Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

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Portfolio abstract

The number of those considered homeless – including the hidden homeless - has been increasing since 2010 (Fransham, 2018). Legislation, such as the Homelessness Reduction Act (2017), has been introduced to tackle rising numbers. This is the first piece of legislation to acknowledge the complexity and prevalence of mental health difficulties in the homeless population, repeatedly highlighted in the literature. Despite increasing numbers, complexity, links to mental health difficulties and backgrounds characterised by trauma, Clinical Psychologists (CPs) currently have no guidelines to support their direct work with this population, nor the organisations and staff they work with. Furthermore, this lack of guidance means commissioners have no way of knowing the resources required for CPs to work effectively with this population. Despite the absence of an empirical evidence base, CPs have been working in homelessness services, meaning they will have generated practice-based evidence. This research sought to harness this practice-based evidence and create consensus-based good practice guidelines.

The Delphi Method was used to elicit and synthesise this practice-based evidence to support the creation of good-practice consensus-based guidelines for CPs working within homelessness. The Delphi was conducted over three Rounds. Prior to Round One, a panel of Expert Citizens were consulted, and asked to discuss their experiences of homelessness and mental health. The information generated from this consultation group was provided to all the CPs – called panel members - for information prior to Round One. The first Round consisted of an initial semi-structured interview with the 12 panel members recruited whom had with experience working in homelessness. This explored their experiences of working with this population. Each panel member was asked to provide six potential guidelines: three for direct work and three for indirect work. All guidelines – 36 direct and 36 indirect – were collated into a survey for

Round Two. This survey was sent to all panel members, who were asked to rate each guideline using a Likert scale to denote its importance for inclusion. Using the data generated from Round Two, Round Three included all collated panel member feedback, detailed amendments to the guidelines and provided panel members with the opportunity to provide more feedback. Required consensus levels for a guideline to be considered important or essential were set apriori at ≥80% guided by existing Delphi literature. Percentages were calculated using the number of panel members who had responded to the Round. Following Round Three, all endorsed guidelines were supplemented with two clinical vignettes taken from the practice-based examples provided by panel members in Round One. All guidelines and vignettes were distributed to panel members in Round Four for member checking, and to provide additional vignettes where a guideline had <2.

The panel endorsed 23 direct and 26 indirect working guidelines. The research team grouped these under similar categories. Direct guidelines fell under the following three categories: "Approach", "Multi-agency working" and "Individual Therapy", and indirect guidelines under four: "Relationships with and support for staff", "Supporting staff to support service users, including building therapeutic skills", "Approaching systems change" and "Contributing to the evidence base".

Limitations include the guidelines having limited international applicability outside of the United Kingdom, the homogeneity of the sample, and lack of external corroboration of the panel members reported experiences of good practice with staff, service users and organisations. This research provides both guidance to CPs and commissioners in an area where this was previously lacking, and also highlights the lack of empirical evidence base in homelessness. Endorsed guidelines echo the importance of CPs working in homelessness to contribute to the evidence-base, reducing the research-practice gap.

Acknowledgements

There are so many people I want to thank for their ongoing support in helping me to produce this work. Firstly, to both my research supervisors – Anna Tickle and Dannielle De Boos. Without your support, expertise, and guidance (alongside a couple of pep talks), I doubt I would have managed to complete this project. I'd also like to thank Framework and all the participants for contributing to this work – without your input, this project would not have been possible.

Secondly, I'd like to thank the cohort of 2018. Despite pressures from the course, life - and of course the pandemic - I cannot imagine having a more supportive and fun cohort. Special thanks to Sarah for supporting me through many teary and frustrated moments, and Kate for providing ongoing supportive conversations - you are both fountains of knowledge!

Thirdly, I'd like to thank all of my friends who have provided ongoing support and have been so patient and flexible. Maybe the day is finally coming when I can talk about topics other than the DClinPsy…?

Fourthly, I'd like to thank Sam. Despite your own ongoing pressures, you have always been there, providing words of comfort and encouragement. I only wish I could remember all the funny moments and ridiculous jokes we have shared.

Finally, I'd like to thank my Mum, Dad, and Sisters (Katherine and Christine). You have all supported me through my journey, both before the doctorate – always moving forward but not quite knowing where I was going – and once I settled on applying for the DClinPsy. You have all been there to pick me up when I'm having an 'unproductive' day. Special shout out to Christine whose own experiences completing a PhD have been invaluable in consoling me when I've been struggling, and Katherine who, despite being across the globe, somehow has provided so much support. I really could not have completed this without you all.

Statement of contribution

Project design. The project idea was proposed by Anna Tickle and refined through conversations with both my supervisors, a protocol proposal panel with two university course staff and a presentation to staff and other trainees.

Ethical Approval. I completed the ethics application and checked the contents with Anna Tickle and Danielle Dr Boos prior to submission. I also completed an amendment to the inclusion and exclusion criteria in February 2020 to provide clarity for participants and the research team.

Literature review. I completed the literature review on trauma informed care, with the support of Anna Tickle.

Review the literature. At the start of the project, Anna Tickle guided me towards some of the key concepts in homelessness. I completed the literature review myself and continued to amend aspects based on feedback from Anna Tickle and Danielle De Boos.

Recruitment of participants. Anna Tickle was instrumental in supporting the recruitment of the Expert Citizens through her connections with Framework. Anna Tickle and I advertised the study on Twitter, and Anna Tickle also provided me with the names of Clinical Psychologists she knew were working in homelessness.

Data collection. I completed all the data collection for this study, including the initial interviews and data from the survey rounds.

Collating responses and making amendments across the Delphi rounds. I collected and collated all data. The majority of amendments were made by myself first and sent on to both supervisors for feedback. In one instance following Round Three, Anna Tickle made changes to one guideline first which she sent to me to review.

Presenting the data. The format the guidelines were presented in through each round was taken and adapted from Dr Brad English's thesis, who used a similar project design. The order data was presented in each round was decided by myself.

Data analysis. All data analysis for the final write-up and discussion was completed by me, with feedback provided by Anna Tickle and Danielle De Boos separately.

Small scale research study. I completed the small scale research project with the support of Dr Nima Moghaddam and Dr Lynn Furber.

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Systematic Literature Review

Trauma-informed care in homeless services: A systematic review

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Purpose To determine whether trauma-informed care is being implemented and evaluated in homeless services and if so, how, synthesising and critically appraising the evidence, considering outcome data where possible.

Design/methodology/approach Seven databases (CINAHL, MEDLINE, PsycINFO, Embase, OpenGrey, Prospero, Ethos) were searched. Eligibility criteria required papers to specifically refer to the implementation and/or evaluation of trauma-informed care in homeless services. Quality was appraised using the Critical Appraisal Skills Programme. Qualitative and quantitative data were synthesised using the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) framework.

Findings Overall, 370 papers were retrieved. Six papers were included, suggesting that evidence of the implementation and evaluation of trauma-informed care in homeless services is emerging. Quality varied and there was a consistent lack of transparent reporting. 'Reach' indicators were reported in all papers. Only one provided clear quantitative outcome data suggesting implementing trauma-informed care improved housing retention. All provided data on the experience of trauma-informed care implementation. Implementation indicators were poorly reported. No papers used a clear set of trauma-informed principles, an implementation framework or fidelity tool(s) to assist with implementation and evaluation.

Research limitations/implications Undue weighting may have been given to grey literature. Implications include the need to establish a set of trauma-informed principles, implementation framework(s) and fidelity tool(s) to assist the future reporting of trauma-informed care implementation and evaluation(s) in homeless services, which may encourage more high-quality research.

Originality/value This is the only review appraising the quality of available evidence on the implementation and evaluation of trauma-informed care in homeless services.

Introduction

Trauma-informed care (TIC) changes the focus from “what’s wrong with you?” to “what’s happened to you?” (SAMHSA, 2012)[1]. TIC is a whole-system approach seeking to increase awareness regarding the impact of trauma on service-users to prevent re-traumatisation, and resolve the relational and system-wide power imbalance (FEANTSA, 2017; Sweeney and Taggart, 2018). Various trauma-informed principles have been proposed (e.g. Sweeney et al., 2016; consensus based principles, Hopper et al., 2010). Though the content of these principles varies, all focus on the importance of relationships due to the interpersonal difficulties which manifest from chronic interpersonal trauma, resulting in a persistent mistrust of others and difficulties forming and maintaining relationships (Scanlon and Adlam, 2005). Whilst principles can help organisations consider the requirements of trauma-informed approaches, they are arguably abstract, possibly posing a challenge for implementation. Consequently, due to a lack of standardised, agreed principles, TIC may appear ill-defined (Hopper et al., 2010). Frameworks to assist implementation are emerging, such as the ‘One small thing’ initiative (Covington, 2016) and measures have been developed to enable services and organisations to capture the extent to which they are trauma-informed e.g. the ARTIC (Baker et al., 2016) and TICometer (Bassuk et al., 2017). However, at present, it is unclear the extent to which these suggested principles, frameworks and tools have been utilised by homeless services to assist in the implementation and evaluation of TIC.

Implementing TIC is part of an overall organisational change process (Sweeney and Taggart, 2018). Accordingly organisations are seeking to amend their ethos, structure and processes (By, 2005), by implementing a ‘trauma-informed’ approach, as exemplified by NHS Education for Scotland (NHS Education for Scotland, 2017). With such an extensive

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[1] References in Harvard style, as per journal guidelines.

cultural shift and costly project (estimated at £1.35million), it is crucial changes are evidence-based, with clear links to practice-based evidence outlining how to effectively implement TIC. Emerging evidence suggests trauma-informed approaches can improve outcomes in a range of services (e.g. inpatient: Chandler, 2008; Hales et al. 2017, 2019). However, Hopper et al.,'s (2010) review found limited evidence on TIC implementation and evaluation in homeless services. This lack of evidence is surprising given the connection between trauma and homelessness. Homeless persons are more likely to have multiple adverse childhood events, resulting in trauma (Fitzpatrick et al., 2013; FEANTSA, 2017). The lack of literature during Hopper et al.,'s (2010) review could be attributed to the infancy of TIC, as it can take between 10-15 years for healthcare innovations to transition from research to practice (Proctor et al., 2009). Therefore, nine years on, new evidence may have emerged. Importantly, a review of practice-based evidence exploring the real-world implementation and evaluation of TIC in homeless services could inform future practice. If no new evidence has emerged, this raises questions as to whether TIC within homeless services remains conceptual.

Therefore, this review seeks to address the following question; 'how is trauma-informed care being implemented and evaluated in homeless services?'. The aim is to systematically identify studies reporting the implementation and/or evaluation of TIC in homeless services, with specific objectives being to:

1) Identify and synthesise quantitative evidence relating to the evaluation of TIC alongside outcomes (if available/appropriate).

2) Identify and synthesise qualitative evidence of TIC implementation, including the experiences of TIC implementation (if available/appropriate).

3) To synthesise the qualitative and quantitative data to consider how TIC is being implemented and/or evaluated (if available/appropriate).

The available evidence will be assessed for quality. Synthesis will be achieved using a program evaluation framework; Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM: RE-AIM, 2019). RE-AIM focuses on the individual and organisational impact of an intervention and has been successfully used in systematic reviews (e.g. Harden et al*.,* 2015).

Materials and methods

Inclusion criteria

To be included papers needed to:

- Focus on homeless adults and/or staff working with homeless adults.
- Concern the implementation and/or evaluation of TIC in homeless services.
- Explicitly state TIC was the approach used in the implementation/evaluation description.
- Be either a peer-reviewed published study or study protocol. Studies in grey literature were also included, alongside accompanying documents, such as process evaluation reports.
- Be written in English.

Searching

Electronic databases were searched between June-October 2019 (PsycINFO, CINAHL, Medline, Embase, Open Grey, Prospero, Ethos). Relevant search terms relating to the population (homeless persons) and intervention (TIC) were as follows; homeless*, hostel*, shelter*, rough sleep*, housing, unshelter*, foyer, refuge, trauma-informed* and trauma informed*. Proximity searches for ‘trauma’ and ‘informed’ were completed within two (N2) words of each other. Associated synonyms, thesaurus and MeSH terms of these words were included.

Titles of papers which could meet the inclusion criteria had the abstract screened for eligibility. Full-text articles were obtained if the paper met the inclusion criteria or if this could not be determined by the abstract. Included studies' reference lists were hand-searched for additional papers. Full texts were reviewed to determine the final list of included studies.

Data extraction

The following information was extracted (where possible) for quantitative papers (Table 1); author, year and location, sample data (number, setting, characteristics), aims, intervention description and primary and secondary outcomes (Appendix A). Qualitative data extraction included; the data collection and data analysis methods (Table 2).

Analysis

Quantitative evaluation and outcome data was analysed using descriptive statistics (e.g. providing relevant frequencies) where possible. To explore the experiences of TIC implementation (where available/appropriate), thematic analysis was used, guided by Braun and Clarke's (2006) inductive data-driven coding process. Identified themes were synthesised with the quantitative data and evaluated using the RE-AIM framework (using indicators derived from the framework, as used within Harden et al., (2015) (Appendix B)), to consider how TIC was being implemented and evaluated. The thematic analysis was supported by first-order constructs (participants' own words) and second-order constructs (researchers' interpretations of these). These were taken to form third-order constructs (the author's themes), though it is likely that the author's epistemological orientation will have guided these.

Using the RE-AIM framework means there were assumptions and expectations about the types of data to be extracted, suggesting a positivist stance. However, the author acknowledged that different experiences may be evident within the qualitative data, hence a critical realist stance was considered most appropriate.

Critical appraisal

Quality was assessed using the Critical Appraisal Skills Programme (CASP;2019). Components are scored a 'two' if completely met, 'one' if partly met and 'zero' if not met.

Results

An overview of the search strategy can be found in the PRISMA flow diagram (Figure 1). Though eleven papers were identified, six relate to the same longitudinal study (2a-2f); therefore, a total of six separate studies were included, numbered 1-6 in the data and quality appraisal tables below (Tables 1-4), and will be referred to by number from this point onwards. Though requested via the library and author(s), two studies were unobtainable. Table 5 (Appendix A) contains secondary outcome data for studies 2a-2d.

TIC implementation and evaluation was the focus of three studies (1-2,5); with papers 2e-2f providing further detail of the implementation and evaluation of TIC discussed in papers 2a-d. The remaining three studies (3,4,6) focused on TIC implementation alone. Two studies (3-4) contained qualitative data regarding implementation. One (6) created a trauma-informed treatment manual to assist the implementation of TIC for street outreach teams. Five papers (1-2d, 5 and 6) focused primarily on homeless persons, two on homeless persons and staff (2e-2f), and two on staff (3,4).

Quality appraisal

Overall quality scores of the quantitative and qualitative studies varied, with the former ranging from 6 (1) to 16 (2a-2c) out of 22, and latter from 7 (3) to 15 (5,6) out of 20. Importantly all but one (4) study which scored above 10 were high quality reports or theses and are not restricted by the wordcount within standard journals; thus, scores may be weighted in favour of these longer articles. These were also the only studies which presented clear data, though the quality of study and data presented varied.

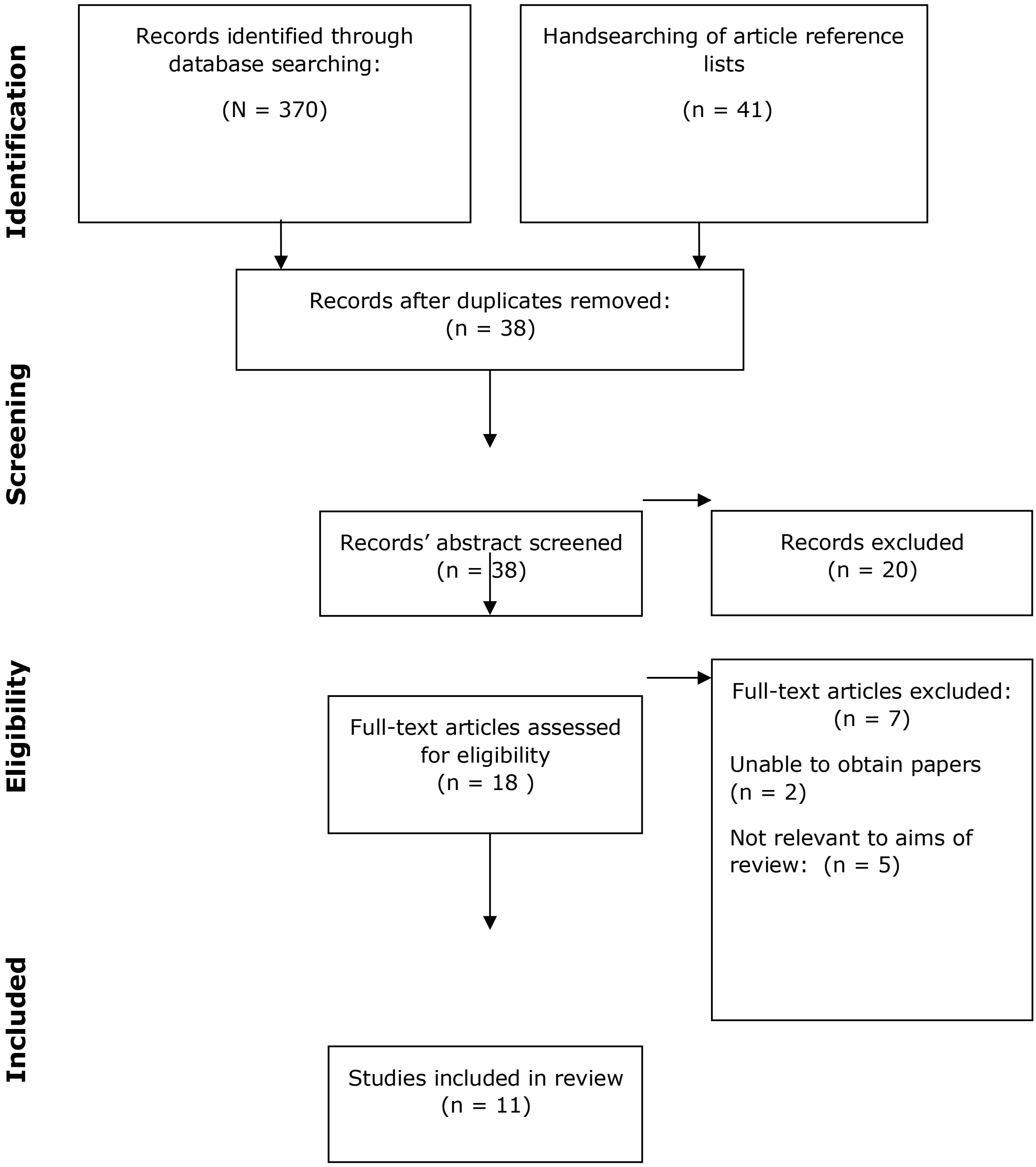

Figure 1. PRISMA flowchart of literature search

Table 1

Quantitative data: key characteristics and findings

Study	*Author (year), location*	*Sample (n, setting, characteristics)*	*Aims/Key questions*	*Intervention description*	*Methodology, data collected, where reported percentage of respondents included*	*Primary outcome***
1	Vallesi et al., (2019), Australia	N=179 (90 in intervention,89 in control) Setting: community Characteristics: Age:25-50	To establish effectiveness of the Journey to Social Inclusion (JS2I):Phase 2 intervention	Intervention group receive trauma-informed and strength-focused approach. Control group to receive TAU	Protocol for RCT 1) Quantitative self-report survey data** (x7) 2) Semi-structured interviews (x3,N=30)	Yet to be reported
2a(SS)	Johnson et al., (2011), Australia	N=83 (unable to fully determine	To evaluate the effectiveness of the JS2I pilot program assisting 40	Intervention group to receive:	RCT Primary outcome: percentage	Baseline Percentage housed:

	sample size from data) Setting: community Characteristics: 40 men,43 women Age:25-50	homeless people into permanent housing (12 months)	1) Support for ≥3 years 2) Intensive support (ratio 1:4) 3) Primary focus: rapid rehousing 4) Respond to mental and psychological health with a focus on trauma 5) Integrated training and skills Control group to receive TAU	obtained and retained housing Range of secondary outcome(s) data** Quantitative housing data collected at 8 time points Qualitative interviews at 4 time points (N=40) 12-month respondents: Intervention–36(90%)	Intervention - 12.5% TAU - 2.4% Percentage housed at 12 months* (p<.05): Intervention-75% TAU–30%

					Control–33 (76.7%)	
2b(SS)	Johnson et al.,(2012), Australia	As 2a(SS)	As 2a(SS), 24-month outcomes	As 2a(SS)	As 2a(SS) including a cost analysis using a cost-benefit analysis 24-month respondents: Intervention–36(90%) Control–32(72.7)	Percentage housed* (p<.05): Intervention–86% TAU–53%
2c(SS)	(Johnson *et al.*, 2014a), Australia	As 2a(SS)	As 2a(SS), 36-month outcomes	As 2a(SS)	As 2a(SS) including a cost-benefit analysis 36-month respondents:	Percentage housed* (p<.05): Intervention–85% Control–41%

					Intervention–34 (77.3) Control–34 (85%)	
2d(SS)	(Johnson *et al.*, 2014b), Australia	As 2a(SS)	As 2a(SS), 48month outcomes (follow-up)	As 2a(SS)	As 2a(SS) including a cost-benefit analysis 48-month respondents: Intervention–28 (70%) Control-28 (63.6%)	Percentage housed* (P<.05): Intervention-75% Control–58%

**for secondary data please see appendix A, * statistically significant
SS–Same study;TAU–treatment as usual;RCT–Randomised controlled trial

Table 2

Quantitative quality criteria (CASP)

		1	2a	2b	2c	2d
1	Did the trial address a clearly focused issue?	2	2	2	2	2
2	Was the assignment of patients to treatment groups randomised?	2	1	1	1	1
3	Were all of the patients who entered the trial properly accounted for at its conclusion?	0	2	2	2	2
4	Were patients, health workers and study personnel blind to treatment?	0	0	0	0	0
5	Were the groups similar at the start of the trial?	0	2	2	2	2
6	Aside from the experimental intervention, were the groups treated equally?	1	1	1	1	1
7	How large was the treatment effect?	0	2	2	2	2
8	How precise was the estimate of the treatment effect?	0	1	1	1	1
9	Can the results be applied to the local population, or in your context?	0	1	1	1	1
10	Were all clinically important outcomes considered?	0	2	2	2	1
11	Are the harms worth the cost?	1	2	2	2	2
Total quality score		6	16	16	16	15

