs met across multidisciplinary networks.

Many of the barriers that participants spoke about have been well-documented in the literature around PEH and healthcare; this includes digital poverty (Heaslip et al., 2021), location barriers, preferring face-to-face (Adams et al., 2022), and a lack of empathy from professionals alongside a lack of trust in services (Ramsay et al., 2019). Many participants had dual-diagnosis needs and used substances to cope, but also felt it was a barrier to service access and support. Policies to support dual-diagnosis working do not go far enough (Alsuhaibani et al., 2021) and focus needs to be on developing pathways to support the mental health of people alongside, and regardless of, motivation for substance-use reduction. The 'NHS Long Term Plan' (NHS England, 2019) proposed £30 million to provide better access to specialist mental health services for PEH, and the NICE guidelines supporting PEH healthcare (2022) goes some way to addressing these barriers. It is a step in the right direction, and early examples of more inclusive services are positive (e.g., Scott-Gatty and Cant, 2021), although continued evaluation of efficacy is needed to address the limited evidence-base.

However, many participants had made their judgements about services based on their past experiences and felt government policies hindered them further. Some participants felt that they would not access services based on what had previously happened, and notably this was not just the impact of mental health services, but of other systems such as legal, social services, and criminal justice too, with some of the problem stemming from childhood interventions. Where the damage is already done, mental health services may need to do more than just offer flexible outreach services for PEH. They need to be proactive in communicating what they offer and demonstrating how they can be trusted, in order to reach those who are still not attending, and prevent PEH from resorting to extreme and harmful actions to get the help they need; rather than best intention, this proactive outreach needs to be written into policies tackling health inequalities (e.g., Pathway Policies for Inclusion Health) and co-designed alongside people with lived experience.

Whilst participants talked about needing mental health support, it is worth noting that what they describe as being desirable is not necessarily how traditional statutory services have to offer. Although two participants spoke of the value of learning ‘skills’, all participants spoke of the importance of having someone that they could reliably talk to about anything, not just mental health, which is markedly different to most evidence-based psychological or psychiatric model-specific interventions and medical prescribing. Given what we know about PEH and attachment styles, it may be that attachment-informed practice is key (Barreto & Cockersell, 2024) and services need to focus more on relational aspects of building safe spaces than targeted interventions per se. This is particularly important when considering the impact of vicarious trauma on staff, and the role that bereavement and loss may have on staff and service-users alike (Valoroso and Stedmon, 2020; Monk et al., 2023). At an organisational level there is a systemic need to recognise and manage the parallel processes between traumatised people and traumatised services (Bloom, 2014). Perhaps the role of professionals, including clinical psychologists, is to hold a meta-position offering consultation and psychologically-informed training to both staff and senior management across a range of services supporting PEH. Building relationships, both within and between organisations, might facilitate the creation of sufficiently containing spaces to engage such a vulnerable client group, and facilitate person-centred approaches that are both sensitive to, and respectful of, the client and their needs.

In keeping with other qualitative approaches, the findings from IPA studies are not generalisable, but there is some transferability of meaning to like services and participants elsewhere. This research contributes to the growing literature on how best to support PEH with their mental health; it offers not just an understanding of the barriers and facilitators to accessing services but insights into how PEH themselves understand the term ‘mental health’ in relation to their experiences. The growing pace of homelessness in the UK necessitates that change happens quickly; providing the right support at the right time may prevent the vicious cycles that leave people feeling entrenched in homelessness.

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