Table 3

Qualitative data: Key characteristics and findings

Study	*Author (year), location*	*Aims/Key question(s)*	*Sample (n, setting, characteristics)*	*Data collected and method*	*Data analysis method*	*Key finding(s)*
2e(SS)	Parkinson (2012), Australia	18-month process evaluation of the JS2I pilot	Sample: staff, service-users and external stakeholders Setting:community-based	Service activity data, management reports and minutes, three rounds of independent surveys to staff, clients and external stakeholders, focus groups and individual interviews.	NS	Pilot was consistent with a trauma-informed approach adopted by JS2I.
2f(SS)	Parkinson and Johnson (2014), Australia	Final process evaluation of the JS2I pilot	As 2e(SS)	AB	NS	Highlights 5 key elements: 1) Staff access to trauma informed training and supervision

						2) Provision of intensive, individualised, long term support 3) Providing a service-users can trust 4) Smaller staff caseloads 5) A strong governance structure
3	Prestidge (2014), USA	To share knowledge of TIC approach in homeless services	Sample:staff Setting:community-based	Case study, collection method NS	NS	TIC provides staff and service users with: 1) An understanding of trauma, helping to improve relationships and recovery 2) Facilitates feelings of empowerment 3) Provides a safe environment
4	Foster et al.,(2009), USA	To describe strategies used by 11 funded projects for individuals transitioning to permanent	Sample:N/A Setting:3 community-based sites	Collated 150 project documents including; program notes, reports and conference calls minutes.	Thematic analysis	Three services adopted TIC finding it helped service-users manage symptoms of trauma and engage in therapeutic services. Helped staff understand the impact of trauma.

		supportive housing.				
5	Coleclough (2015), USA	To create guidelines for a trauma-informed environment in a homeless healthcare clinic.	Sample:30 service-users (21 male,9 female) Setting:homeless healthcare clinic	Qualitative semi-structured interviews	Thematic analysis	Identified three key themes for TIC implementation; 1) Safety in the Lobby 2) An integrated wraparound structure 3) Fostering client empowerment Highlighted the need for TIC being agency wide.
6	Apfel (2007), USA	To create a trauma-informed treatment guide for homeless women	Sample:7 single homeless women recruited via assertive outreach Setting:street outreach team	Content analysis of various treatment manuals, qualitative semi-structured interviews	Content analysis	Creation of a trauma-informed treatment guide highlighting importance of safety and provision of resources

NS–not specified;SS–same study;AB-as above

Table 4

Qualitative quality criteria (CASP)

		2e	*2f*	*3*	*4*	*5*	*6*
1	Was there a clear statement of the aims of the research?	2	2	2	2	2	2
2	Is a qualitative methodology appropriate?	2	2	2	1	2	2
3	Was the research design appropriate to address the aims of the research?	1	1	0	1	1	1
4	Was the recruitment strategy appropriate to the aims of the research?	2	2	0	2	1	2
5	Was the data collected in a way that addressed the research issue?	2	2	0	1	1	1
6	Has the relationship between researcher and participants been adequately considered?	0	0	0	0	2	1
7	Have ethical issues been taken into consideration?	0	0	0	0	2	2
8	Was the data analysis sufficiently rigorous?	0	0	0	1	1	1
9	Is there a clear statement of findings?	2	2	2	1	2	2
10	How valuable is the research?	2	2	1	1	1	1
Total quality score		13	13	7	10	15	15

Quantitative quality

All papers from the longitudinal study and the protocol adopted RCT designs. Though justification for this design was provided, there was a lack of transparency regarding randomisation with the process adequately documented in only one study (1). Though documented from initial recruitment to the trial’s conclusion (hence obtaining full marks), the recruitment process in 1 and 2a-2d was challenging to follow due to fluctuating retention rates. It is also unclear whether it was the same participants responding at each timepoint. The similarity of the comparison group is reported in some papers (2a-2d) and is a clear strength.

Though acknowledged as a challenge of social studies, no participants were blinded (2a-2d). Blinding is discussed and reported to be implemented in relation to external agencies in the subsequent pilot study (1), highlighting improvements to the future study design. The majority of data collected (2a-2d) was self-report data, particularly secondary outcome data (Appendix A), and predominantly utilised established questionnaires (e.g. HILDA, Wilkins and Lass, 2018). Three measures were developed (2d) for social acceptance, connectedness and support, though this data was only collected at a single timepoint. However, the authors reported Cronbach’s alpha for each, demonstrating internal consistency. The authors acknowledge the drawbacks of self-report data, such as social desirability bias.

All papers were marked down for treatment imprecision due to the possibility of external variables influencing outcomes. Though the project (2a-2d) reported significant changes in housing retention, the effect size for this change was not reported; consequently, the extent of the difference between the intervention and comparator is unclear. One (1) is a protocol, therefore was unable to be scored against several of the CASP components, hence receiving a lower score.

Qualitative quality

All papers provided a clear statement of aims and appropriate data collection methods. However, all could improve their methodology such as by facilitating anonymous feedback (5), increasing participant numbers (6) or including semi-structured interviews with project staff (4). Only two (5,6) linked their chosen methodology to their epistemological position, considered a critical aspect of qualitative research due to the inherent role of researcher bias, and considered methodological improvements.

Only three studies clearly stated their method of analysis (4-6), thematic or content analysis, though they provided only a partial account of the process. These could have been strengthened by outlining which documents contributed to each theme and evidencing these through constructs (4) and information regarding the coding process (5,6). Three (3,2e-2f) provided no information about the data analysis process. The participant-researcher relationship and ethical considerations of the research were discussed in only two (5,6).

Clear statements of findings were present in four (3,5,2e-2f), though one scored poorly due to the limited amount of data available for extraction (4). Only two (5,6) obtained a partial or full score on all appraisal measures.

RE-AIM synthesis

A synthesis of quantitative and qualitative data follows. Two qualitative themes were identified through thematic analysis, staff training and flexibility, and are incorporated into the RE-AIM framework where applicable. Descriptions of the RE-AIM dimensions can be found in Appendix B alongside indicators tailored to this review.

Reach

All papers clearly identified the appropriate target population for the intervention (homeless adults). Those which involved recruitment (1,2a-d,5-6) stated and applied appropriate inclusion and exclusion criteria.

These predominantly concerned current housing circumstances (e.g. homeless) and in some cases, age (2a-2d), recruiting new and current service-users.

Due to fluctuating retention rates within studies 2a-2d and lack of reporting of the number of participants in the qualitative studies, the total number of participants reached is hard to determine. Based on the data available for extraction, a total of 203 service-users (including study 1 as participants have been recruited and the trial in ongoing) are currently receiving or have received input from a service implementing TIC principles. This is likely to be an underestimate as no sample size data is reported for two papers (3-4). Homeless persons may benefit from the TIC treatment guide (6) being used in the future.

TIC increased the reach of services by providing staff training and flexibility assisting access to services where necessary. Training helped staff consider the impact of trauma (3), improving relationships. Providing a flexible service and assisting access to a range of support services on an idiosyncratic basis increased engagement (2a-2f,3-5). Several studies (1,5,2a-2f) offered a holistic service by providing support services at a single location (5) or assisting service-users to access services elsewhere (2a-2f). Following TIC implementation, participants felt a flexible 'one-stop shop' approach (5) helped alleviate anxiety around accessing services and meeting new people, supporting continued engagement.

Effectiveness

All studies, excluding 1 and 6, provided qualitative data from either staff or service-users on their experiences of TIC; however, only 2a-2f presented comprehensive primary and secondary outcome evaluation data at multiple time points, including 12-month follow-up (2d), alongside attrition rates.

In studies 2a-2d there was a significant increase in housing retention compared to control. Whilst the causal mechanisms for change cannot be clearly identified, qualitative data of service-users' experiences implied that forming a relationship with a dedicated support worker when obtaining housing was critical, with one service-user reporting it “made a big difference…and was the one thing that helped me to settle in” (Johnson et al., 2012, 16). However, of the participants, 15% did not obtain housing during the study (2c) and, following the study’s termination, housing retention dropped to 75% at follow up (2d). This indicates that the intervention positively impacted on participants’ ability to retain housing. Participant experiences described in the qualitative data attributed the subsequent reduction predominantly to reduced support and ending of relationships.

Studies 2a-2d collected a range of secondary report data (Appendix A). Whilst there are limitations to self-report data, participants in the intervention group overall demonstrated improved outcomes; for example, they reported reduced physical pain compared to control. Additionally, though there was no significant difference between the groups for mental wellbeing, qualitative data indicated that the support provided for the TIC intervention group helped service-users manage their mental health more effectively, with one service-user stating: “if it wasn’t for the JS2I program, I would be a lot sicker than what I am” (Johnson et al., 2014a, 13). Therefore, the full impact of TIC implementation may not be accurately reflected in quantitative data alone.

Attrition rates were tracked by the number of responses to the survey at each ‘round’ (2a-2d). However, it is unclear whether the respondents were the same for each round of the survey.

Adoption

Of the six studies identified, TIC had been adopted at at least seven sites. All clearly stated the setting for TIC implementation; five were community-based services (1,2a-2f,3,4,6) though two of these (1,6) had yet to fully implement TIC. One was a healthcare clinic and was the only study which highlighted the importance of providing a TIC-informed physical space.

Though one (4) had access to eleven sites, only three chose to implement TIC, with the reasons behind this not explored. However, based on the positive feedback relating to staff training, several additional sites have since incorporated TIC training, implying that the practice-based evidence generated encouraged further adoption elsewhere. Importantly, there is no indication that this adoption of TIC is being formally evaluated to add to the evidence base.

Though study 2a-2f described the staff involved in the project, none provided information on the extent to which staff adopted TIC. Additionally, none detailed how staff were identified to deliver TIC, though the assumption within all studies appeared to be that all staff working with service-users were TIC trained. Furthermore, though studies 3-4 highlighted that staff consistently provided positive data regarding TIC, the extent to which it was adopted at a service and organisational level was largely unclear. Only 2a-2f specifically referenced the extent to which TIC had been adopted by the organisation, highlighted in the following:

> "The relationship-based approach…has been sustained through a conscious effort to ensure that the philosophical, governance and practice elements are fundamentally aligned." (Parkinson, 2012, 7)

Implementation

It is challenging to explore how TIC was implemented since no studies used an implementation framework or fidelity tool. Though several studies referenced TIC principles (e.g. Hopper et al., 2010; 2a-2f,3,5,6), none explicitly stated that they were used to guide implementation. Therefore, it is unclear what was used to inform implementation, and the extent to which implementation followed TIC principles. It was evident that the focus for implementation differed depending on the service, for example; for 5, emphasis was placed on the physical environment, whilst for 6, this was less pertinent as the TIC intervention is for an assertive outreach team.

Only studies 1 and 2a-2d, when considered alongside the process evaluations (2e-2f), provided an adequate description of the changes implemented to deliver TIC, to enable replication of service delivery. Due to lack of transparency in the studies identified, it is challenging to compare how TIC was implemented at a service-delivery level using a specific set of TIC principles. Study 2a-2f provided information on specific changes to service delivery associated with TIC implementation, such as providing information on changes to staff-to-client ratio, the types of interventions offered (e.g. 'Building up and Developing Skills' programme': BUDS) and the number of times they were accessed (BUDS *N*=28). However, none of the papers were able to provide a clear intervention pathway for service-users, highlighting an important theme for TIC implementation derived from service-user and staff experiences: flexibility. Flexibility ensured that the service-user received tailored support, helping to build trusting relationships. For example, in two studies (3,4), clients could attend groups before receiving individual support. Study 2a-2d built flexibility into the service delivery model through smaller caseloads. Additionally, service-users would remain open to the service and able to access support even if they disengaged for a period of time.

Provision of TIC training was also key to implementation. Training helped staff effectively recognise and manage possible triggers for re-traumatisation before meeting service-users (3), helping service-users to feel safe, increasing engagement (5). One study stated that staff experiences of training was 'universally positive', reporting increased staff resilience and decreased reliance on managers (3). However, finding the right 'level' of training appeared problematic (2a-2f) due to the range of staff backgrounds in the service. Therefore, tailoring TIC to the service and staff appeared essential.

Only 2a-2f included information on the cost of initial implementation and a breakdown of TIC operating expenditure, with total funding being AU$3,920,000 for three years.

Maintenance - individual

None of the studies maintaining TIC (3-5) directly referenced how TIC was being maintained at an individual-level. As a result, none considered the ongoing impact on service-users, though 2a-2d did consider the impact at 12-month follow-up, detailed under 'effectiveness'. However, all bar one study (6) facilitated staff training on TIC, which provided staff with skills in working from a TIC perspective. Therefore, even in services where TIC has been discontinued, staff will be able to take their knowledge and skills from training forward and incorporate them into practice. Though 2a-2d did not continue TIC, it provided costings for individual support per participant over the three years, with the average cost being AU$80,000. It was also the only study to consider staff turnover, a key issue in homeless services (see Mullen and Leginski, 2010), with a specific focus on increasing staff supervision and support.

Maintenance - organisational

Of the six individual studies, three (3-5) reported continuation of a TIC approach; two (1,6) are ongoing studies. Of those maintaining TIC, none provided sufficient indication of TIC alignment with the organisational ethos, though one (5) alluded to additional changes across the organisation, but these were not considered within the study.

Though discontinued, study 2a-2d was the only study to provide a cost-benefit analysis (CBA) for the ongoing TIC implementation, an important consideration for policy-makers. Set-up costs were excluded from the analysis. Despite initial conservative predictions indicating that at 36 and 48-months the short-term costs would be higher than the economic benefit seen during the study, the final CBA indicates the converse, with the projected net benefit per participant being greater than the overall cost. Additionally, despite the associated short-term cost, the subsequent protocol (1) suggests there is a desire to modify and improve the TIC approach implemented in study 2a-2d, implying that the initial cost may not be the sole driver for policy-makers.

Discussion

This review sought to identify studies implementing and evaluating TIC in homeless services, appraise their quality, and synthesise the evidence using the RE-AIM framework, considering key outcomes.

The identification of six separate studies, excluding two that were unobtainable, suggests there is emerging evidence of the implementation and evaluation of TIC in homeless services, implying that it is more than conceptual. However, the number of studies identified highlights the continuing paucity of evidence in the public domain. The adoption of TIC in homeless services may be higher (e.g. 4), though there is a lack of freely available practice-based evidence to support implementation. This evidence may still be within the 'translational gap' between research to implementation into practice (Tansella and Thornicroft, 2009).

When considering the evidence using the RE-AIM framework, the findings highlight the lack of clear and consistent reporting of key information needed to consider how TIC is being implemented. A range of settings implemented TIC; from a homeless healthcare clinic to community-based services. However, details relating to TIC implementation varied significantly, with only two providing sufficient detail to facilitate replication at a service provision level (1,2a-2f). This lack of clear reporting may be hindering the uptake of TIC into other services. Whilst TIC should be tailored to the service, hence the variation in focus from physical space (5) to the delivery of a trauma-informed treatment guide (6), examples of applications in services could be used as 'templates' or 'guides' to assist future implementation elsewhere.

None of the studies used a specific set of TIC principles or framework(s) to support implementation, or a fidelity tool to evaluate TIC implementation (e.g. TIC-ometer or ARTIC, Bassuk et al., 2017; Baker et al., 2016). This further highlights the lack of transparency which could hinder subsequent implementation(s) and replication(s). The latter is of particular importance; by omitting a fidelity tool, there is no way of measuring whether TIC has actually been implemented, or whether it is in name only, possibly fuelling accusations that TIC remains predominantly rhetorical. The reasons behind these principles, frameworks and tools not being used is unclear. Despite Hopper et al.,'s (2010) attempt to construct consensus-based principles from the available literature, it could be attributed to the absence of these being formally agreed. Not utilising these reduces the ability to compare and contrast implementation of TIC between different settings due to a lack of clear implementation objectives. This impacts on the ability to ascertain what is most effective, which could reaffirm the notion that TIC is 'fuzzy'. Consequently, future research should seek to produce high-quality evidence, providing clear, transparent reporting of how TIC is implemented and evaluated. Consensus around a clear set of principles, an implementation framework and recognised fidelity tool could assist future implementation and evaluation, ensuring that implementors can demonstrate that their efforts are more than rhetorical.

Though this review has highlighted the lack of clear reporting of how TIC is being implemented, the themes identified from the qualitative data of staff and service-user's experiences indicates what may have assisted with implementation. Increased flexibility and staff training allowed staff to work flexibly to provide idiosyncratic care, and increased staff understanding of the impact of trauma on service-users, facilitating the founding principle of TIC: building and sustaining relationships. Therefore, TIC implementation should seek to include these aspects which are likely to facilitate the relationship-based approach.

Implementation of TIC was predominantly evaluated through qualitative data (2a-2f,3-5). Only one study (2a-2f) provided quantitative evidence, excluding the use of a fidelity tool. Increased housing retention rates alongside improvements in secondary outcomes highlights the possible benefits of implementing TIC, supported by the subsequent decline after the study's termination. Though the causal mechanisms for this change are unclear, qualitative data indicates that service users attributed these improvements to the forming of supportive relationships. Despite housing retention being the primary aim of 2a-2d, 15% of participants in the intervention group did not achieve this. Though the reasons behind this are not explored, this could suggest that implementing TIC will not resolve homelessness, or it may take some longer to feel safe enough to be housed. Alternatively, there is at present nothing to indicate that the intended outcome of implementing TIC is increased housing retention. It may be that the intended outcome of TIC implementation is to foster feelings of safety to facilitate relationships, with housing being a secondary outcome. Therefore, whilst research may wish to consider the experiences of TIC implementation by this 15%, prior consideration may need to be given to the intended outcome of TIC implementation amongst homeless persons.

Based on the evidence, though implementing TIC in homeless services is likely to be costly, the estimated economic cost of trauma (Dolezal et al.,2000) and projected benefits (2d) may outweigh the costs. However, the delayed return in investment may be off-putting for policy-makers and commissioners; though the additional protocol (1) suggests that commissioners may see future value in the implementation of TIC. Further high-quality, practice-based evidence exploring future benefits is needed but would require initial investment.

The quality of the data did vary. Whilst contributing to the wider understanding of how TIC is being implemented in homeless services, some studies' quality and transparency was lacking (e.g. 3). Future qualitative research should seek to clearly document how TIC was implemented in specific services, alongside service-users' and staff perspectives of implementation. This is likely to result in high-quality contributions to the evidence base relating to TIC implementation and evaluation. This aside, the quality ratings and RE-AIM framework highlight gaps and provide clear areas for improvement; some of these are being addressed within the quantitative studies (e.g. 1). Critically, in relation to the evaluation of TIC, studies 1 and 2a-2f highlight the ability for high-quality RCTs and CBA to be conducted in this complex area of research, which may encourage others to evaluate TIC implementation in this way.

Review strengths and limitations

A methodological strength of this review is combining qualitative and quantitative studies: if this data was considered separately such detailed findings may not have been uncovered. However, there will be an inherent bias in this review, as the author's own epistemology will have guided the chosen methodology, data analysis and synthesis and therefore, its findings.

Most of the studies which received the highest quality scores did not have to adhere to the same wordcount stipulated within standard journals, highlighting a bias in the quality appraisal process, with undue weighting given to these. Future reviews should seek to address this imbalance.

Conclusion

Overall, though low in numbers and varied in quality, evidence is emerging of TIC implementation and evaluation in homeless services. The evidence highlights the need for more robust and transparent reporting of how TIC has been implemented, to highlight strengths and areas for improvement, facilitate replication and assist other services who may wish to implement TIC. Lack of transparent reporting could be attributed to the absence of an agreed set of TIC principles, implementation framework(s), and fidelity tool(s) meaning services and organisations may struggle to evidence TIC implementation and evaluation. This may result in organisations facing uncertainty about how to implement TIC due to lack of clarity. Consequently, it is important that consensus is gathered around a set of clearly defined principles, frameworks and fidelity tools, helping TIC become tangible and therefore measurable. This is likely to support further high-quality research, such as RCTs and the transparent reporting of the implementation and evaluation of TIC in a range of homeless settings. Demonstrating the efficacy of TIC and possible cost savings may encourage wider service and organisational uptake.

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Appendix A

Table 5

Quantitative secondary outcome data

Study	*Author (year), location*	*Secondary data collected*	*Outcomes (where applicable and reported: mean difference between control and intervention groups, significance value)*
1	Vallesi et al., (2019), Australia	*Demographics* General demographics (e.g. age, gender, aboriginality) Education (highest attained) *Homelessness and housing* Housing history Current living arrangements Housing location Adequacy of accommodation *Life experiences and skills*	Yet to be reported

Independent Living Skills Scale

Reported problems experienced (e.g. gambling, reading, writing)

Family history and support networks

History of family violence

Relationship state

Children

History of out-of-home care

Current contact with family

Enriched Social Support Instrument

Three item Loneliness Scale

Support received from services

General health

Diagnoses of conditions held*

Health service utilisation*

Mental health and wellbeing

Short Warwick-Edinburgh Mental Well-being Scale*

Kessler Psychological Distress Scale*

Depression Anxiety Stress Scales, Short form (DASS)*

Single-item Self-Esteem Scale*

Mental health diagnoses and treatment*

Quality of Life

World Health Organisation Quality of Life – BRIEF*

Trauma

World Health Organisation Composite International Diagnostic Interview

Abbreviated PTSD Checklist*

Alcohol and Drug Use

Alcohol and drug use*

Detox service usage*

		Economic participation Labour force participation history *Justice system* Involvement with justice system*	
2a(SS)	Johnson et al., (2011), Australia	Secondary outcome(s) at 12 months for 6-12month reporting. Range of self-report data on: Physical health measured by score of 'bodily pain'* Mental health measured by the DASS* Social acceptance and support* Health service usage* Homeless service usage* Substance misuse* Workforce participation* Incarceration rates*	*Physical health* Mild bodily pain, no significant difference (M = -15.2, p> .15) Moderate bodily pain, no significant difference (M = -10.4, p> .28) Severe bodily pain, no significant difference (M = 2.3, p> .84 *Mental health* Mean DASS score, no significant difference (M = 1.5, p> .84) Depression score (DASS), no significant difference (M = .7, p> 0.81)

Anxiety score (DASS), no significant difference (M = -0.2, p> .95)

Stress score (DASS), no significant difference (M = 0.9, p> .74)

Health service usage

Proportion used health services, significant difference (M = 23.5, P <.045)

Number of times used an emergency ward, no significant different (M = -0.6, p > .65)

Proportion used psychiatric ward, no significant difference (M = -3.5, p >.58)

Average number of times used psychiatric ward, no significant difference (M = -5.8, p> .61)

Proportion used hospital (M = -10.9, p>.30)

Average number of days in hospital, no significant difference (M = -3.1, p >.128)

Average number of days in hospital if used, no significant difference (M = -9, p >.15)

Proportion used psychiatric unit, no significant difference (M = -3.5, P>.58)

Average number of days in psychiatric unit if used, no significant difference (M = -12.5, p> .774)

Substance misuse

Problematic and/or frequent substance use, no significant difference (M = -15.2, p >.15)

Homeless service usage

Average number of times used homeless service, no significant difference (M = -7.2, p> 17)

Average number of times used crisis accommodation facility, no significant difference (M = -0.2, p>.15)

Average number of times used JSA-Job network, no significant difference (M = 0.1, p >.73)

Average number of times used JSA-Personal Support program, no significant difference (M = 0.7, p>.179)

Social support

Scale of social acceptance, no significant difference (M = -0.2, p>.886)

Scale of social support, no significant difference (M = -1.9, p>.557)

Incarceration

Proportion incarcerated, significant difference (M = 14.3, p<.02)

Workforce participation

			Proportion doing paid work, no significant difference (M = 8.1, p> .19) Proportion not employed and looking for paid work, no significant difference (M = 18.4, p>.06) Proportion not employed and looking for paid work, significant difference (M = -26.5, p<.01) Proportion currently doing unpaid work, no significant difference (M = 2.5, p>.60)
2b(SS)	Johnson et al.,(2012), Australia	Secondary outcome(s) at 24 months for 18-24month reporting. Range of self-report data on: Physical health measured by score of 'bodily pain'* Mental health measured by the DASS* Social acceptance and support* Health service usage* Homeless service usage* Substance misuse* Workforce participation* Incarceration rates*	*Physical health* Percentage reporting no bodily pain, no significant difference (M = -22.4, p> .06) *Mental health* Mean DASS score, no significant difference (M = -10, p> .2) Depression score (DASS), no significant difference (M = -2, p> .53)

Anxiety score (DASS), no significant difference (M = -3, p> .24)

Stress score (DASS), no significant difference (M = -5.1, p> .08)

Health service usage

Number of times used an emergency ward, no significant different (M = -0.3, p > .97)

Proportion used emergency psychiatric services, no significant difference (M = 4.5, p >.56)

Average number of times used psychiatric ward, no significant difference (M = -5.8, p> .61)

Proportion used hospital, no significant difference (M = -5.9, p>.58)

Average number of days in hospital if used, no significant difference (M = -3.7, p >.46)

Proportion admitted to psychiatric unit, no significant difference (M = -1.5, p>.472)

Average number of days in psychiatric unit if used, no significant difference (M = -9.8, p>.58)

Substance misuse

Percentages reported for all substances surveyed, please see original text for full details.

Homeless service usage

Average number of times used homeless service, no significant difference (M = -0.2, p> .698)

Average number of times used crisis accommodation facility, no significant difference (M = -0.4, p> .32)

Social support

Scale of social acceptance, no significant difference (M = -0.2, p>.91)

Scale of social support, no significant difference (M = -2, p>.43)

Incarceration

Proportion incarcerated in last 6 months, no significant difference (M = -0.7, p<.09)

Proportion charged with a criminal office in last 6 months, no significant difference (M = 15.6, p>.08)

Workforce participation

Proportion doing paid work, no significant difference (M = -7.3, p> .36)

Proportion unemployed and looking for paid work, significant difference (M = -23.6, p<.02)

Number of times participated in all employment services, significant difference (M = 6.5, p<.01)

2c(SS)	(Johnson *et al.*, 2014a), Australia	Secondary outcome(s) at 36 months for 30-36month reporting. Range of self-report data on: Physical health measured by score of ‘bodily pain’* Mental health measured by the DASS* Social acceptance and support* Health service usage* Homeless service usage* Substance misuse* Workforce participation* Incarceration rates* Life satisfaction survey (HILDA)	*Physical health* Report no bodily pain in the last four weeks, no significant difference (p>.8) *Service usage* Number of times used crisis accommodation, no significant difference (p>.82) *Incarceration* Charged with a criminal offence in the last 6 months, no significant difference (p>.12) Incarcerated in the last six months (p>.56) The following provided no mean or significance values, and were reported in the main body of the document: Intervention group’s DASS score lower in all domains at 36 months compared to baseline. Control’s also declined.

			No significant difference in health service usage reported. No significant difference reported in substance usage. No significant difference reported in employment rates. No significant difference reported in social acceptance or report. No significant difference reported in life satisfaction.
2d(SS)	(Johnson *et al.*, 2014b), Australia	Secondary outcome(s) at 48 months for 42-48month reporting. Range of self-report data on: Physical health measured by score of 'bodily pain'* Mental health measured by the DASS* Social acceptance and support* Health service usage* Homeless service usage* Substance misuse*	*Physical health* Reporting no bodily pain in the last four weeks, no significant difference (p> .42) Reporting severe bodily pain in the last four weeks (M = 28, p>.94) Reporting moderate bodily pain in the last four weeks, no significant difference (p >.7)

	Workforce participation* Incarceration rates* Social connectedness (created for programme, Cronbach’s alpha score of 0.782) Social support and satisfaction (created for programme, Cronbach’s alpha score of 0.795)	*Health service usage* Average number of times used crisis accommodation facilities, no significant difference (p>.5) *Incarceration* Charged with a criminal offence between interviews, no significant difference (p>.75) Incarcerated in the last six months, no significant difference (p>.64) The following provided no mean or significance values, and were reported in the main body of the document: Scores on the DASS increased for the intervention group following the programmes termination, but no significant difference was reported. Health service usage show that the number of emergency hospital

admissions increased slightly for the control by 4% and decreased for the intervention group by 2%. Little difference was seen at other hospital usage e.g. emergency psychiatric admission. There was a marked decline in the reported usage intensity for intervention participants, such as a decline in psychiatric unit admission days falling from 24 to 4 days but increased to 19.5 at 48months. Overall there was an increase in the control groups health service usage. Overall the average health usage, combining the service usage and duration, decreased at 48month follow up for the intervention compared to control, who remained the same.

Substance misuse showed little change in either group for the duration of the programme, including at 48-month follow up.

Economic participation reduced to baseline at 48-month follow up.

Social connectedness, support and satisfaction showed small increases in both groups at 48-months.

*data collected at 6 month intervals. Table contains 12 month report data. Please see original paper(s) for all available data.

Appendix B – RE-AIM framework and indicators

Table 6

RE-AIM indicators

Dimension*	Dimension description	Indicator
Reach	Number of individuals willing to participate in an intervention	Identified target population
		Inclusion and exclusion criteria
		Number of target population reached
		Factors improving reach
Effectiveness	An interventions outcome(s) including negative outcomes	Evaluation/results presented, either qualitative or quantitative from implementation
		Follow up results reported
		Service users/staff experiences of TIC (if available)
		Attrition rates
Adoption	The number of settings which adopt the	Number and description of TIC implementation setting

	intervention and/or initiative	Method of identification and description of staff delivering intervention
		Consideration of staff adoption of TIC model
		Consideration of service and/or organisation adoption
Implementation	Fidelity to elements such as a protocol, consistency of delivery over time and the interventions cost. This may also refer to the clients use of strategies	Reference to TIC principles used to facilitate implementation
		Fidelity tool used to evaluate implementation
		Implementation framework tool used to facilitate implementation
		Description of implementation adequate to facilitate replication
		Service users/staff experiences of TIC implementation (if available)
		Cost of initial implementation

Maintenance: individual	Long term effects of the programs outcomes for the individuals involved	Staff continuation of TIC Staff turnover & supervision Impact on service users
Maintenance: Organisational	Extent to which the intervention/program/policy becomes institutionalised or part of routine practice.	Indication TIC was maintained Indication of alignment with organisational ethos Cost of maintenance

Journal paper

Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

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Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Running title: Guidelines for Clinical Psychologists in Homelessness

Running title: Guidelines for Clinical Psychologists working in Homelessness

Key words: Clinical Psychologists, practice guidelines, homelessness, delphi

Abstract

Objectives: Clinical Psychologists are increasingly being employed to work within homelessness. Many in the homeless population are considered severely and multiply disadvantaged (Sosenko et al., 2020). Despite growing numbers, there are no guidelines to support their work and commissioner's understanding of the resources required. Given the lack of evidence, it was hypothesised Clinical Psychologist's may have access to practice-based evidence (PBE) which could be harnessed to create practice-based guidelines, filling the research-policy gap.

Design: The Delphi Method of consensus building was used, intending to last up to three survey rounds.

Methods: A panel of 12 UK Clinical Psychologist's with experience of working within homelessness were recruited. The Delphi Method was used to develop practice-based consensus guidelines to support UK Clinical Psychologist's direct and indirect work in homelessness. Each proposed three guidelines for direct and indirect work in Round One. Consensus was set at ≥80% agreement across two survey rounds.

Results: Consensus was reached after two survey rounds. The panel endorsed 23 direct and 26 indirect working guidelines. Direct guidelines fell under three categories: "Approach", "Multi-agency working" and "Individual Therapy", and Indirect guidelines under four: "Relationships with and support for staff", "Supporting staff to support service users, including building therapeutic skills", "Approaching systems change" and "Contributing to the evidence base".

Conclusions: Clinical Psychologist's working in homelessness have generated PBE which can fill the research-policy gap. This can support

practice alongside commissioners' understanding of the resources required. Future research should explore staff and service users experience of the guidelines in practice.

Practitioner points

- Practice-based guidelines can support Clinical Psychologist's working in homeless services by providing them with readily accessible, flexible guidance on how best to support service users and staff, seeking to improve outcomes.
- Commissioners can use these guidelines to understand what resources are required to deliver effective Clinical Psychology support within homelessness.
- These guidelines relate specifically to the United Kingdom; thus, international applicability is limited.
- Lack of specificity of the guidelines – though supported by clinical vignettes – may make the guidelines less operationally viable.

Introduction

Social policy in the United Kingdom (UK) is increasingly recognising the needs of the homeless population[2]. In England, between 2010-2017, rough sleeping increased by 165% and from March 2019-2020, use of temporary accommodation rose by 9.4% (Ministry of Housing Communities & Local Government, 2019, 2020). As these figures do not account for the "hidden homeless" including those sofa surfing or squatting, this number is likely to be higher[3], and is expected to rise following COVID-19 (British Medical Association, 2020). Consequently, homelessness is high on the UK's political agenda, with legislation such as the Homelessness Reduction Act (HRA) introduced to reduce rising numbers (United Kingdom Parliament, 2017)[4,5].

Numerous risk factors for homelessness have been identified highlighting the complex interplay between structural and individual issues (Bramley & Fitzpatrick, 2018)[6]. Evidence repeatedly highlights poor mental health is a predictor and consequence of homelessness (Fazel et al., 2008; Mejia-Lancheros et al., 2020)[7]. Roughly 45% of those who are homeless have at least one diagnosed mental health problem, twice the rate of the general population (Homeless Link, 2014b). Histories of offending and substance misuse are prevalent, alongside histories of trauma and Adverse Childhood Events (ACEs; Felitti et al., 1998; Fitzpatrick et al., 2013)[8]. Escaping domestic violence is a significant contributing factor to women becoming homeless (Sosenko et al., 2020). Furthermore, becoming homeless is often traumatic and increases the risk of further traumas (Hopper et al., 2009). Consequently, backgrounds of

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[2] See extended 1.1
[3] See extended 1.2
[4] See extended 1.3
[5] See extended 1.4
[6] See extended 1.5
[7] See extended 1.6
[8] See extended 1.7

compound traumas are common, whereby an individual cannot recover from one traumatic event before the next occurs (Cockersell, 2015).

People experiencing combinations of homelessness, mental health problems, violence and abuse, and substance misuse are considered to be facing "severe and multiple disadvantage"[9] (SMD; Sosenko et al., 2020) and are often socially excluded[10]. They have complex needs only likely to be met by a multiple non-statutory and statutory services, but these often lack integration (Canavan et al., 2012). Thus, whilst they are only a small portion of the general population, they are relatively costly to society (Fitzpatrick et al., 2013; Pleace, 2015)[11].

Scanlon and Adlam (2006) have conceptualised those who struggle to maintain housing and engage with services as having an 'unhoused mind'[12]. They hypothesise experiences of childhood trauma – particularly those impacting on feelings of safety – can result in chronic relational difficulties, manifesting in a pervasive mistrust in others. Consequently, they face exclusion from services due to their inability to consistently engage (Scanlon & Adlam, 2006, 2012; Seager, 2015)[13]. Limited preventative services and inadequate responses to this group give rise to significant challenges for both the individuals who need support and the services attempting to deliver support, often without adaptation/flexibility from mainstream service delivery.

Considering the resource constraints and lack of access to services, it is unsurprising organisations and staff teams may struggle to effectively work with this population. Homeless and mainstream support service staff often have no formal training in supporting individuals facing SMD (Canavan et al., 2012), and often have access to few resources to support such complexity, resulting in many feeling powerless (Cockersell, 2015).

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[9] See extended 1.8
[10] See extended 1.9
[11] See extended 1.10
[12] See extended 1.11
[13] See extended 1.12

Though research indicates comparable levels of burnout to other frontline professions (Waegemakers-Schiff & Lane, 2019), staff have elevated levels of stress (Lemieux-Cumberlege & Taylor, 2019) and higher rates of Post-traumatic Stress Disorder (Waegemakers-Schiff & Lane, 2019)[14].

Psychologically Informed Environments (PIES; Haigh et al., 2012) and Trauma-Informed Care (TIC; Hopper et al., 2009) adopt a system-wide approach, promoting the importance of relationships and recognition of the impact of trauma on service users (FEANTSA, 2017)[15]. Despite both being major drivers in homelessness service development (FEANTSA, 2017; Keats et al., 2012) evidence of their efficacy, though broadly positive (Breedvelt, 2016; Templeton, 2018; Williamson, 2018), remains sparse.

Alongside developments regarding PIEs and TIC, guidance is increasingly advocating that psychological support should be an integral aspect of service provision (Department of Health, 2013; Maguire, 2015). Evidence indicates homeless people are accessing psychological support including Clinical Psychologists (CPs) through statutory and non-statutory organisation’s for both initial assessments and ongoing treatment (Reeve et al., 2018). CPs are trained in a range of therapeutic models to support understanding of complex psychosocial difficulties. They have skills in critically appraising, systematically applying, and evaluating psychological theory and research in practice, with additional training and knowledge in systems change and leadership (HCPC, 2015; The British Psychological Society [BPS], 2019)[16]. However, despite growing numbers, guidance on how best to work within homelessness and SMD is not a compulsory part of CP training. Furthermore, there is little evidence available about how best to support this population, and no guidelines to support CPs in applying their multifaceted skillset in this complex area, or the

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[14] See extended 1.13

[15] See extended 1.14

[16] See extended 1.15

commissioner’s likely to employ them. This research seeks to address this gap.

Services and professionals seek to follow evidence to inform practice (evidence-based practice; EBP)[17], using guidance (e.g. National Institute for Health and Care Excellence, 2020) informed by rigorously conducted trials, which arguably lack ecological validity, neglecting variability of context (Knaapen, 2013). However, there are areas – such as homelessness – where this evidence does not exist, resulting in a research-policy gap. Despite the absence of evidence, CPs have been working in homelessness services, meaning they are likely to have valuable knowledge into how best to work with this population. Consequently, it is likely that CPs have generated practice-based evidence (PBE) which could be synthesised to form the basis of practice-based guidelines (PBG) for CPs working in homelessness, an approach used effectively in other areas with little available evidence[18] (e.g. English et al., 2020). Complementary to this is the notion of “mindlines”[19], which proposes when gaps in knowledge are identified, clinicians seek out the wisdom of others even if evidence-based guidelines (EBG) are available. This shared knowledge results in the forming of tacit guidelines, termed “clinical mindlines” (Gabbay & le May, 2004, 2016). Thus, the aim of this research was to harness existing CP knowledge and synthesise this PBE using the consensus-based Delphi Method (Linstone & Turoff, 1975)[20], and providing consensus was reached, create consensus-based PBG for CPs working in homelessness.

Method

The Delphi method is a method of consensus building. It has been applied to synthesise practice-based knowledge of experts in areas where research-based evidence is lacking (Linstone & Turoff, 1975). It is

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17 See extended 1.16
18 See extended 2.1
19 See extended 1.16
20 See extended 2.2

increasingly being applied in guideline development (e.g. Bisson et al., 2010; English et al., 2020)[21].

The lack of methodological guidance for conducting a Delphi (Hasson et al., 2000) means measuring the quality and strength of a study can be challenging. Though not a formally agreed framework, Diamond et al.,'s (2014)[22] proposed quality criteria to evaluate a Delphi was used throughout to guide the research team.

Study approval was obtained from the University of Nottingham Faculty of Medicine & Health Science Research Committee (reference number DPAP-2020-0436-3).

Study design

A classic Delphi (Young & Hogben, 1978) was conducted. As consensus diminishes after three Rounds (Thangaratinam & Redman, 2005), a maximum of four Rounds was planned. Round One consisted of an initial interview with panel members (PMs)[23] from which guidelines were suggested, followed by two survey Rounds to build consensus. Round Four would only be used as a survey if multiple guidelines were 'approaching consensus'. If consensus had been reached, this final round would be used to obtain feedback and clinical vignettes from the expert panel.

Prior to the Delphi, a group of four members of an existing Expert Citizens' group were consulted[24] to provide the following:

- insights into their lived experience(s) of homelessness, mental health and contact with CPs
- input they may have found helpful from CPs

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[21] See extended 2.3
[22] See extended 2.10
[23] See extended 2.4
[24] See extended 2.5

Participants' consented to being audio-recorded. The recording was transcribed, anonymised, and analysed semantically by the primary researcher who identified and summarised key quotes and responses by participants'. The recording and summarised information was then reviewed by the second researcher and distributed via email to PMs prior to Round One.

Participants and recruitment

Four expert citizens - all male - were recruited via a local Fulfilling Lives Programme that supports individuals facing SMD. To compensate them for their time, each were given a £10 voucher.

CPs in the UK were recruited to the panel through advertisement on social media, snowballing and, if working in the third sector, through direct correspondence initiated via email by the primary researcher. The inclusion criteria were:

- Qualified and HCPC registered CP
- Currently or until recently involved in either direct work (which includes working directly with clients and/or supporting staff working directly with clients) and/or research work with the target population
- ≥1 year of experience working with the target population (direct or indirect)
- Access to a computer and the internet

CPs were asked to email the researcher to express interest. After confirming they met inclusion criteria, participants were sent the consent form and participant information, and asked to sign and return the form via email. To thank CPs for participating, a £10 donation was given to a homeless charity of their choice.

Considering the panel size and accounting for attrition across the Rounds (Donohoe & Needham, 2009; Jorm, 2015), we sought to recruit 15-20 PMs. However, as the Covid-19 pandemic coincided with participant recruitment, the research team agreed ≥10 would be sufficient.

Round One[25]

To help PMs orientate to the interview topic, reflect on their own work, and consider the service users views in their interview responses and suggested guidelines, one working day before the interview, PMs were sent a summary of the information derived from the Expert Citizen consultation via email.

PMs were given the option of telephone, virtual or face-to-face semi-structured interviews to provide flexibility, increasing the pool of available participants across the UK. This was reduced to virtual or telephone meetings due to Covid-19. Using the first round for interviews provided an opportunity for the researcher to clarify the study aims and build a relationship with PMs, important in improving response rates across rounds (Hasson et al., 2000; Whitman, 1990). Broad questions provided space for clinicians to explore concepts whilst ensuring all aspects relevant to the research were covered (Keeley et al., 2016).

Round One served two purposes: the first to elicit potential guidelines from participants, and secondly to explore practice-based examples with CPs of their work in homelessness, which would later be used as the practice-based examples to accompany the guidelines. Consequently, interviews focused on exploring PMs experiences of working with individuals experiences homelessness, considering what had and had not gone well, and what may have supported their practice. Each interview explored direct working and then indirect working. For each, PMs were asked to provide three potential guidelines for CPs working within homelessness settings. Guidelines from PMs were included

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[25] See extended 2.6

verbatim, amended only for grammatical clarity. They were collated and arranged in categories identified by the researchers, as previous research has indicated this improves accessibility (English et al., 2020). The collated guidelines were distributed to PMs for rating in Round Two.

Round Two[26]

Guidelines from Round One were collated into a survey on Microsoft Word and divided into those relating to direct and indirect working. Guidelines were grouped under similar 'categories' identified on a semantic rather than inductive level (e.g., 'the relationship') to reduce the burden on PMs. All PMs received surveys via email.

PMs were required to rate each guideline using a five-point Likert scale to indicate its importance (figure 2) and provide feedback in a free-text box. All were given ten working days to respond. A reminder email was sent to those who had not responded a week before and on the day of the survey deadline. All items from Round Two were included in the Round Three, using a similar Microsoft Word-based survey to Round Two.

Round Three[27]

PMs received a personalised survey which included their response alongside the panel's overall response for the last round, presented in percentages (figure 2). All qualitative feedback from Round Two was anonymised and presented in Round Three below the corresponding guideline. All guidelines were presented, including those that had reached the required consensus level for inclusion/exclusion from the final set. Those that had reached consensus for inclusion with no modification were presented at the start of each section and those that had reached consensus for exclusion were presented at the end. Guidelines that were 'approaching consensus' or had undergone significant modification were included to be re-rated and placed in the same order as in Round Two. All

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[26] See extended 2.7

[27] See extended 2.8

guidelines retained the same numbering to facilitate transparency between surveys, allowing PMs to track changes. Instructions were included above each guideline which required re-rating and/or further input with details of how each guideline had been modified. The original guideline was included below in grey for transparency, showing PMs how each guideline had been modified by the researcher following feedback. PMs were given 10 working days to respond; however, the deadline was extended to 15 working days to reduce the impact of the summer holidays on response rates (Donohoe & Needham, 2009).

Round Four – final guidelines[28]

Round Four was used for member checking of all endorsed direct and indirect guidelines (Birt et al., 2016). The researchers sought to provide two practice-based vignettes for each guideline, taken from the Round One interviews and anonymised. To create the vignettes, the primary researcher reviewed and extracted relevant examples from the Round One interview recordings, removing and/or redacting any potential identifiers of the clients, staff, organisation(s), or CPs in the practice-based examples, whilst using the PMs own words. Whilst the examples focus on CP experiences of their work in homelessness, anonymising and protecting anonymity was clearly a crucial component given the inability to determine whether those included in the PMs practice-based examples had consented to this information being shared.

Vignettes were sent to the second and third authors to ensure they were relevant to the guideline prior to circulating. PMs were asked to provide practice-based examples for eight direct guidelines and 13 indirect guidelines where <2 vignettes had been identified.

Round Four was also used to collate general feedback regarding the output, with a free-text box included at the end of the direct and indirect guidelines. Instructions indicated no modifications would be made to the

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[28] See extended 2.9

guidelines following Round Four unless multiple PMs highlighted the same issue. Original numbering was retained to support transparency and altered after Round Four after vignettes had been finalised to ascending numerical order. The deadline was extended to allow several PMs who expressed a desire to input but were unable to in the original timescale.

Figure 2.

Example of Likert scale and Round Three survey item with percentage and PM response(s).

5. *Be accessible and available so that people can reach you, working where they are and feel comfortable and be visible to the homeless community.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				45%	55%
How you responded in Round 2:				X	

Comment:

- Is an overlap with 3 and 4, but I prefer 5
- There’s two points here allowing people to come to you as well as going to them as covered earlier.
- Essential but very similar to 3. I prefer 3 wording and breadth it covers
- Similar to 4

Determining consensus

As there are no guidelines to help determine the level of consensus required, Delphi literature was referred to (Donohoe & Needham, 2009; Jorm, 2015). Consensus was set apriori to 80-100% to reduce the impact of individual responses and achieve content validity (Lynn, 1986), and ≥70 for 'approaching consensus' in either direction on the Likert scale. Guidelines rated as 'approaching consensus' would require re-rating in the following Round unless enough overlap was present to allow for incorporation into another guideline, alongside those deemed by the research team to have:

- Undergone significant modification to guideline wording.
- Had a change in focus and/or meaning following amendments.
- Combined two or more guidelines.[29]

Results

The full Delphi process including Expert Citizen consultation group, selection of the final sample of 12 PMs and PM input throughout the Delphi Rounds is shown in figure 3, with demographics[30] for 11 of the 12 PMs in table 7. Fourteen individuals expressed interest in participating in the research. Two did not meet the inclusion criteria regarding length of time working in homelessness. Thus 12 participants formed the expert panel. Ten of the panel had direct clinical experience, and one predominantly research. Consensus levels for each guideline were calculated based on the number of PMs who had provided a response to each proposed guideline[31]. For data on the feedback received across Rounds Two and Three, please see tables 3 and 4[32].

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[29] See extended 2.11 for epistemological position

[30] See extended 3.1

[31] See extended 3.2

[32] See extended 3.3

Figure 3.

Delphi process and participant contribution.

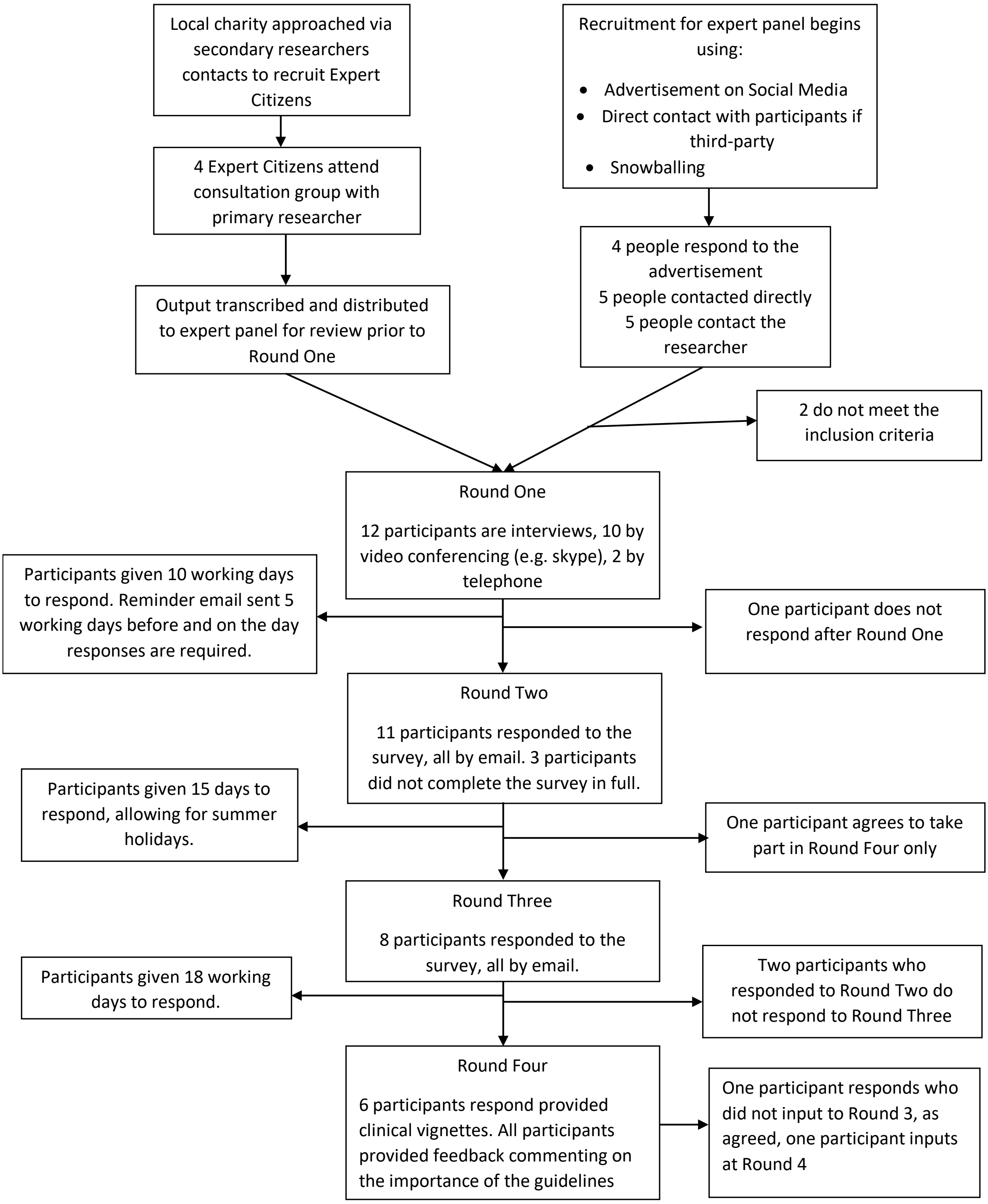

Table 7. Expert panel (N=11) demographics[1]

Gender	*N*	Age	*N*	Ethnicity	*N*
Male	6	30-39	6	White British	8
Female	5	40-49	4	Other White	1
		50-59	1	Black Caribbean and White	2
Religion	*N*	Location	*N*	Number of years' experience within homelessness as a Clinical Psychologist	*N*
Christian	2	Lancashire	1	1-9	7
Buddhist	1	West Midlands	1	10-19	3
Atheist	2	London	3	20-29	1
Agnostic	3	Merseyside	1		
Spiritual	2	Avon,			
		Somerset, and	2		
		Gloucestershire	1		
		Oxfordshire	1		
		West Yorkshire			
Main type of work with the population	*N*				
Clinical	7				
(direct and					
indirect)	1				
Research					
Clinical and	3				
research					

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[1] One participant did not complete the demographics form and one partially completed the form.

Round One

Interviews with PMs lasted between 63 and 140minutes, generating 72 guidelines: 36 direct working, and 36 indirect working. Guidelines generated during Round One can be found in Table 8.

Table 8. Original guidelines made by PMs during Round One.

	Original Round One guidelines Direct guidelines
1	Be flexible in your hours and the amount of work you will do. Do not stick to standard protocols.
2	Be flexible in your approach.
3	The co-locations of services - psychological therapies are taken to the point of need, located in familiar settings and locations, and going out to where homeless people find themselves (e.g., hostels, day centres, streets).
4	Meet the person physically where they are at. Having a person centred approach, encouraging all opportunities to engage and acknowledge the context you are working in.
5	Be accessible and available so that people can reach you, working where they are and feel comfortable and be visible to the homeless community.
6	Get out of the consulting room and meet service users where they are, being flexible and more relaxed about therapeutic boundaries particularly at the pre-treatment phase. Without this, other parts of the work will not proceed.
7	Be flexible - do not expect the work to stick to a predetermined route. Things may throw you off the way and it is important to journey alongside someone.
8	Prioritise relationship building and be flexible
9	Be mindful of the interaction between trust and attachment. A complex attachment can be formed between you and your client.

10 Consider the likely trauma histories of service users you are working with, appreciating engagement is likely to be a long process as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc .

11 Attend to the relationship e.g., listen, kindness, power dynamic.

12 Engagement - be prepared to spend longer engaging someone. Use supervision to manage any rejection or suspicion you face.

13 Pay attention to endings as much as beginnings.

14 Formulation is key and sometimes the most basic are the best. Sharing it collaboratively is essential, making them something more than just a 'label'.

15 Trauma is highly prevalent in this population (both historic and current/repeated patterns of trauma). Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.

16 Maintain active hope by grounding your formulation in the social/economic/political context and a systems-thinking stance

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17 They should be screened for brain injury at some point even if it is not the first thing you do. It can be critical to aid understanding.

18 Be aware of the high prevalence of cognitive and neurological problems and how therapy may need to be adapted. Include cognitive difficulties in formulations, as these can contribute to the breakdown of placements and impact on social and day to day functioning.

19 Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies. It is important to recognise that you may

retraumatising them during interventions so you need to recognise the impact of trauma on an individual.

20 To eliminate and discard the hierarchy of needs, working with the pre-contemplation stage is critical. You have to work with where the person is at regarding their sense of self, motivation, and values.

21 Acknowledge the wider context that the person is in at an individual level, not just offering 1-2-1 therapy. Using an approach flexibly to do the work needed at that time.

22 It is important that goal setting has to be done collaboratively. It may need to be guided by the professional but the individual needs to lead the process to some extent.

23 Make use of integrated models of psychology, paying attention to attachment and theories of motivation.

24 Approaches to direct work should be trauma-informed Psychologically Informed Environments (PIEs) and encompass all elements that come with this (e.g., building relationships, helping people connect and feel empowered, strengths-based, recognise the impact of trauma on an individual and avoiding re-traumatisation).

25 Adaptability, flexibility, and creativity are essential, you are never going to be doing manualised treatment. Consider what model fits the person and think of how to adapt it.

26 Think carefully about what your role should be with this person and what adaptations you need to make to your practice.

27 People are likely to present with multiple difficulties (including dual diagnosis/substance misuse). Do not exclude someone from psychological therapy because of their presenting difficulties. Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g., motivational interventions) that can help people to make changes to substance use and engage with other services. Work creatively to

	do this and following the relevant guidance (e.g., NICE guidance for dual diagnosis and substance misuse) can support this work.
28	Clear communication is key with everybody. Be clear with everyone - the service user and others - about the direct work you are completing. This includes - the boundaries, what I am doing, this is why and this is how I have come to understand this person and what we can offer.
29	Promote good multi-agency working especially when working with complexity and risk.
30	Clinical Psychologists should not work in isolation from colleagues in social services and housing. They should be part of an integrated team but the make-up will be dependent on the local circumstances.
31	Even in direct work, work as both a Clinical Psychologist and a care co-ordinator to work effectively with the whole system.
32	If you are doing direct work with people experiencing homelessness, be employed by the NHS
33	Be co-located and embedded within the multidisciplinary team.
34	Encourage curiosity.
35	Have a realistic sense of optimism, having a sense of it being worth trying even with a deep level of complexity.
36	Have strong self-awareness and reflective practice, whether this is through journaling, supervision etc
	Indirect guidelines
1	Pay attention to the trauma staff will have experienced. Many will have come into this because of their own past and present experiences.
2	To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential, including training, reflective practice, consultation, consistent team approaches and debriefs.

3 Attending to the emotional impact of the work on colleagues is an important starting point. Trauma Informed Care provides a 'universal precaution' approach which can be used with staff as well as service users. The work is potentially traumatising for staff many of whom also come with trauma backgrounds.

4 The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them.

5 Be mindful of the stress and pressures that staff (e.g., outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be. Staff may not have the supervision and training that we would like them to have.

6 Providing a space for validating workers’ emotional reactions/toll of the work and understanding behaviour.

7 To recognise the skills, beliefs, and ways of working already in the system and prioritise these.

8 To offer something practical and useful other people can see e.g., offering reflective groups and case discussion and consultation to add value.

9 Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes. Ensure that consultation is useful to care planning, not only theoretical.

10 Build relationships and partnerships as everything you are doing is through the staff. Emphasise good practice, consider evolution not revolution.

11 Model and reinforce the skills that you want to develop within systems and staff groups.

12 Work from a position of building capacity (e.g., through formulation) and developing existing strengths in staff teams.

13 Learning and building up therapeutic and practical skills, giving people a sense of control.

14 Clinical Psychologists should be involved as far as possible in providing support and mentoring for frontline staff.

15 Think about your language and how you explain things in a way to staff that is accessible, interesting, and more than just common sense.

16 Try to pay attention to the night workers, as it is likely that there will be a lack of consistency in approach.

17 It is important to make sure your indirect work is led by service user involvement and feedback.

18 Creating opportunities to be present or available if you cannot be physically present. Showing a willingness means you can understand challenges in different services if you are not able to be in a service all the time.

19 Contract work as transparently as you can. Ensure all including senior managers are involved, have authorised, and support the work.

20 Clinical Psychologists should be involved in ensuring that initial needs assessments consider relevant psychosocial factors.

21 Use and share the available evidence base and any additional evidence generated as much as possible, with the recognition of the context that they were developed in. Consider what are you going to do with what you have.

22 Consider how to take what you have done and share it more widely in the organisation, how to develop the evidence base, and how to influence wider societal norms to develop more helpful narratives around homelessness.

23 Clinical Psychologists should be a source of guidance and expertise on the evaluation and research of services.

24 Contributing to the evidence base of effective ways of working with this population to influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities.

25 Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.

26 Develop psychological formulations and understanding of what is happening within teams or organisations (using any model) in order for organisations to understand how they are influencing the service users and the different levels within the service. This offers space for the organisation to think about what they do.

27 Service level structures (e.g., PIE, TIC) are really useful to help guide the work. It cannot just be about individual therapy; we need to be promoting system change.

28 Working towards and contributing to the development of PIE both locally (e.g., training, reflective practice) and PIE as a concept.

29 Psychologically Informed Environments leadership and service design: thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work.

30 Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector to work in a way which is PIE and TIC (trauma informed care) informed.

31 Setting up specialist services for homeless people is not sufficient. Inclusivity needs to be promoted within the wider system (e.g., local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.

32 Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.

33 Think about how your indirect work can become part of the system. Not seeking to create an entirely new initiative which has minimal chance of survival. Doing with people and organisations rather than doing to.

34 Working to bring different services together and to proactively support the needs of people with multiple complex needs.

35 Remember to tell stories as these can motivate people to work together. People often remember these and will help to draw in multiple agencies.

36 Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible. People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the service-user.

Round Two[33]

Eleven (92%) of the twelve participants responded to the Round Two survey. Three did not rate all guidelines. One rated 16 of the direct guidelines and none of the indirect, one did not provide a rating for six of the direct and four of the indirect, and the third provided no rating for one direct and two indirect guidelines.

For the direct guidelines, 34 achieved the ≥80 consensus indicating the guideline was important or essential, one reached consensus that it should not be included and one was 'approaching consensus' (≥70). Of the 34 which achieved consensus, five required no amendments and six required minor amendments to phrasing. Therefore, eleven did not require re-rating. The remaining 24 which had achieved consensus, including the guideline 'approaching consensus', required further panel input. Sixteen of the guidelines, including the guideline which was 'approaching consensus' received feedback indicating significant levels of overlap with other guidelines. Therefore, these sixteen guidelines were reduced into seven guidelines, requiring re-rating. A further five had undergone significant revisions to wording, also requiring re-rating. Three further guidelines required PM input; two which the researchers and one PM identified as overlapping so sought clarification from PMs regarding their views, and another which received feedback regarding the lack of specificity. PMs were asked to help provide clarity on the guidelines meaning. Consequently 15 guidelines required re-rating and panel input in Round Three.

For the indirect guidelines, of the 36 proposed, 35 achieved consensus that they were essential or important (≥80). One did not achieve consensus. Of the 35, seven required no modification and twelve required only minor modifications. These nineteen guidelines did not require re-rating in Round Three. Of the remaining guidelines, eight were

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[33] Please see extended Appendix H for supplementary figures (figures 3-6) of guideline modifications across the Rounds

combined into four guidelines due to overlap, and four were combined into one new guideline created by the researchers due to considerable overlap, requiring re-rating. The final four had undergone significant wording amendments and also required re-rating in Round Three, meaning a total of nine guidelines required re-rating by PMs in Round Three.

Round Three

Eight participants (67%) responded to the second Delphi survey. Following Round Two, one PM requested only to be included in Round Four. One PM who responded provided no rating for one of the direct guidelines.

All fifteen direct guidelines reached consensus (≥80) that they were 'important' or 'essential' and should be included. PM feedback resulted in six guidelines having minor amendments to wording to improve clarity, including one the researchers had requested participants provide further clarity to improve the guideline's meaning. Six were combined, reduced to three guidelines. Finally, three guidelines were modified to reduce overlap and improve clarity. One guideline which reached consensus in Round Two and therefore did not require re-rating by PMs in Round Three also had a minor phrasing amendment to reduce overlap with another guideline amended in Round Three. Thus, following Round Three, 23 guidelines – 11 from Round Two and 12 from Round Three – were included in the final guidelines (table 11).

For the indirect guidelines, eight of the nine requiring re-rating in Round Three achieved consensus that they were 'important' or 'essential' (≥80), and one was 'approaching consensus' (≥70). Following participant feedback, only one was included in the final guidelines with no amendments (number 24). Five guidelines had wording amended following PM feedback and three were combined into a single guideline to reduce overlap, which included the guideline approaching consensus. Following this, 26 guidelines – nineteen from Round Two and seven from

Round Three – were included in the final 26 guidelines for indirect working (table 12).

Table 9. Number of comments provided per PM in Round Two and Round Three.

Round Two respondents (*N*=11)		
No. of guidelines commented on	Direct guidelines	Indirect guidelines
0	1	4
1-10	5	3
11-20	2	1
21-30	2	1
30-36	1	1
Round Three respondents (*N*=8)		
No. of guidelines commented on	Direct guidelines	Indirect guidelines
0	1	1
1-5	3	4
5-9	2	3
10-15	2	

Table 10. Feedback data for Round Two and Round Three for direct and indirect guidelines including mean(s).

Round	Number of guidelines	Total number of comments received (*N*)	Mean number of comments for guideline (range)	Overall mean number of comments from PMs[1]
Direct guidelines				
2	36	145	4.02 (1-7)	13.1
3	15	61	3.81 (2-7)	7.63
Indirect guidelines				
2	36	101	2.8 (2-4)	10.1
3	9	31	3.44 (2-6)	3.87

[1] Indirect guideline date for round two exclude one PM who did not rate or comment on any of the guidelines.

Addressing feedback[34]

Despite high levels of consensus across rounds[35], following Rounds Two and Three, PM feedback resulted in significant modifications including combining and modifying guidelines. Acting on PM feedback is key to the Delphi process, given the output should reflect panel input. Similar to Eubank et al., (2016) where PMs identified overlap, providing all were either ‘approaching consensus’ or had reached consensus to be included, guidelines were combined, to remove redundant statements and group similar constructs. To facilitate transparency, guidelines had both the original and combined format presented alongside the PMs rating, the groups rating and anonymised expert panel feedback. Each was accompanied by instructions explaining modifications and what input was required by PMs.

Following Round Three, as all but one had reached consensus, PMs were not required to re-rate the modified guidelines. Considering the majority had reached consensus, the research team agreed the panel had endorsed the contents of each guideline, indicating it should be included. Additionally, given consensus has been found to diminish, it was agreed Round Four would be used instead to gather feedback and clinical vignettes. For transparency, Round Four included two appendices detailing the changes made to each guideline following Round Three alongside the PMs rating, the groups rating and feedback for each guideline.

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34 See extended 3.4

35 See extended 3.5

Round 4 – Finalised guidelines and clinical vignettes[36]

Fifty percent (6) of the PMs responded, two of whom had not contributed to Round Three. Together, they contributed 21 direct and 20 indirect clinical vignettes. Three indirect guidelines had only one clinical vignette identified from the recordings and one received several additional examples but the research team did not think these captured the guidelines. Two guidelines had two vignettes each, but the research team agreed one vignette of each did not capture the guideline. Consequently, a member of the research team working in homelessness provided vignettes for four guidelines, checked by the primary researcher and a PM offered to provide an example for one. For guidelines where more than two vignettes had been provided – either through responses during Round One or Round Four – the research team decided which was most appropriate and provided the breadth to cover the guideline.

PMs did not comment on the layout of the guidelines throughout the process and this was not actively sought. Initially, guidelines were included from Round One under similar categories identified by the research team and remained in this order to help tracking. For Round Four, the authors felt it was important for PMs to see the 'finished product' including the order of the guidelines. Therefore, a final set of categories were identified and agreed by the research team and distributed as shown in tables 5 and 6.

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[36] See extended 3.6

Table 11. Final guidelines for direct working, collated into categories.

Category	No.	Direct Guideline	Details of modifications required following round Two and Three[1] (none, major, minor, combined)	Round consensus achieved and guideline finalised	Level of consensus achieved[2]
Approach					
	1	Be flexible in your approach, holding the person at the centre of your work, encouraging all opportunities to engage. For example, flexibly implementing protocols, moving your working hours to facilitate appointments, and considering how and where you engage people. Use outreach and in-reach approaches, taking psychological interventions to the point of need, going out to where homeless people find themselves so you are visible to the homeless community and their support networks (e.g., hostels, day centres, streets). This may mean meeting outside of the clinic or office base, meeting where service users feel comfortable e.g., meeting in public spaces providing confidentiality can be maintained.	Round Two: guidelines combined Round Three: guidelines combined	Three	All guidelines before combining achieved ≥80 consensus during survey Rounds Two and Three
	2	Prioritise relationship building as it can take time to build trust and engagement. Do not expect the work to follow a pre-determined or 'manualised therapy' route. Life events will get in the way (i.e.,	Round Two: major modifications	Three	All guidelines before combining

	moving accommodation, becoming street homeless, physical health concerns), so it is important to journey alongside someone.	Round Three: guidelines combined		achieved ≥80 consensus during survey Rounds Two and Three
3	Attend to the therapeutic relationship, being mindful of the interaction between trust and attachment. Use supervision to discuss and reflect on how best to manage the relational and power dynamics between yourself and the service user. DNA's and re-referrals may be part of the engagement process - reflecting on these with service users can help build understanding and trust with staff and services.	Round Two: guidelines combined Round Three: guidelines combined	Three	All guidelines before combining achieved ≥80 consensus during survey Rounds Two and Three
4	Consider the likely trauma histories of service users you are working with, appreciating engagement can be a long process, as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc.	None	Two	100%
5	Many people who are homeless may have lost touch with hope, so it is important to actively maintain it. Communicating hope to the service user and others in their system can be a radical force for change. Use supervision to nurture hope and support you to avoid problem saturated stories about service users. Avoid individualising the	Round Two: Major modifications Round Three: Major modifications	Three	Round Two consensus: 81% Round Three

	problems of the person who is homeless by accounting for the socio-political context and social/relational history of the person. Individualising and pathologising discourses can counteract hope and agency.			consensus: 100%
6	Have a realistic sense of optimism, having a sense of it being worth trying even with a deep level of complexity.	None	Two	100%
7	Encourage curiosity in both staff and service users and their wider support network (e.g., family members and staff). Approaching clients with curiosity can help validate their experiences and support them to reflect on factors impacting their lives and explore how they are responding to these. This in turn can encourage them to become curious about psychological approaches and how they may help. Encouraging curiosity can help staff, including Clinical Psychologists, avoid assumptions and falling into dominant narratives relating to homelessness and consider what happened to the person and why they are working with them at this time.	Round Three: major modification following request for clarity from PMs on guidelines meaning. PMs were not required to re-rate the guideline in Round Three	Consensus achieved Round Two, guideline finalised in Round Three	Round Two consensus: 89%
8	Have strong self-awareness and reflective practice, for example through journaling and/or supervision.	None	Two	100%
Multi-agency working				
9	Think carefully about what your role should be with this person. Consider the network of professionals, whose role is what, boundaries, who is best placed, who has the best relationship with the service user and how you can help.	Round Two: achieved 100% consensus but overlap identified.	Three	All guidelines before combining achieved

		Requested PMs to identify possible overlap. Round Three: Guidelines combined and modified		≥80 consensus during survey Rounds Two and Three
10	Clear communication, within the boundaries of consent, is key with everybody. Be clear with everyone - the service user and others (e.g., those involved in the person's wider network including family, friends, GP etc.) about the direct work you are completing.	Minor amendment following Round Two Though not asked to re-rate, another minor amendment was also made following Round Three to reduce overlap	Two	100%
11	Promote good multi-agency working across professionals especially when working with complexity and risk. Coming together regularly, including with the client, is vital.	Minor amendment following Round Two	Two	100%

	12	Where possible, be co-located and embedded within the multidisciplinary team. If this is unavailable, think of how you can access the network of services working with these groups that do offer multiple disciplines. If a care co-ordinator or someone in a similar role is not involved, consider working in ways that ensure all of a person's needs are met.	Round Two: Major modifications Round Three: Guidelines combined	Three	All guidelines before combining achieved ≥80 consensus during survey Rounds Two and Three
Individual therapy					
	13	Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse). Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g., motivational interventions) that can help people work towards their goals e.g., make changes to substance use and engaging with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g., NICE guidance for dual diagnosis and substance misuse) that can support this work.	Round Two: Major modifications Round Three: Minor modifications	Three	Round Two: 90% Round Three: 100%
	14	Working with the pre-contemplation stage is critical - you have to work with where the person is at regarding their sense of self, motivation, and	Round Two: Guidelines combined	Three	All guidelines before

	values. It is important that Maslow’s hierarchy of needs does not influence whether you offer psychological interventions. Service users may also need time to understand how this support can be helpful for them, as they may have had limited experience of these approaches.	Round Three: Major modifications		combining achieved ≥80 consensus during survey Rounds Two and Three
15	Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies. It is important to recognise that you may retraumatise them during interventions so you need to pace the sessions carefully, allowing the service user to control what is discussed.	Minor amendment following Round Two	Two	100%
16	Consider screening for cognitive and neurological problems. Assessments should consider asking clients about learning problems, previous head injury and other trauma. Including cognitive difficulties such as brain injury and intellectual disability in formulations can support understanding, as these can contribute to the breakdown of placements, and impact on social and day to day functioning. Consider how therapy may need to be adapted in relation to difficulties identified.	Round Two: Guidelines combined Round Three: Major modifications	Three	All guidelines before combining achieved ≥80 consensus during survey Rounds Two and Three

17	It is important that goal setting is done collaboratively.	Minor amendment following Round Two	Two	90%
18	Formulation is key and sometimes the most basic are the best. Sharing it collaboratively is essential, helping the individual to feel valued, making them more than just a 'label'.	Minor amendment following Round Two	Two	100%
19	Trauma is highly prevalent in this population (both historic and current/repeated patterns of trauma). Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.	None	Two	100%
20	Make use of integrated models of psychology, paying attention to attachment and theories of motivation.	None	Two	100%
21	Consider what model fits the person, how to adapt it based on their current circumstances (e.g., briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work).	Round Two: achieved 100% consensus but overlap identified. Requested PMs to identify possible overlap.	Three	All guidelines before combining achieved ≥80 consensus during survey

		Round Three: Guideline combined		Rounds Two and Three
22	Approaches to direct work should seek to apply the frameworks of Trauma-informed and Psychologically Informed Environments (PIEs) where possible, encompassing all elements that come with this (e.g., building relationships, helping people connect and feel empowered, value-based, recognise the impact of trauma on an individual and avoiding re-traumatisation).	Minor amendment following Round Two	Two	90%
23	Endings are just as important as beginnings. Actively paying attention to and working jointly with staff and service users e.g., by devising care plans at the beginning of the work for the end of the work, can help work through feelings of rejection and service withdrawal users may experience.	Round Two: Major modifications Round Three: Major modifications	Three	Round Two consensus: 92% Round Three consensus: 100%

Table 12. Final guidelines for indirect working, collated into categories.

Category	No.	Indirect Guideline	Modifications needed and if so, level indicated (none, major, minor, combined)	Round consensus achieved and guideline finalised	Level of consensus achieved
Relationships with and support for staff					
	1	The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them.	None	Two	100%
	2	Build relationships and partnerships with staff who are key to much of what we do. Emphasise good practice, consider evolution not revolution.	Minor amendment following Round Two	Two	90%
	3	Think about your language and how you explain things in a way to staff that is accessible, interesting, and more than just common sense. Doing so will help to prevent staff feeling disempowered.	Minor amendment following Round Two	Two	100%
	4	Be mindful of the stress and pressures that staff (e.g., outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be. Meet staff where they are at considering what they would find helpful, as staff may not have the supervision and training that we would like them to have.	Minor amendment following Round Two	Two	100%

5	Clinical Psychologists should provide a space for validating workers' emotional reactions/toll of the work and understanding behaviour.	Minor amendment following Round Two	Two	90%
6	To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential. Clinical Psychologists should provide training, reflective practice, consultation, consistent team approaches and debriefs.	Minor amendment following Round Two	Two	100%
7	Develop psychological formulations and understanding of what is happening within teams or organisations and share with organisations in order for organisations to understand how they are influencing the service users and the different levels within the service. This offers space for the organisation to think about what they do.	Minor amendment following Round Two	Two	90%
Supporting staff to support service users, including building therapeutic skills				
8	Where possible and appropriate, work should be led by service user involvement and feedback. Be creative and flexible in your approach to this, implementing a range of methods to work co-productively e.g., through focus groups, surveys, informal verbal feedback.	Round Two: Major modifications Round Three: Minor modification	Three	Round Two consensus: 90% Round Three consensus: 87.5%
9	Clinical Psychologists should be involved in ensuring that team screenings and initial needs assessments consider relevant psychosocial factors.	Minor amendment	Two	100%

		following Round Two		
10	Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes which are evaluated. Ensure that consultation is useful to care planning, not only theoretical.	Minor amendment following Round Two	Two	100%
11	Clinical Psychologists should assess the service context in which they work, recognising and acknowledging the skills, beliefs, and ways of working already in the system and prioritise these. Work from a position of building capacity by offering what is meaningful and practical for the staff and service, developing existing strengths in staff teams. This may be by sharing knowledge and discussing ideas through reflective groups, providing additional training, formulation, case discussions and consultations. Mentoring for frontline staff should also be considered.	Round Two: Guidelines combined Round Three: Guidelines combined	Three	All guidelines before combining achieved ≥80 consensus during survey Round Two. Two of the three combined following Round Three achieved consensus, and one was ‘approaching consensus’ (≥70)

12	Learning and building up therapeutic and practical skills with appropriate supervision, giving people a sense of control and fostering Psychologically- and Trauma-Informed environments.	Minor amendment following Round Two	Two	90%
13	Model and reinforce the skills that you want to develop within systems and staff groups.	None	Two	100%
14	Remember to tell stories for both direct and indirect work as these can motivate people to work together. People often remember these and will help to draw in multiple agencies.	Minor amendment following Round Two	Two	80%
15	In relevant contexts, when there is consent from service users, develop your interventions collaboratively with all staff including those working on shifts at night and domestic workers to promote consistency of approach.	Round Two: Major modifications Round Three: minor modifications	Three	Round Two consensus: 90% Round Three consensus: 100%
16	Contract work as transparently as you can. Ensure all including senior managers are involved, have authorised, and support the work.	None	Two	90%
17	Demonstrate that services are Trauma-Informed e.g., through staff training, awareness of processes and procedures being Trauma-Informed, providing a space for reflective practice and offering trauma therapy to service users if needed. Attending to the emotional impact of the work on colleagues is an important starting point. The work is potentially	Round Two: Guidelines combined Round Three: Major modifications	Three	All guidelines before combining achieved ≥80 consensus during

	traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences. Where necessary, Clinical Psychologists can provide sign posting to staff to support services to manage this impact.			survey Rounds Two and Three
Approaching systems change				
18	Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.	None	Two	90%
19	Think about how your indirect work can become part of the system. It is not always about seeking to create an entirely new initiative which has minimal chance of survival. Doing and planning with people and organisations rather than doing to.	Minor amendment following Round Two	Two	100%
20	Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible. People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the service-user.	None	Two	100%
21	Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector. Service level structures such as Psychologically Informed Environments (PIEs) and Trauma-informed Care (TIC) can be really useful to help guide the work, for	Round Two: Guidelines combined (N=4), new guideline created		All guidelines before combining achieved ≥80 consensus

	example by supporting thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work. It cannot just be about individual therapy; we need to be promoting system change. Clinical Psychologists should explore structures such as PIEs and TIC and consider whether the structure or elements of them would be beneficial in guiding work the context they are working in.	Round Three: Minor amendment		during survey Rounds Two and Three
22	Setting up specialist services for homeless people is not sufficient. Inclusivity needs to be promoted within the wider system (e.g., local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.	None	Two	100%
23	Working to bring different services together and to proactively support the needs of people with multiple complex needs, bridging the gaps between services that service users can fall between, helping to address service exclusion.	Minor amendment following Round Two	Two	100%
24	Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.	None	Two	100%
Contributing to the evidence base				
25	Clinical Psychologists should allocate time to research and evaluation. As well as seeking out opportunities to promote and complete research, they should be a	Round Two: Guidelines combined	Three	All guidelines before combining

	source of guidance and expertise for staff, working collaboratively on research and evaluation projects whenever possible, highlighting its value to senior management.	Round Three: Minor modification		achieved ≥80 consensus during survey Rounds Two and Three
26	Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community. Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness.	Round Two: Guidelines combined Round Three: None	Three	All guidelines before combining achieved ≥80 consensus during survey Rounds Two and Three

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[1] Modifications following Round Three did not require re-rating

[2] Consensus levels from Round Three report consensus levels for the guidelines prior to modifications (if required)

Discussion

Summary of findings

This research sought to elicit and synthesise PBE generated by UK CPs working in homelessness and use this PBE to create consensus-based PBG for direct and indirect work. Twenty-three direct and twenty-six indirect guidelines were endorsed by the expert panel. The discussion broadly summarises each theme, concluding with limitations and recommendations.

Direct guidelines

Approach*.* Broadly relating to disposition (Burnham, 1999), practicalities and relational needs are intertwined throughout, highlighting the importance of flexibility in building relationships. The approach theme is relevant in many endorsed guidelines, denoting its importance in all aspects of a CPs work in homeless services. Emphasis is placed on acknowledging the common co-occurrence of relational difficulties and trauma in the homeless population, echoed in the literature (Fitzpatrick et al., 2013). Canavan et al. (2012) found reduced trust in services and healthcare professionals was a key reason for reduced engagement. Therefore, the provision of psychological support may need to be significantly more flexible than other services including the need for flexible non-attendance policies and duration of contact. Though at odds with the movement towards specific treatment durations particularly in statutory services, Fluckiger et al. (2020) urges caution given the lack of empirical evidence for optimal treatment duration. Furthermore, given non-specific factors including the therapeutic relationship are a predictor of positive outcomes (Zilcha-Mano et al., 2019), it is plausible those whose lives have been characterised by unsafe or rejecting relationships need more time to build a therapeutic alliance to facilitate positive outcomes.

Multi-agency working. Guidance reflects evidence that collaboration through co-ordinated care and service integration improves outcomes for homeless persons (Canavan et al., 2012; Cornes et al., 2019; Hwang et al., 2005). However, integrated approaches remain rare in homeless services (Canavan et al., 2012). The HRA (2017) and Local Government Association (Preston-Shoot, 2020) recognise the importance of effective, co-ordinated, multi-agency working in tackling homelessness, echoed by the panel. Challenges associated with multi-agency working include differing organisational philosophies (Williams, 2009) which may be even more pronounced in homelessness given the combination of statutory and non-statutory services. Cameron et al. (2007) found non-statutory services were less constrained by organisational policies, allowing for more flexibility. However, research indicates numerous benefits of increased integration including improved access to services (Kennedy et al., 2001); understanding of service differences (Moran et al., 2007); and increased opportunities for problem solving complex cases (Atkinson et al., 2007). Kennedy et al. (2001) identified key enablers in multi-agency working in homelessness including communication, agreed aims, boundaries, goals, and roles, all echoed in the guidance, all considered CPs core skills (BPS, 2019).

Individual therapy[37]*.* Core CP competencies are highlighted including formulation and collaborative goal setting, cognitive assessment, and critical thinking (BPS, 2019). The guidelines confirm therapy is being provided to homeless persons irrespective of whether they have secured accommodation, confirming CPs have generated EBP indicating that the basic need of housing is not a necessity to engaging in therapy. However, this may be contingent on the level of flexibility the service can facilitate, particularly the amount of time available for initial engagement and flexibility

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[37] See extended 4.1

regarding non-attendance. Whilst a range of therapeutic orientations are mentioned, no single orientation has primacy. Those specified are predominantly relational. Considered within the concept of an unhoused mind, this may be unsurprising, given the focus on building relational-safety (Seager, 2015).

Indirect guidelines

Relationships with and support for staff. Frontline staff are frequently exposed to traumatic situations resulting in high levels of burnout (Olivet et al., 2009), and staff wellbeing is repeatedly linked to care quality (Boorman, 2009; Hall et al., 2016). Scanlon and Adlam (2012) explore the distressing effects of working in homelessness, with staff experiencing similar feelings to those considered to have an "unhoused mind", such as reduced feelings of safety in under-resourced working environments, manifesting in incohesion. Consequently, similarities to direct client work are evident including the importance of building relationships and understanding what staff need to ensure sustainability of interventions. Guidance generally takes a wider-systems approach, emphasising a range of support mechanisms including reflective practice and training, proposed to mitigate the adverse effects of working with this population (Lemieux-Cumberlege & Taylor, 2019). Evidence indicates increased job satisfaction, outcomes and retention when provided (Homeless Link, 2014a). Thus, guidance reflects research that system-level rather than personal-level interventions are more effective in creating sustainable staff wellbeing interventions (Brand et al., 2017).

Supporting staff to support service users, including building therapeutic skills. Staff spend significant amounts of time with service users and are therefore well placed to detect early signs of distress. Consequently, they can support the implementation and ongoing evaluation of interventions (Blackman, 2003). Recognition is given throughout the guidance to the lack of resources in services, including CP provision. Consequently, guidance focuses on building relationships and capacity within teams using a strengths-based approach by promoting psychological knowledge and understanding. Formulation is a key proficiency for practitioner-psychologists (HCPC, 2015). Encouraging homeless service staff to think psychologically about their work can improve consistency in approach amongst staff (Whitton et al., 2016), understanding of service users difficulties and increase feelings of optimism (Berry et al., 2016; Buckley et al., 2020) which can change staffs approach (Buckley et al., 2020).

Approaching systems change[38]*.* Whilst PIEs and TIC are considered, none of the guidelines make specific recommendations for how to approach system-change. Given the prevalence of the PIE framework in the homelessness literature (e.g., Keats et al., 2012), it is surprising PIEs are not represented more, particularly at this systems-level. Interestingly, guideline 21 was combined with other guidelines also recommending PIE due to overlap and because feedback was split between those who view PIEs as 'vital', and those who felt it was too specific. Consequently, this shows previously unidentified divergence within the profession regarding PIEs utility in homelessness. This could be attributed to difficulties in applying the PIE framework in different homeless settings, which may be compounded by limited evidence for the approach. Guidelines emphasise the importance of context when exploring news ways of working (BPS, 2011), indicating the panel's recognition of the range of services and available resources. Whilst recognising the role CPs play in promoting inclusion in services, recognition is repeatedly given to the complexity and challenge of systems-change (Foster-Fishman et al., 2007).

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[38] See extended 4.2

Contributing to the evidence base. Consensus indicated CPs should generate and disseminate research, yet it is highly probably the lack of resources has hindered research in the area (Maguire, 2015). Consequently, whilst serving as an important reminder for CPs to utilise their skills in undertaking research, audits, and evaluations (BPS, 2019; 2017), structural and organisational barriers are likely to remain[39].

Strengths and limitations[40]

Recruitment numbers were reduced to allow for a smaller sample size largely due to the impact of Covid-19 but remained above Linstone and Turoff (1975) recommendation of 10. Compared to larger panels, whilst smaller panels are inevitably less representative, they may have conversely increased reliability given the samples' homogeneity (Briedenhann & Butts, 2006). Additional challenges included sustaining adequate response rates across Rounds, particularly important in smaller panels in managing individual response weighting. Whilst flexibility was given, attrition rates exceeded the desired 16-28% (Hanafin & Brooks, 2005) from 8% in Round Two to 33% in Round Three. Reasons for this may relate to the 'fatigue factor' (Whitman, 1990). Despite this, levels of consensus remained high, with little divergence of opinion across Rounds. This could partially be attributed to the same core PMs responding across Rounds who may have a more vested interest in the output (Yousuf, 2007), who may be significantly more homogenous in their views.

Similar to other consensus-based guidelines, these guidelines use the self-report of CPs without any corroboration from service users, staff, or commissioners. Whilst this is a clear area for further

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[39] See extended 4.3 for guidelines which did not reach consensus

[40] See extended 5.1 - 5.8

exploration, CPs are trained to reflect and routinely evaluate their practice (HCPC, 2015). Thus, their views hopefully reflect feedback from stakeholders, and the accompanying vignettes do suggest evidence of successes within practice.

Lack of specificity in the guidelines is evident throughout, arguably making the guidelines less operationally viable. This research did not provide a set of expectations at the start for what the guidelines would look like. Broad guidelines ensure they are relevant to the range of contexts CPs are working within, providing space for flexibility and adaptability, with accompanying vignettes providing examples of how to implement the guideline(s) in different ways.

Similarly, a strength and limitation of these guidelines is their specificity to the UK context. Given the UK's unique statutory systems, country-specific guidelines seemed the most appropriate. Whilst the lack of specificity may improve their utility in other countries, this is an inevitable limitation.

Clinical implications

These guidelines provide commissioners with information on the resources needed to support CPs work in homeless services, such as increased flexibility. They incorporate core CP competencies stipulated by the BPS (2019), providing evidence of the breadth of the CP role in homelessness.

As recruitment increases, it is highly probable many of those starting in these roles will have little experiences of working with such complex individuals and systems. Thus, it is hoped these guidelines will be able to support them[41]. Given the guidelines utilise PBE generated by CPs working in the area, it is likely these guidelines can be readily implemented. Considering the lack of resources in

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[41] See extended 5.10

homelessness, having guidelines that support CPs using their current skillset rather than recommending specific therapies or interventions supports their applicability compared to more specific guidance (e.g., NICE, 2020). Thus, whilst many are broad, the vignettes ground the guidelines in varying contexts. Furthermore, whilst recruitment is increasing, it is likely many CPs will continue to find themselves working in relative isolation. Not only do these guidelines recommend CPs share knowledge to support their work, they were created using the mindlines paradigm. They acknowledge the value clinicians place on others by replicating knowledge sharing at a local level (Gabbay & le May, 2016). Thus, these guidelines seek to replicate real-world conversations, meaning they may be more salient, increasing their utility.

Future research

Whilst these guidelines seek to fill the policy-practice gap and were generated using PBE endorsed by experts in the field, it is important their clinical utility is evaluated and is a clear recommendation[42]. Future research should explore staff and service users experiences of the guidelines alongside whether mainstream services would consider adopting the underlying principles to better service those facing multiple exclusion.

Conclusions

The successful creation of these guidelines demonstrates that PBE has been generated which can inform commissioners about the potential roles of CPs in services and the resources required when recruiting CPs. More importantly, they provide guidance on both direct and indirect ways of working within homeless services for CPs and can promote wider conversations about what does or does not

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[42] See extended 5.11

work, and how best to build an evidence base to support psychological work with those experiencing homelessness[43].

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[43] See extended 5.12 for additional reflections

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Extended paper

1. Extended Background

1.1 Defining homelessness

Despite no international definition of what it means to be "homeless", nations have begun to generate ideas and definitions (Fitzpatrick & Stephens, 2007; Toro, 2007; Toro & Warren, 1999). Historically, the term homelessness conjures up images associated with a lack of physical accommodation – namely rough sleeping – and attempts at international definitions previously reflected this "literal" homelessness. However, literal definitions neglect the scale of the problem, excluding those who may be squatting or sofa surfing, sleeping in cars or tents, considered the "hidden homeless". Consequently, there is a growing recognition of a "continuum of housing", range from those who are stably housed to those without a roof over their head – the literal homeless (Engender, 2020; Toro, 2007). Public Health England (2019) defines homelessness as when: "…a household has no home in the UK or anywhere else in the world available and reasonable to occupy. Homelessness does not just refer to people who are sleeping rough".

Due to the broad nature the term "homeless", researchers have attempted to categorise the homeless population, as there is a risk of them being represented as a homogenous group (Somerville, 1992). The most frequent categorisations in the literature are based on data from the United States (US) homeless shelters by Kuhn and Culhane (1998), who identified three 'clusters' of homeless persons which has been replicated in the US, Canada and to a lesser extent, Europe; transitional, episodic and chronic (Aubry et al., 2013; Benjaminsen & Andrade, 2015; Fazel et al., 2014; Kneebone et al., 2015; Pleace & Bretherton, 2013; Savage, 2016). The transitional homeless were found to be the largest group but needed the least support, often becoming homeless due to a specific event(s) e.g., poverty or a relationship breakdown, and were most likely to return to housing with little support (Fazel et al., 2014; FEANTSA, 2017). The second largest were those chronically homeless who accounted for a smaller proportion of the population, using shelters less than others, but episodes in shelters and time spent on the streets was likely to last longer. They also had higher support needs, consuming significant resources. Finally, those episodically homeless had frequent episodes in hostels, shelters, and other types of accommodation, or were in and out of various institutions, consuming less resources than those chronically homeless, but more than those transitionally homeless.

Alternatively, the European Federation of National Organisations Working with the Homeless (FEANSTA) developed the European Typology of Homelessness and Housing model (ETHOS) (Edgar, 2009; Edgar et al., 2003), providing both a definition and typology of homelessness, seeking to standardise the concept of homelessness across the European Union, supporting comparable data sets (Pleace & Bretherton, 2013). ETHOS breaks homelessness down into three overlapping domains in which homelessness can occur – exclusion from the physical, the social and legal domain. It has since been updated by Amore et al. (2011) to include spaces which are below the minimum adequacy for habitation, forming seven constructs. Savage (2016) notes this broader definition of homelessness is more reflective of the notion of homelessness being along a continuum, including the hidden homeless. However, Pleace and Bretherton (2013) highlight ETHOS focus on where individuals are living, rather than the differing and often complex support needs homeless persons have compared to other populations. Additionally, despite being the most widely used and accepted measure in Europe (Amore et al., 2011), research suggests ETHOS does not fully represent patterns of homelessness in Europe. Pleace and Bretherton (2013) found some ETHOS concepts had limited applicability to data generated in Northern Ireland, with the available data considered high quality and relatively extensive compared to other nations.

To promote accessibility of terminology and maintain focus on support rather than housing needs, Kuhn and Culhane (1998)'s terminology is used for this research. Though this research seeks to provide support for Clinical Psychologists (CPs) working with all homeless persons, given the increased complexity and support needs, its purpose is to predominantly provide support for CPs working with those considered chronically homeless.

1.2 Prevalence

Establishing the prevalence of homelessness globally comes with many challenges. Even those Fitzpatrick and Stephens (2007) identify as having credible data use different definitions, varying measures and timescales.

Within the United Kingdom (UK), homelessness has been rising since 2010 attributed to austerity policies (Fitzpatrick et al., 2018; Fransham, 2018). Prevalence rates include those rough sleeping - determined by headcounts likely to be inaccurate - those in shelters, hostels and temporary accommodation, and the number of homelessness applications received by local councils. As of Autumn 2019, an estimated 4,266 people were sleeping rough for at least a single night, the majority of whom were single adult males (ONS, 2020a). However, the Combined Homelessness and Information Network (CHAIN) figures – combining the figure of multiple agencies whom are in regular contact with rough sleepers in London – report significantly higher numbers of 10,726 between 2019-2020 (St Mungo's, 2020). The Statutory Homelessness Annual Report for England 2019-2020 (ONS, 2020b) reported 288,470 applications for prevention or relief duties, a 14% increase on 2018-2019, with 71% attributed to single adult households, reflecting changes from the Homelessness Reduction Act (HRA; please see section 1.1.3 for further information on the HRA; 2017). However, these figures do not account for other, more hidden homelessness which is impossible to count (ONS, 2020a; The Big Issue, 2020). Crisis (2017) estimate roughly 2.27million households contain one concealed single person, and 288,000 concealed lone parents and couples. Thus, combined with the hidden homeless, the scale of the problem is difficult to determine but is likely to be significantly higher than reported. Importantly, homelessness includes not only families and adults, but also young people. Centre Point (2020) estimates that between 2018-2019, 110,000 16-24 year olds were at risk of becoming homeless or were homeless in the UK, with 57% of cases in England ending with the young person becoming homeless.

Given the difficulty establishing prevalence, it is unsurprising there is limited data reporting the demographics of the homeless population. Overall, most literature reports more single adult men compared to women, particularly when considering rough sleeping (Fazel et al., 2014; Toro, 2007). Women experiencing homelessness are more likely to be in temporary accommodation and classed as part of a single or two-part family. They are also more likely to access informal support such as staying with friends and family, meaning it is likely they are just as prevalent but more "hidden" than men (Baptista, 2010; Bretherton, 2017; Engender, 2020; Sosenko et al., 2020).

1.3 UK legislation

The absence of an international definition means a lack of agreed benchmark to hold governments accountable against in their efforts to tackle homelessness (Amore et al., 2011). Within nations, defining homelessness may influence who has the right to receive immediate housing and support (Springer, 2000). The impact of such decisions can be seen in the UK, which is relatively unusual in providing some homeless persons the legal, enforceable right to temporary accommodation until settled housing becomes available (Fazel et al., 2014; Fitzpatrick & Stephens, 2007). Though aspects of the guidance produced by this study may be applicable to other nations, considering the differences in definitions and support services, it was decided that this guidance would focus on the UK only.

The Housing (Homeless Persons) Act (1977) was introduced due to increasing links being drawn to housing shortages and homelessness – a change from the emphasis previously being on individual factors to structural factors (Fitzpatrick, 2005) - and to clarify local authorities duties to homeless persons, consolidated in the Housing Act (1985) (Fitzpatrick et al., 2000). Introducing legislation resulted in the differentiation between those considered statutorily homeless – meaning they should receive support obtaining housing – and those deemed the non-statutory homeless, who do not meet the required criteria and therefore receive reduced or no support (Fitzpatrick et al., 2000). Both were criticised for reducing those considered statutorily homeless to those with families and dependent children, meaning single adults and couples without dependent children were often deemed non-statutorily homeless (Anderson & Christian, 2003; Crisis, 2015).

Given the significant rise in homelessness, the Homelessness Reduction Act (HRA; 2017) was introduced to reduce the rising numbers and address this gap in provision (Ministry of Housing Communities & Local Government [MHCLG], 2020). Importantly, in addition to seeking to reduce single-person homelessness, it is also the first legislation to begin to consider the individuals circumstance and range of support needs homeless persons may have, such as support for mental illness or impairment. Consequently, it is the first legislation to begin to – albeit briefly – acknowledge the complexity of the homeless population alongside the prevalence of mental health difficulties present and promote multi-agency joint working.

The HRA (2017), evaluated just two years after its implementation reported an increase in non-priority households – namely single adults or couples without dependent children – being offered prevention or relief duty. However, the evaluation found local authorities reported insufficient access to affordable housing and the administrative burden reduced practical case work with service users (MHCLG, 2020). Additionally, uncertainty of future and insufficient funding impacted on local authorities abilities to meet the differing and complex needs of service users. Therefore, it has faced criticism for significantly underestimating the scale of "the problem", resulting in inadequate funding for local authorities to implement the HRA effectively. Criticisms also extended to not responding to wider structural housing and policy reforms which create additional barriers to tackling homelessness, such as the introduction of Universal Credit (Heath, 2019; Shelter, 2017). Despite pledges to explore how to improve multi-agency working and review funding difficulties, at present, there are no signs that the HRA will be renewed. Reviews considering welfare reforms, housing supply and access to healthcare will be considered separately (National Housing Federation, 2020), highlighting a disjointed approach to tackling the complexities surrounding homelessness.

In light of Covid-19, recent policy provisions and initiatives have adopted a public health approach including "Everyone In" – removing legal barriers to housing, placing homeless persons in hotel and emergency accommodation and halting evictions. This initiative provided housing to 14,500, significantly reducing homelessness (Crisis, 2020; Kirby, 2020). This however is a short-term solution with the scheme ending in July 2020, resulting in thousands back on the streets (BBC, 2020; Crisis, 2020).

1.4 Housing First

Solutions to homelessness frequently centre around providing accommodation, including the HRA. Pathway Housing First (PHF) – often called Housing First (HF). This was initially introduced in the US in response to the "staircase model", which seeks to end chronic homelessness by supporting the person to work towards "goals", such as engaging in detox programmes, with the reward being their own independent housing (Pleace, 2012). Throughout the 90s the staircase model was increasingly found to be ineffective and expensive at stopping chronic homelessness. Many became stuck at different stages and others disengaged completely from services due to the requirements placed on them (Bebout et al., 1997; Gulcur et al., 2005; Pleace, 2012). Given that homeless persons are likely to feel insecure in their housing, placing continual requirements on them to demonstrate that they need to "earn" it reinforces this feeling of insecurity (Pleace, 2012). Arguably, it also reinforces the notion that they are the "cause" of their problems, which may be particularly problematic in a population characterised by relational difficulties (see section 1.11). PHF removes these "goals", providing housing to those who need it as soon as possible, removing the exclusion criteria, such as abstinence in other models, adopting a "harm reduction" approach (Pleace, 2012). It is recovery orientated but also encourages self-determination, providing service users with the choice of whether they would like to access additional support services, without removing their accommodation (Pleace, 2012). Thus, PHF removes many of the barriers to accessing services, provides flexible long-term support and, following success in the US (Stergiopoulos et al., 2014; Tsemberis, 2013) has since been adopted by other countries with positive effect including; Canada (Aubry et al., 2019), France (Agha & Roebuck, 2018) and to a limited extend the UK (Bretherton & Pleace, 2015; Homeless Link, 2015).

However, the application of the PHF model varies, from the original to the "light" implementation (Pleace, 2012). Arguably, this is logical given the differences in cultural perceptions and understanding of homelessness. However, there are challenges to implementing the basic principle of providing housing as it assumes there is access to adequate and affordable housing, though this is likely to be dependent on the area of implementation (Bretherton & Pleace, 2015). As discussed previously, this has been a barrier in the HRA implementation. The harm-reduction component of HF – specifically relating to drug and alcohol use – has also been criticised, as PHF does not actively seek to reduce harmful behaviours which threaten well-being which, as Pleace (2011) notes, is unlikely to fit well with national policies. Finally, whilst PHF efficacy rates are clearly a reason to celebrate, there remains a proportion of service users – often those deemed chronically homeless - whom HF does not successfully rehouse, with little evidence to indicate why. In the UK, those who do not embrace housing are deemed "intentionally homeless" and may be denied housing (Adlam & Scanlon, 2005), which often impacts a persons' ability to access mainstream support services (British Medical Association, 2020; Canavan et al., 2012).

1.5 Structural and Individual factors

Individual (micro) and structural (macro) factors have both been used to explain the cause of homelessness. Individual factors locate the issue in the persons behaviour and characteristics, often resulting in the person being blamed for their circumstances (Anderson & Christian, 2003; Bramley & Fitzpatrick, 2018; Fitzpatrick et al., 2000). Structural explanations locate the causes within the wider economic and social context, attributing the cause of homelessness to things such as the amount of affordable housing, the characteristics of the labour market, and relationship breakdowns.

Until the 1960s, individual factors were used to explain homelessness, shifting to a more structural-view following a drama called “Cathy Come Home” (BBC, 1966), and the establishment of Shelter, resulting in the Housing (homeless) Persons Act (1977) and Housing Act (1985). However, research through the 1980s continued to highlight individual factors experienced by homeless persons, such as mental ill-health and substance misuse, resulting in many explanations of homelessness now considering both structural and individual factors (Fitzpatrick, 2005). Pleace (2000, 2016) termed this the “new orthodoxy”, with structural factors creating conditions where homelessness is more likely to occur, combined with those who experience more individual factors being more vulnerable to these adverse structural trends, thus being more likely to become homeless. This account has been criticised for being purely descriptive, and unable to account for why these individual and structural factors cause homelessness. Furthermore, many of the factors contributing to homelessness cannot be categorised as purely structural or individual e.g., experiencing poor parenting or family fragmentation (Fitzpatrick, 2005). Fitzpatrick (2005) proposes causal mechanisms may exist on four levels and are non-linear, meaning small changes in one area can result in a range of positive and/or negative consequences. Structures include housing, economic, interpersonal and patriarchal structures, alongside individual characteristics. Using poverty as an example, Fitzpatrick (2005) explains that, whilst repeatedly linked to homelessness (e.g. Bramley & Fitzpatrick, 2018), not everyone experiencing poverty experiences homelessness. Furthermore, even when there is access to affordable housing, homelessness still exists. Thus this suggests that whilst interlinked, poverty is not a ‘necessary’ component in causing homelessness (Fitzpatrick, 2005), indicating the reasons behind homelessness are much more complex and nuanced (Fitzpatrick et al., 2013).

1.6 The health of the homeless population

Given the complexity of presentations, it can be challenging to determine what is the cause and what is symptomatic. Homeless persons have significantly worse emotional and physical health compared to the general population, particularly those rough sleeping (Fitzpatrick et al., 2000). The combination of physical and mental illness is common, both of which are risk factors for becoming homeless (Anderson & Christian, 2003; Sosenko et al., 2020). Many engage in coping strategies such as substance misuse, with homelessness and substance misuse closely related (McVicar et al., 2015). Poor physical health is well documented (Fazel et al., 2014; Fitzpatrick et al., 2000; Martens, 2001; Victor, 1997). In a retrospective study, Field et al. (2019) reported that of 1135 hospital admissions of homeless persons across seven hospitals over one year in the UK, 94.4% had an acute physical health need, with 5% dying within 12 months of admission. Mortality rates are significantly higher for homeless persons. In England and Wales in 2018, estimates suggest 726 homeless persons died, a 22% increase from 2017, with roughly 641 (88%) being men. Being homeless drastically reduces life expectancy, with the average life expectancy being 43 years for women and 45 for men compared to the general population, for whom the average in 2018 was 76 for men and 81 years for women (ONS, 2019). The reasons for such a high mortality rate include: deaths from accidents, overdoses, suicides and violence. Fitzpatrick et al. (2013) found that, of 452 participants, 56% had attempted suicide and 47% had deliberately self-harmed. Deaths are also more than double compared to the general population for chronic and treatable health conditions such as cancer and pneumonia (Field et al., 2019).

Though often unrecognised, instances of traumatic brain injury (TBI) are also considerably higher than the general population, sustained both before becoming homeless and during instances of homelessness (Forrester et al., 2017; Hwang et al., 2008; Topolovec-Vranic et al., 2012). Using a systematic review and meta-analysis, Stubbs et al. (2020) found the lifetime prevalence of sustaining a TBI was 53.1% with similar results found in homeless adolescents (Mackelprang et al., 2014), and was consistently associated with: higher risk of suicidality and suicide; increased health service usage; poorer mental and physical health; and increased contract with criminal justice systems. In addition, the longer a person is homeless, the greater the risk of them sustaining a TBI (Young & Hughes, 2020). Sustaining a TBI may be a causal and maintaining factor in homelessness, as deficits sustained (e.g., memory) may result in the lack of cognitive resources to gain and sustain employment and housing (Oddy et al., 2012).

1.7 Adverse Childhood events and other risk factors

Adopting Fitzpatrick (2005)’s non-linear explanation of homelessness, though it is likely there is no single cause (e.g. Sosenko et al., 2020), certain risk factors have been consistently highlighted as increasing the probability of a person becoming homeless.

Adverse Childhood Events (ACEs) can be seen in part as the consequences of psychosocial deprivation and social exclusion (Scanlon & Adlam, 2008). ACEs are events experienced during childhood which are considered stressful or potentially traumatic including; sexual, psychological and physical abuse; witnessing domestic violence; neglect; living with caregivers who are substance users or affected by mental and/or physical illness or incarcerated; bullying; and family breakdown (Felitti et al., 1998). Experiencing ACEs increases the probability of an individual developing psychological trauma, occurring when an event(s) overwhelms an individual’s ability to cope, resulting in pervasive feelings of terror, helplessness and shame (FEANTSA, 2017; Hopper et al., 2009). Sundin and Baguley (2015)'s review indicates that in Western countries, ACEs are disproportionality recognised in the homeless population, and other research has found ACEs are more common in the homeless than general population (Herman et al., 1997). Furthermore, Fitzpatrick et al. (2013)'s study found only a minority did not report any ACEs (Mar et al., 2014; Theodorou & Johnsen, 2017). Those with the most ACEs – particularly relating to abuse and deprivation – were more likely to be experiencing extreme exclusion (Fitzpatrick et al., 2013). Experiencing exclusion is also associated with mental illness, being both a cause and consequence (Morgan et al., 2007). Experiencing one ACE increases the probability of experiencing another (Bywaters et al., 2016), and the number of ACEs indicate a 'dose-relationship' with mortality and risk behaviours such as substance misuse in adulthood (Chang et al., 2019). Experiencing poverty also increases the risk of experiencing ACEs, and both are risk factors for becoming homeless (Bramley & Fitzpatrick, 2018; Bywaters et al., 2016). Consequently, many homeless persons have a history of complex or compound trauma (Cockersell, 2015) which continues into adulthood. Many also find the process of becoming homeless traumatic, often losing social connections. Many also experience additional traumas when homeless such as being a victim of or witnessing violence (FEANTSA, 2017).

Experiencing ACEs can have long lasting effects on the brains development (Bellis & Zisk, 2014; Herzog & Schmahl, 2018). Though all areas of the brain are interlinked, specific areas have been highlighted as being of particular importance in relational interactions, particularly during sensitive periods of plasticity. For example the theory of the neuro-environmental loop of plasticity (NELP; Callaghan & Tottenham, 2016) emphasises the importance of early parental interactions on the amygdala-medial prefrontal cortex (mPFC) network being at the centre for emotional processing. There is evidence for changes in the mPFC when experiencing ACEs. For example, the amygdala – considered a central component of the threat detection system important for survival – is one of the most rapid systems to develop from birth. Linked to the hippocampus – important for memory and learning - the amygdala uses incoming information to quickly learn about potential threats. In people who have experienced ACEs, studies generally indicate reduced amygdala volume and increased amygdala activation in fear tasks (Oshri et al., 2019). Le Doux (2000) theorises that the orbitofrontal cortex holds back the fast response of the amygdala, regulating our own behavioural response by providing a reflective, less immediate response. This region also supports the ability to understand others, to mentalise, considered 'emotional intelligence' (Gerhardt, 2015). Thus, the orbitofrontal cortex processes incoming relational information, and helps decide the most appropriate response instead of acting impulsively. Those who experience ACEs such as physical or emotional abuse or neglect are also more likely to have reduced orbitofrontal cortex volume compared to controls (Brito et al., 2013; Gerhardt, 2015; Hanson et al., 2010). Finally the anterior cingulate cortex – supporting internal affect-regulation in relation to others responses by considering what will reduce internal negative experience and increase positives (Stevens et al., 2011) - is also reduced in those whom experience ACEs (Cohen et al., 2006). Consequently, the brain develops - at least in part - to the incoming experiential information it gathers from others during childhood. This is evolutionarily advantageous, as it provides information about the world and how best to develop to ensure survival. However, as Gerhardt (2015) notes, if the orbitofrontal cortex is underdeveloped and does not maximise the sensitive period for plasticity, it may be less likely to stop the impulsive amygdala fear responses, with poor connectivity between the amygdala and pre-frontal cortex correlated to psychopathology (Dannlowski et al., 2009; Park et al., 2018). In addition, affect regulation may be impaired, alongside the ability to understand other's intentions and emotions. Thus, the brains development is inherently linked to relational interactions.

Considering the impact of ACEs on neurobiology, it may be unsurprising that ACEs are consistently recognised as having a significant long-lasting impact on health – both physical and mental - and future life opportunities linked to adverse housing outcomes (Bebbington et al., 2004; Brown et al., 2009; Hughes et al., 2017; Hughes et al., 2016; Larkin & Park, 2012). Those who experience ACEs are more likely to have lower educational attainment and to have left school before completing exams (Metzler et al., 2017; Theodorou & Johnsen, 2017), putting them at a disadvantage in the "structural" arena. Poor literacy and numeracy skills are highly prevalent in the homeless population. In a sample of 139 single homeless adults, Dumoulin and Jones (2014) found 55% had poor numeracy skills and 51% poor literacy. This exacerbates barriers and exclusion from employment and support opportunities, as these difficulties may go unrecognised by services and professionals, perpetuating the cycle of homelessness.

Gender can impact on associated risk factors. Though not exclusive to women, the proportion of those citing homelessness as a result of escaping sexual abuse and domestic violence is significantly higher than men, with 1 in 4 women experiencing partner-related violence during their life (Engender, 2020; McNeish & Scott, 2014). For example, Reeve (2018) found the most common experiences which resulted in women being homeless were; sexual abuse; maternal trauma such as the loss of a child; bereavement; neglect; and experiencing violence. Again, though not exclusive, for men, risk factors often relate to drug use, which can be considered both a cause and way to cope with the impacts of being homeless (McVicar et al., 2015; Powell & Maguire, 2018; Salkow & Fichter, 2003). Another risk factor particularly, though not exclusively for men, is contact with the criminal justice system before and during homelessness (Fitzpatrick et al., 2013; Walsh et al., 2019), and experiencing ACEs in childhood increases the probability of contact with the criminal justice system either as a victim or perpetrator (Craig et al., 2017). It also increases the probability of engaging in substance misuse (Sundin & Baguley, 2015). Finally, for men and women, mental health has been consistently highlighted as a risk factor for homelessness (Sosenko et al., 2020).

1.8 The complexity of terminology

Historically the term "complex needs" (CN) has been used to describe people with multiple problems considered the hardest to help (Rankin & Regan, 2004). CN has been applied to homeless persons due to their often interlocked, complex and persistent needs. This has developed with other terms such as "multiple complex needs" (MCN) and "severe multiple disadvantage" (SMD), being used to describe broadly the same set of issues, often requiring a person to present with a combination of three or more of the following; homelessness, mental illness, substance misuse, and offending behaviour (Bramley et al., 2015; FullFilling Lives, 2020; Rankin & Regan, 2004; Rosengard et al., 2007). Poverty or "chronic poverty" is also included in some definitions (Duncan & Corner, 2012), though in many it is implicitly assumed to accompany the difficulties encountered (Belcher & DeForge, 2012; Bramley et al., 2015; Duncan & Corner, 2012). Grouping these domains together is partially due to the interrelated nature of the difficulties. For example, those whom are homeless may be more likely to engage in offending behaviour to 'survive' (e.g., shoplifting), increasing the probability of them having had contact with the criminal justice system (Bramley et al., 2015; Fitzpatrick et al., 2013).

Rankin and Regan (2004) highlight that, though different terms are used interchangeably and sometimes vary slightly in their definitions, there are two common themes; firstly, the importance of the *breadth* of need in multiple areas which are interrelated; and secondly the *depth* of need being profound. Importantly, the *depth* in any area does not need to be severe. Instead, it focuses on the multiplicity and cumulative impact of having multiple issues, hence the importance of considering *breadth* (Bramley et al., 2015). Therefore, irrespective of the term used, it should be seen as a framework for understanding someone's needs, rather than an individuals' characteristics (Rosengard et al., 2007). Defining MCN using breadth and depth provides policy-makers and services guidance in identify the level of support needs required. However, it may also result in a barrier to support, deciding whom has "simple" needs and therefore are excluded from accessing support (Rankin & Regan, 2004).

Duncan and Corner (2012) argue that, unlike MCN, SMD places emphasis on the *relativity* of the individuals position compared to others, moving the focus away from the individual which may perpetuate stigma, placing responsibility on wider societal structures. This is an important component of terms associated with describing homelessness – the acknowledgement of the impact of stigma and exclusion – which is not explicitly included within the term 'MCN'. SMD or "Multiple Exclusion Homelessness" (MEH) place prominence on other factors such as poverty, welfare policies and the design of the housing market – all considered structural factors - on the ability to obtain and sustain safe and secure housing, by emphasising the relativity (SMD) and exclusion (MEH) components of homelessness (Anderson & Christian, 2003; Busch-Geertsema et al., 2010; Engender, 2020; Savage, 2016; Stephens et al., 2010). This is of particular importance, given that persons experiencing homelessness face increased if not profound stigma and thus discrimination and exclusion compared to the general population, which, as previously discussed, can result in significant psychological distress.

Other nuances within the terminology are worth exploring – namely the recognition of the impact of gender and its role in altering the pathways into and experience of homelessness. As the number of visible homeless women – particularly those rough sleeping – is smaller than men, research has tended to reflect the experiences of men (Engender, 2020). For example Bramley et al. (2015)'s study highlighted that the majority of individuals in contact with substance misuse, homelessness and criminal justice services – all considered disadvantaged - were men, highlighting a clear gap. However, Bramley (2015) also indicates that evidence is emerging to show women also experience episodic and chronic homelessness.

1.8.1 The role of gender

Differences in risk factors have already been highlighted, which Savage (2016) and Casey (2001) attribute to gender-based inequality. Women are disadvantaged (see McNeish & Scott, 2014 for summary) in numerous ways including economically, as they are more likely to have lower-paid jobs and be responsible for childcare, and therefore are often at a disadvantaged in labour markets and less able to afford adequate housing. Considering the risk factors, Bretherton (2017) explains this economic marginalisation means women are less likely to have an economic 'buffer' to protect them against the impact of negative events. The loss of such housing often results in women experiencing further violence and exploitation whilst homeless, and can impeded their ability to obtain and maintain future housing (Engender, 2020; Wenzel et al., 2001). For example, "survival sex" – defined by Reeve (2018) as the "exchange of sex for material support" such as in exchange for a safe place to sleep - is almost exclusively gendered. Gaetz and O'Grady (2002) attribute this to the homeless population being “male-defined”, meaning women are the minority out-group within the homeless population (Reeve, 2018). Consequently, survival strategies are hierarchical, with men more likely to engage in more desirable activities such as street begging, whilst women are more likely to take up other, less desirable strategies (Reeve, 2018). Batty et al. (2010) describes those engaging in survival sex as the most marginalised and excluded groups in the UK homeless population.

Terminology has sought to encompass these gender differences and differing experiences of homelessness. Fitzpatrick et al. (2013) does this by framing MEH as someone who has been homeless and has one of more of the following: institutional care; substance misuse; or have participated in *“street culture activities”* including activities such as begging, “survival shoplifting”, sex work or street drinking. Though “mental illness” is not explicitly included in this list, it is in part incorporated under the “institutional care” component. Not only does this term include structural issues and allows for diverse categories of homelessness, the explicit inclusion of “street culture activities” represents gender differences.

Alternatively, following Bramley et al. (2015)’s and McNeish and Scott (2014) report highlighting the different gender experiences, Sosenko et al. (2020) sought to broaden the definition of SMD to acknowledge these differences. Sosenko et al. (2020) does this by including women’s experiences in the definition, referring to the following “primary” domains; substance misuse; poor mental health; homelessness *and violence and abuse*. This also differs from Bramley et al. (2015) definition of SMD in two ways: firstly, it includes mental illness in the primary definition. Secondly, it includes a list of “secondary” domains, frequently accompanying the primary domains; social isolation; poverty and disability; contact with the criminal justice system; being a migrant or a lone parent. A person must have at least two of the domains, with one falling in the primary domain to be considered SMD (Sosenko et al., 2020). Considering the range of SMD definitions, this arguably has necessary the breadth and depth of all the SMD definitions (see Duncan & Corner, 2012 for review). Using this definition, Sosenko et al. (2020) estimates in a year in England between 2010-2014, 336,000 adults – with equal figures estimated across the genders - experienced a combination of three to four of the primary domains. Furthermore, they estimate roughly 2.3 million adults experience two or more the primary domains in a year (Sosenko et al., 2020).

1.9 Social-based and stigma-based exclusion

Humans are inherently social, automatically seeking out relationships, wanting to be included and to belong. Social life is defined as much by who is included as is excluded, a process considered a normal but undesirable product of human interaction (Heatherton et al., 2003). Though initially defined as a type of "social closure", where one group attempts to secure and advantage over another through subordination (Agulnick, 2002), more recent definitions of social exclusion have widened, encompassing those who have slipped through support systems (Agulnick, 2002; Belcher & DeForge, 2012), and in the UK, exclusion is intrinsically linked to poverty and inequality (Agulnick, 2002). Thus, homeless persons often face social exclusion, placed 'outside' of mainstream society in numerous ways. Given the importance of social interaction on the brains development and impact if this is lacking, it is unsurprising that experiencing social exclusion at any point in the lifespan is linked to many material and negative psychological consequences including; contraction of the self; anger; emotional denial; frustration; low self-esteem; cognitive impairment; and threat to the self-concept (Abrams et al., 2005). Additionally, evidence indicates social rejection and separation utilises similar pathways to and can manifest in physical pain, hypothesised as a product of the social attachment system to promote closeness to caregivers and therefore survival (Eisenberger et al., 2003). Consequently, this suggests that experiencing social exclusion can have the same impact on someone as other traumas. Repeatedly experiencing social exclusion can result in depleted resources for coping, leading to mental health difficulties and feelings of helplessness, with individual differences appearing to do little to mitigate the negative effects (Williams, 2006).

Abrams et al. (2005) asserts stigma-based exclusion – an extreme form of social exclusion - is distinguishable from other forms, due to the need for a shared agreement amongst the collective including some form of supportive social justification or ideology. Johnstone et al. (2015) identifies three reasons why homeless persons face social exclusion, discrimination, and stigma. Firstly, many of the difficulties homeless persons experience are perceived as "controllable" (Belcher & DeForge, 2012). For example, homeless persons are often blamed for their inadequate ability to obtain or sustain housing or employment, attributing their homelessness to individual rather than structural inadequacies present in a capitalist system (Belcher & DeForge, 2012; Evolve, 2018; Parsell & Parsell, 2012; Phelan et al., 1997). Therefore, they are more likely to face discrimination perceived to be "legitimate" and socially justified – as can be seen from being deemed "intentionally homeless". The stigma that homeless persons experience – namely that they are responsible for their situation – is one that also consistently appears in the self-narratives of homeless persons in the literature (Lyon-Callo, 2000; Savage, 2016).

Secondly, homeless persons are more likely to have other difficulties associated with stigma. For example, many have backgrounds of and current associations with offending and substance misuse, which are perceived to be in the individuals control and considered “socially harmful” (Bramley et al., 2015), increasing the stigma they experience. Mental illness could be considered the least stigmatised difficulty homeless persons may experience due to its prevalence in the general population, which may increase levels of compassion and understanding. However the level of stigma remains high (Barry et al., 2014). Other gender-specific stigma also exists. For example, homeless women with children may be considered “bad mothers”, being unable to “maintain a home”, failing societal expectations of what they should be – a feminine homemaker - or may engage in survival-sex, both of which are high stigmatised (Fitzpatrick et al., 2013; Savage, 2016; St Mungo's, 2014). Thus, many homeless persons are members of multiple stigmatised groups.

Finally, Johnstone et al. (2015) notes that whilst homeless persons may elicit compassion from others with the recognition that they are struggling, evidence also suggests they are often viewed as not being “fully human”, placing them away from mainstream society, highlighting deficits and lack of contribution to society, perpetuating thoughts that they are “undeserving’ of help” (Belcher & DeForge, 2012; Shelton et al., 2010; Zufferey & Kerr, 2004). Harris and Fiske (2006) assert the “less than human” label associated with the out-group elicits feelings of contempt and disgust towards them, meaning that they are treated as undesirable objects rather than humans. This creates an “us” (in-group) and “them” (out-group) narrative, separating the majority from the minority. Self-categorization theory (SCT; Turner et al., 1987), closely linked to Social Identity Theory (SIT; Tajfel, 1978; Tajfel & Turner, 1979) is one of the most prominent theories used to explain intergroup theory through identity, and can go some way to explain this process of the stigmatised “other”. SIT hypothesises that identity and self-definition is formed through affiliation and sense of belonging to different categories. Each of these categories or group memberships provides a sense of how you should behave, feel, and think, and become more salient in different contexts. Consequently, you become part of the "in-group" who ascribe to the same category, reducing identification with the "out-group". Inter-group relations generally become, to varying degrees, competitive and/or discriminatory. In general, people will adopt strategies to ensure they either become or remain a member of the in-group (Hogg et al., 1995). SCT uses SIT to emphasise the interaction between groups as a whole. SCT accentuates perceived differences between the groups and emphasizes the similarities of the in-group. Members become "prototypes", embodying the category prescribed to them rather than being seen as an individual. This process is called depersonalization and is considered to be one of the mechanisms underlying stereotypes and stigma, as the in-group is regarded positively, whilst the out-group is viewed negatively, lacking individuation. This can result in the outgroups value in society being questions, particularly if the outgroup in clearly the minority (Heatherton et al., 2003). In essence, SIT refers to individual identity within a group whilst the individual maintains their individuality, whilst SCT describes the process of individual to group member (Hogg et al., 1995). Within homelessness, this mean that a homeless person is seen as a prototype – or an undesirable object - rather than a person, and this comes with all value – or lack of value - ascribed to that label. Interestingly, identifying with the out-group has been found to be a psychological buffer for the stigmatised, protecting against some of the negative consequences, with other members of the out-group acting as a resource group-members can turn to for support when facing external stressors such as exclusion and/or discrimination (Branscombe et al., 1999; Crocker & Major, 1989; Johnstone et al., 2015). However, whilst external classifications may be given by the majority, Walter (2015) highlights that this may not map onto the individuals self-definitions. In essence, an individual may have been ascribed the label of being “homeless” but they do not define themselves in this way. Indeed, Walter et al. (2015) found that 31% of those gaining entry to homeless services rejected the term homeless, and a further 14% were ambivalent. Additionally, those who rejected the label “homeless” reported comparatively greater well-being and less depressive symptoms, suggesting that unlike other groups, in this instance not identifying with the out-group is protective. This could be attributed to the levels of stigma associated with the group being too great, or the group being so heterogenous meaning there is no stereotypical framework to identify with (Johnstone et al., 2015; Parsell, 2010).

1.10 The financial cost of homelessness

The human cost of homelessness is inescapable. When homelessness is repeatedly experienced or prolonged, the probability of deterioration in physical and mental health increases, with individuals “aging in place” (Pleace, 2015). Whilst many may not access mainstream housing services, use of acute and other support services such as emergency accommodation is considerably high, given the complexity many homeless persons present with, resulting in a significant economic impact (Pleace, 2015). Additionally, though those chronically homeless may be small in proportion to the number of individuals experiencing homelessness, evidence repeatedly highlights that they are the most costly over time (Culhane, 2008; Pleace, 2015). Though homeless persons accessing statutory services are no different from others, the difference is the frequency of usage (Pleace, 2015), with homeless persons being up to four times more likely to access accident and emergency departments compared to the general population (Homeless Link, 2014b).

Considering the range of services utilised (e.g., statutory services and third party), obtaining a clear estimate of the cost is problematic. An evidence review by the MHCLG (2012) estimated that annual gross costs per person ranges from £24,000-£30,000, with an annual gross cost of roughly £1billion, including; access financial support, healthcare services, the justice system and from local authority estimates. However, these figures include only single adult rough-sleepers and those living in hostels and therefore exclude the hidden homeless, meaning this is likely to be an underestimate. Additionally, as with many estimates, they are not longitudinal, and therefore cannot provide an accurate "lifetime cost" for an individual experiencing prolonged homelessness. Considering all of these combining factors, homelessness could be considered a significant public health problem and financial burden, hence efforts such as the HRA (2017) seeking to reduce homelessness. Whilst interventions can be costly, a review by Culhane (2008) in the US indicated the reduced use of services often fully offsets the costs of the intervention. Consequently, though in this instance the intervention was housing support, providing appropriate support early is likely to reduce future support needs. Similarly Pleace (2015) highlights that the longer an person experiences homelessness, the more likely it is they will experience additional episodes of homelessness. Furthermore, given they are more likely to "age in place", this means increased health conditions over time increasing complexity, further increasing the financial cost to the taxpayer. Thus resolving homelessness quicky, though initially costly, reduces future and overall financial costs (Pleace, 2015).

1.11 Trauma and an unhoused mind

The concept of an "unhoused mind" combines attachment theory (Ainsworth, 1979; Bowlby, 1957) with trauma. Attachments are formed early in childhood between the child and caregiver whom the child depends on to survive, feel safe and uses to help them understand and explore the world. Attachment type is thought to be dependent on how the caregiver responds to the child when they feel threatened, unsafe, or unsecure and provides a template for understanding the self, world, and others. Four patterns have been identified, three of which are 'secure' meaning the infant can predict how the caregiver will respond, and one is unpredictable. Secure attachments are characterised by the child's needs being responded to promptly with reassurance, allowing them to safely explore the world. Of the following three, whilst the first two are also predictable, they are also deemed 'insecure' as each strategy increases the risk for developing adjustment problems. Insecure-avoidant attachments are characterised by caregivers who respond to the child with rejection and insensitivity, resulting in the child ignoring or avoiding their caregiver when distressed, reducing, or avoiding showing negative emotion. Alternatively, when a child receives an inconsistent response from their caregiver, they manage this through extreme displays of negative emotion when distressed in an attempt to consistently draw the caregiver to them in the hope they will receive a positive response, also known as insecure-ambivalent. Finally, a disorganised attachment occurs when a child experiences "atypical" parenting behaviour which is considered frightening, occurring in multiple interactions not limited to when responding to the child's distress. Children in this category will often become distressed when separated and attempt to seek proximity whilst also trying to avoid contact, and other mechanisms such as 'freezing' have been recorded (Lahousen et al., 2019). Whilst all insecure attachments are associated with higher rates if traumatic events, this final category is often associated with (though not exclusively) backgrounds involving sexual abuse and neglect (Benoit, 2004; Lahousen et al., 2019).

Our neurobiological and emotional development is intrinsically linked to our early engagement and experience with others (Gerhardt, 2015). Early attachments form part of our inner working model through largely unconscious mental representations.

These provide a framework for navigating the world, impacting on our responses in future relationships (Slater, 2007). Research indicates those children who grow up with a secure attachment are generally able to regulate their emotions and form positive interpersonal relationships, whilst those who experience insecure attachment styles and trauma are more likely to find forming positive, secure attachments in adulthood challenging (Allen, 2013; Lahousen et al., 2019). Those with insecure or disorganised attachment styles have had less opportunity to gather appropriate psychosocial feedback to understand their psychological self, and the mental states of others (Gerhardt, 2015). Consequently, evidence indicates they are less likely to be able to regulate their own emotions and be able to "mentalise", and are more likely to experience anxiety and be diagnosed with a personality disorder (Fonagy et al., 1996; Hong & Park, 2012). Considering the evidence relating to the reduced functioning of the amygdala, anterior cingulate and orbitofrontal cortex, these difficulties are relatively unsurprising; thus, attachment theory does have a growing neurobiological basis (Schore, 2001). However, when considered critically, though attachment theory does have consistent evidence relating to the ways in which early relationships impact on our neurodevelopment and interpersonal relationships, aspects such as inner working models are largely an untestable concept. Furthermore, they are unable to account for those whom are able to overcome severe adversity experienced in childhood (Slater, 2007). It may be that having access to an attachment figure – even if not a primary caregiver – who provides a secure enough attachment can buffer some of the negative effects.

ACEs are clear risk factors for homelessness, meaning many homeless persons - particularly those considered chronically homeless - are likely to have experienced childhoods characterised by ACEs. Furthermore, inconsistent, traumatic or frightening experiences of caregivers is likely to impact on the ability to trust others, particularly when the perpetrator is the caregiver they trusted and relied upon to survive (FEANTSA, 2017). Consequently, insecure, and disorganised attachment styles are theoretically far more likely to occur in the homeless population. Considering the neurobiological impact ACEs can have, it is unsurprising that areas of the brain which support understanding oneself and others – particularly the orbitofrontal cortex and anterior cingulate gyrus - are reduced due to the lack of access to a safe space to do so. This provides the foundations for an “unhoused mind”, a theoretical concept where an individual does not “know” themselves and struggles to understand and connect with others. Given that humans are considered predominantly social creatures with a social brain and desire to connect with others, this can result in the oscillation between engagement and disengagement seen in services. Homeless persons distrust of services may be a result of them experiencing services as rejecting (see section 1.12), mirroring past traumas (Hudson et al., 2016; Wen et al., 2007). Consequently, they tend to find themselves on the margins of society, by trying to occupy a space where they do not feel like they are intruding nor intruding upon, not trapped nor abandoned (Williamson & Taylor, 2015). For those who have experienced the most severe neglect, coming into contact with people may be too frightening. They isolate themselves away from social bonds – referred to as being “dismembered” (Adlam & Scanlon, 2016; Scanlon & Adlam, 2006, 2012) - occupying a space between the antisocial and social, resisting support from others (Brown, 2019). Homes, whilst considered safe for many, may be frightening, eliciting feelings of being trapped (Brown, 2019). Healthcare services may deem them “untreatable”, labelled as “difficult clients” and “non-engagers” (Maguire et al., 2009; Scanlon & Adlam, 2006, 2008). They oscillate between wanting to engage with professionals and services and become mentally and physically “housed”, alongside a pervasive fear of what this may mean, pushing away those trying to help (Seager, 2015).

Seager (2015) states providing physical shelter cannot solve the absence of psychological shelter. Seager argues those with an unhoused mind are still trying to build the foundations for their life, having the absence of key, safe relationships, and sense of self, yet often assumed to have an adult mind. Considering this, Seager (2015) notes it is highly improbable a few sessions of psychotherapy offered by the National Health Service (NHS), a brief inpatient admission or stay in a hostel with a roof and the offer of training programmes is going to resolve feelings of a lack of psychological safety. Focusing on the psychological needs – such as the provision of consistent, caring and compassionate relationships alongside the physical environment - can form the basis of a genuine home that may never have been experienced (Seager, 2015). This is conceptualised by Seager (2015) to provide "psychological housing" and a safe space to begin to understand themselves and rebuild broken attachments. Whilst there are sensitive periods for neuroplasticity to occur, it is also a lifelong capacity which can, though reduced, continually change based on new incoming information (Fuchs & Flugge, 2014; LaRosa et al., 2020). Using rat models Koe et al. (2016) demonstrated that providing an enriched environment during adulthood increased the density of basolateral amygdala neurons during and for some time after the initial stress reduction phase, indicating that early adversity can be rescued by later life interventions. Additionally, evidence from persons whom sustain brain damage also demonstrate the ongoing plasticity of the brain and ability to build new neural connections (Jasey & Ward, 2019). Thus, whilst it may take time and flexibility to form positive therapeutic and working relationships, new neural connections and relationships can be formed, reducing care-avoidance, and helping to house the unhoused mind.

1.12 Accessing services

Despite attempts to reduce inequalities, barriers to accessing healthcare services such as the removal of the need for proof of address (NHS England, 2017), a recent NHS England report (2018) found 39% of registrations to GP practices were refused due to a lack of identification, 13% due to immigration status and 36% due to a lack of address. This may inadvertently increase use of accident and emergency departments, as homeless persons struggle to access services for routine support – thus they access emergency services only when the health issue becomes acute (Homeless Link, 2014b; Pleace, 2015).

Other barriers may relate to language barriers or relational difficulties such as absence of feeling safe with others or in the physical space appointments take place in (Canavan et al., 2012; Klop et al., 2018; Seager, 2015), with non-attendance being a common issue. Practical reasons for non-attendance could be attributed to the range of services and different appointments homeless persons may have, or a lack of finances to get the necessary transport to attend appointments. Providing a one-stop integrated easy access service such as the 'health pods' operating in West Wakefield, can help reduce these barriers (NHS England, 2018). Despite evidence indicating increased integration of services is more cost-efficient and cost-effective than standard care (e.g. Cornes et al., 2019), the lack of sustainable funding opportunities often results in closure (Aldridge, 2020). Consequently, reduced co-ordination amongst services mean many will fall through gaps (Bramley & Fitzpatrick, 2018; Canavan et al., 2012).

Given the inclusion and exclusion policies of services, many will be "discharged" after not attending a set number of appointments or may be refused access to services depending on their presentation e.g., if they are under the influence of substances or are dual diagnosis. Exclusion criteria may also be used to reduce the level of complexity and regulate the demands of specialist skillsets, thus providing access to those whom are thought to receive the most benefit (Timms & Taylor, 2015). Consequently, many will experience accessing services as distressing and rejecting, feeling dehumanised and unwelcome (Wen et al., 2007). Professionals may inadvertently interact with this by also experiencing care-avoidance due to the sheer complexity and frustrations relating to continual disengagement, cancelling appointments or refusing care (see 'staff groups'; Klop et al., 2018). Thus, many are excluded from services.

Given the difficulty accessing services, many will never have had access to any mental health support. Outreach teams, implemented in the late 1980s through the Rough Sleepers Initiative (Timms & Taylor, 2015), uses an assertive community treatment approach, with a specialist multidisciplinary team taking support to the point of need through outreach on the streets, hostels and shelters. Such an approach reduces access barriers and provides both initial assessments, whilst helping (re)build relationships with a view to providing longer-term care through successful rehousing and engagement with other local services (Perry & Craig, 2015). Many of these outreach teams are within third party organisations and are uncommon in the NHS where the majority of CPs work. CPs are therefore often under-represented in outreach teams (Pipon-Young et al., 2010). This could be for two reasons; firstly, the assumption that physical needs are more important than psychological needs. Secondly, delivering psychological therapy has historically taken place in a set therapeutic setting, with two or more people meeting in a room for a set period of time to talk. Given the presentation of many in the homeless population – particularly the chronically homeless -

this is unlikely to be effective. The British Psychological Society ([BPS], 2011) 'Guidelines for Clinical Psychology Services' states CPs should offer services in both the NHS and voluntary sector which are non-stigmatised, non-discriminatory, valuing diversity and in a non-institutional setting in the community. It adds this may mean Psychologists may need to question traditional psychological practice, exploring new ways to build rapport (2011). Thus, the requirement for CPs to work in services promoting inclusion, taking services to the point of need is growing, acknowledging the importance of exploring different ways of working to facilitate access and support engagement with those considered disadvantaged. However, whilst there is some evidence that integration of CPs working with both NHS and homeless service is occurring (Williamson & Taylor, 2015), as with many areas of homelessness, evidence remains sparse.

1.13 Staff working in homelessness

Working with clients whom have backgrounds of trauma and relational difficulties can result in a range of reactions such as: compassion fatigue, burnout or moral injury and secondary trauma, also called vicarious trauma (Rogers et al., 2020; Scanlon & Adlam, 2012). Waegemakers-Schiff and Lane (2019) found of 472 staff in frontline positions in homelessness, 33% had symptoms consistent with Post-Traumatic Stress Disorder. Furthermore, frequent contact with individuals who have experienced trauma increases the probability of staff burnout and vicarious trauma (Lemieux-Cumberlege & Taylor, 2019; Mette et al., 2020; Rogers et al., 2020; Shoji et al., 2015). Those working in homelessness may also have past histories of trauma and/or homelessness and witnessing or hearing about similar traumas may retraumatise them. Despite working with trauma on a daily basis, many staff members are not trained in understanding the impact of trauma on themselves and others and may not be offered regular supervision or opportunities for self-care (Canavan et al., 2012; Hopper et al., 2009). Caseloads are often high and organisational resource scarce, particularly in the third sector where organisations and jobs often rely on securing the next contract, reducing job security. Continually shifting policies and provisions mean services are frequently having to adapt alongside their workforce (Mullen & Leginski, 2010). Consequently, levels of burnout are high, impacting on job satisfaction and, due to impaired performance, can impact on the quality of care provided (Lemieux-Cumberlege & Taylor, 2019; Waegemakers-Schiff & Lane, 2019). Staff sickness and reduced retention rates in the homeless workforce are frequently reported (Fitzpatrick, Pawson, Bramley, WIlcox, Watts, et al., 2017; Mullen & Leginski, 2010; Poskitt, 2019; Rogers et al., 2020).

Staff teams may find themselves feeling frustrated and lost when working with service users. This is then compounded by difficulties in the wider healthcare system (Brown, 2019). The concept of the unhoused mind has also been applied to the impact on staff teams working with homeless persons and in such organisations. Scanlon and Adlam (2012) highlight that those working with complex clients often work in (dis)organised organisations and within a distressing or disorganised social context. Both clients and staff are stuck – clients are encouraged to be resettled and housed when there is limited housing, whilst staff work to similar aims, with very few available resources, with high caseloads and little time for self-care. Thus, as the demands placed on staff and clients cannot be met, staff feel helpless, stuck, and anxious. Such feelings begin to impact on staff interactions, manifesting in various forms of incohesion within the team such as isolation and emotional detachment from the clients, the team and wider organisation. Alternatively, the team becomes massified, forming a unit of staff against the wider organisation, separating or more aptly excluding themselves from contact with others (Scanlon & Adlam, 2012). Many of these mimic the experiences of clients, thus both become unhoused, with staff members stuck in between the distress of their clients and structural violence in the wider organisation and society (Scanlon & Adlam, 2012). In essence, staff become traumatised by the impact of working with clients who are traumatising, and by an organisation which places demands on them which often cannot be met.

Scanlon and Adlam (2012) propose tools used to support the team, such as supervision and training, become problematic, as the nature of the work is too distressing. They suggest reflective team practice may be effective, providing a space for staff to reflect, either in a one-to-one or group setting on how they think and feel about their work. Such work can be completed informally through ad-hoc conversations, through formal commissioned meetings or can be an integrated into the services structure (e.g. PIEs) (Homeless Link, 2014a). Provision of adequate support systems including reflective practice, training and supervision have been proposed to mediate the impact of burnout (Lemieux-Cumberlege & Taylor, 2019). Improving access to emotional support can also increase resilience, also found to mediate stress and burnout (Grant & Kinman, 2014). All of the skills and knowledge Scanlon and Adlam (2012) highlight as important for facilitating such groups such as: an understanding of the wider psychosocial context; organisation and service; alongside knowledge of the impact of trauma, are built into the core CP training competencies (BPS, 2019). This indirect work – both through reflective practice and consultation to support psychological interventions – are integral components of a CP work. Yet this is often inaccurately reflected in electronic records, which generally record only face-to-face formal rather than informal contact (BPS, 2012).

1.14 Psychologically Informed Environments and Trauma-Informed Care

Psychologically Informed Environments (PIEs) emerged from a multi-agency working group called the "Enabling Environments working group" (EE). Convened by the Royal College of Psychiatry (Royal College of Psychiatrists, 2007-2008) the EE sought to explore a concepts similar to a therapeutic community (TC) and its application in improving community mental health provision in the UK (Haigh et al., 2012). TC's are structured PIEs, designed to reduce rigid aspects of psychiatric and mental health support, promote relationships and wellbeing (The Consortium of Therapeutic Communities, 2020) and are often associated with rehabilitation settings. Though acknowledged internationally, they struggled to gather an evidence base due to the lack of a specific framework – thus the EE sought to explore a way the concepts for a TC could be turned into something concrete to support service development and suit current commissioning frameworks. Considering the primary focus was those with complex psychological and emotional needs, homeless services and hostels were integral to the development of PIEs, initially focusing on settings where people live together (Johnson, 2010; Johnson & Haigh, 2010).

The PIE framework originally included the following five key areas; developing a psychological framework; consider the physical environment and how it facilitates feelings of safety; staff training and support; managing relationships; and evaluating outcomes (Breedvelt, 2016). The "Psychologically informed services for homeless people: Good Practice Guide" (Keats et al., 2012) was produced by a range of authors and implementors of PIEs in response to frontline staff asking for more direction on implementation. In 2018, PIE 2.0 was released, seeking to provide clarity and functionality, which the original framework lacked. Consequently, the revised account includes five domains; psychological awareness; staff training and support; learning and enquiry; spaces of opportunity; and the three 'R's; rules, roles and responsiveness (PIE Link NET, 2020). Underlying all these are reflective practice and relationships.

PIEs are flexible and should be applied to suit the specific populations needs. Therefore, no PIE will be the same, which may explain why much of the research concerning the evaluation of PIEs is found in grey literature. However, the available evidence indicates implementing a PIE can have positive outcomes including; reductions in mental distress and increased engagement with services, alongside staff reporting increased feelings of accomplishment (Ritchie, 2015); reductions in staff burnout (Homeless Link, 2018); increased engagement between staff and service users and reduced evictions (Williamson, 2018); staff adopting different approaches when working with service users (Phipps et al., 2017); and an increased understanding of the impact of trauma (Templeton, 2018). Challenges in generating an evidence base may relate to the need for PIEs – though following a framework - being applied to suit the specific population. This means no PIE will be the same, and measures used to explore the implementation and effectiveness may not be readily comparable across services. Consequently, generating a robust evidence base for PIEs faces similar issues to TC's, which PIEs were hoping to overcome.

Trauma-informed care (TIC) changes the focus from "what's wrong with you?" to "what's happened to you?" (SAMHSA, 2012). TIC is a whole-system approach seeking to increase awareness regarding the impact of trauma on service-users to prevent re-traumatisation and resolve the relational and system-wide power imbalance (FEANTSA, 2017; Sweeney & Taggart, 2018). Despite no agreement on what a TIC framework would look like, various TIC principles have been proposed (Hopper et al., 2009; Sweeney et al., 2016). All focus on the importance of relationships due to the chronic interpersonal difficulties many of those whom have experienced multiple trauma face. Thus, the principles of TIC are complimentary to the notion of an unhoused mind (see section 1.11; Scanlon & Adlam, 2006). Whilst principles can help organisations consider the requirements of trauma-informed approaches, they are arguably abstract, posing a challenge for implementation. For example, a range of psychological orientations can be used by services, all of which would still be 'trauma-informed'. This flexibility is arguably helpful, providing organisations with flexibility to utilise models which suit the population, and, though limited, there is emerging evidence of TIC being implemented in homeless services (Hopper et al., 2009). The lack of a clear framework may be impacting on generating a robust evidence base with little evidence outside of grey literature. However, the evidence which does exist does suggest trauma-informed approaches can improve outcomes in a range of settings (e.g. Chandler, 2008; Hales, 2017, 2019). Maguire (2015) asserts the lack of data for both PIE, TIC and evidence relating to homelessness services and appropriate interventions can at least in part be attributed to the lack of available research infrastructure in the sector. Additionally, the lack of literature in Hopper et al.,'s (2010) review could be attributed to the infancy of TIC, as it can take between 10-15 years for healthcare innovations to transition from research to practice (Proctor et al., 2009).

1.15 Clinical Psychology and homelessness

The lack of Clinical Psychology provision – particularly in the NHS – could be attributed to psychological wellbeing being considered less important than physical needs. As highlighted by Rosebert (2000), Maslow's Hierarchy of Needs (Maslow, 1968) emphasises the importance of obtaining food and shelter before safety (considered both physical and psychological safety),is widely accepted due to face-validity. However, closer inspection calls aspects into question. Given the nature of the hierarchy, this would assume all the basic "needs" need to be met before you can move on to the next stage. All stages would need to be moved through before a person is finally able to reach their full potential through self-actualisation. Applying this to homelessness – particularly those chronically homeless or entrenched – is problematic, given that many do not have access to shelter. The hierarchy would assume that, until shelter is provided, they remain in the "pre-contemplation stage" – defined as when an individual is unable to make changes or cannot see that they need to make changes (Prochaska & Norcross, 2014). This suggests psychological interventions at this stage are inappropriate and ineffective. However, though some who are given shelter may find that this does help them to 'move up' the hierarchy, there are some whom for whom the provision of this 'required' basic need of shelter does not help (see section 1.4). Furthermore, given the nature of the hierarchy, it would suggest that those who do not have access to basic shelter are unable to self-actualise. This was acknowledged by Maslow (1987) to be flawed, with evidence indicating those without a home are also able to self-actualise (Sumerlin & Bundrick, 2000). Thus, this begins to beg the question of whether fulfilling basic needs is required before psychological support is provided.

CPs receive training in multiple therapeutic modalities to support direct work. Additionally, they receive training in promoting psychological knowledge more widely through supervising staff in understand and applying psychological concepts and interventions. They also provide training and reflective practice, alongside psychological formulation. The latter is a core competency for CP training (BPS, 2019) and stated by the HCPC (2015) as one of the standards of proficiency encompassing the reflective-practitioner model. Combining the objective and subjective, formulations use psychological theory to support the understanding of a persons' difficulties and presentation, providing an initial hypothesis to support exploration of potential interventions (Aveline, 1999). Formulation can be delivered in a range of ways. In individual work, it can support service users to make sense of their experiences. Wider team formulations can help bring information together and form a shared understanding of what may be happening for the client, identifying any gaps, and consider the best ways of intervening.

Despite being seen as a core component of a CPs role, research into the efficacy of team formulation remains limited (Geach et al., 2019). This can in part be attributed to the difficulties in operationalising research into formulation, such as selecting appropriate outcome measures. Difficulties with operationalising activities is a problem across other areas of a CPs core role, such as the efficacy of reflective practice. These can be defined in various ways and implemented in a wide range of areas, using a variety of models, and measured using a range of outcomes (Mann et al., 2009). Thus, evidence for the efficacy other components of the CPs role is also relatively sparse. However, the evidence available does indicate that these skills can be effective. For example, formulation can support team working. Buckley et al. (2020)'s explored team formulation in a homeless hostel using a PIE framework. They found team formulation helped challenge staff perceptions and change staff approaches to working with service users, thus supporting staff to work more effectively. Additional benefits, although not replicated in homeless services, include improved confidence in staff teams, alongside increased consistency (Berry et al., 2016; Whitton et al., 2016). Berry et al. (2016) also found team formulation increased feelings of positivity towards service users and themselves. It may be that these increased feelings in positivity go some way to buffering against burnout, as Jimenez and Dunkl (2017) found a negative correlation between low-workplace resources and reduced feelings of personal accomplishment. Both of these are associated with burnout.

Additionally, unlike other mental health professionals, CPs are trained using the scientist-practitioner model, also developing doctoral level research skills as part of their core training. Therefore they are well placed in supporting high-quality research projects to support wellbeing and promote effective cost provision (Smith & Thew, 2017). Finally, they also receive training in audit, service development and redesign, alongside leadership to support organisational development (BPS, 2018). Thus, as the BPS states they have a "unique clinical profile" (2018), hence this research seeking to support CPs specifically, rather than mental health professionals in general.

It could be argued many CPs do not utilise these additional skills, with high-quality research generation in practice being uncommon (Smith & Thew, 2017). This could be for a range of reasons such as: high caseloads meaning they struggle to dedicate the time to evaluations; lack of available resources to fund research; or lack managerial support (Smith & Thew, 2017). Elphinston and Pager (2015)'s research found that, despite feeling they had the capacity, team capacity mediated whether CPs felt able to undertake research work, indicating it is seen as less valuable. Lack of support was also found to be a key facilitator by Newman and McKenzie (2011). Thus, a potential barrier to CPs engaging in formal research work may be the support and perceptions of the wider team and organisation on its utility. This may be particularly relevant in under-resourced areas such as homelessness. Lack of identification with the scientist-practitioner model has also been proposed, to account for low research output (Newman & McKenzie, 2011). However, estimates often use published work, meaning they do not account for other research avenues such as service evaluations, meaning the actual output may be higher (Smith & Thew, 2017). Alternatively, it may be that many go into Clinical Psychology because they prefer the clinical, person-centred work rather than research work, as shown in the demographics of this sample. Irrespective of the reason, services and CPs not utilising these key research skills impacts on the ability to which they can promote and expand the commissioning of their services. This lack of research also undermines the ability to evidence a CPs unique selling point (Smith & Thew, 2017)

The Mental Health Strategy (Department of Health and Social Care, 2011) acknowledges that there is often no single or concrete diagnosis for many mental health difficulties to guide interventions, which is of particular relevance for the SMD population given their complexity. Thus, the need for flexible provision of input through direct and indirect working, promoting psychological understanding through assessment and formulation is critical to support appropriate interventions, all of which are key skills for CPs. However, given the multifaceted approach and complex area with little evidence, it can be challenging for commissioners to understand the role and requirements of a CP. For CPs they are likely to experience two difficulties: firstly, commissioners may not provide adequate resources to support effective working with this population. Secondly, the complexity associated with this population and the reduced provision in the sector means it is likely many will have little contact with other CPs working in homelessness. In such situations, both commissioners and CPs may turn to the evidence base and relevant guidelines to support job plans and their work. However, in addition to this lack of evidence, despite there being other population-specific guidelines (BPS, 2011, 2015), there are at present no guidelines for CPs working within homelessness. Furthermore, guidelines are generally written for those working in the NHS. Therefore, they are tailored to the NHS systems and services (e.g., with specific inclusion and exclusion criteria), which, though increasing, is still only a small proportion of the number of CPs working in homelessness (Brown, 2015). Thus, their applicability and utility is questionable.

1.16 Practice-based evidence, evidence-based practice and mindlines

There are many different types of guidelines, seeking to improve the care quality and outcomes. Within healthcare the most common are Clinical Practice Guidelines, which are statements systematically developed using the available evidence and offer specific instructions based on specific clinical circumstances (Graham & Harrison, 2005). Consequently, clinicians utilising guidelines to inform their work are engaging in evidence-based practice (EBP).

EBP – also called evidence-based medicine (EBM; Sackett et al., 2000) – is considered a paradigm shift away from the application of unsystematic clinical knowledge and experience, towards a more rigorous, systematic and scientific basis (Knaapen, 2013). It is a tripartite model, focusing predominantly on the evidence, though also includes components of the clinicians judgement and patients values (Thornton, 2006). Though originally a movement in medicine, it has moved into other areas including Clinical Psychology. Clinicians are encouraged to utilise clinical guidelines in their work to guide their assessments and chosen interventions. It provides them with guidance and certainty about what ‘works’ and what does not ‘work’ and can support the effective implementation of treatments and interventions. Arguably implementing EBP guidelines can support parity of care provision.

Despite the common misconception that the term ‘evidence-base’ would indicate both quality and quantity of evidence, Knaapen (2013) notes EBP refers to evidence which has been reported transparently, not its quality or quantity. Research has highlighted increasing concerns around the quality of the available evidence-based guidelines based on their lack of methodological rigour (e.g. Grilli et al., 2000). This suggests some EBP guidelines may be of poor quality and should be quality-assessed prior to implementation. EBP is also inherently based on the "evidence hierarchy" – the concept that some evidence, such as that from highly controlled clinical trials (e.g., Randomised Controlled Trials; RCTs) are more "valid" or "valuable" than other evidence. Though this hierarchy originated in medicine, arguably this has moved across into other disciplines. Therefore, irrespective of quality and possibly quantity, quantitative data is often seen as much more efficacious than qualitative data – such as case studies – as it lends itself well to internal validity and therefore, replicability. Considered within the context of Clinical Psychology, the application of EBP can be particularly problematic given that much of the data on the efficacy of therapies are considered lower forms of evidence. Many therapies cannot be easily assessed using gold standard procedures – arguably one reason behind Cognitive Behavioural Therapy being represented in a significant number of National Institute for Health and Care Excellence guidelines (National Institute for Health and Care Excellence [NICE], 2020). Additionally, the reductionist methods which seek to reduce complexity into a series of distinct causal mechanisms is problematic, given the necessity to include a myriad of additional contributing factors within the biopsychosocial model. Consequently, EBP seeks to provide an objective empirical view, which is often at odds with the subjective psychological experience Clinical Psychology seeks to work with.

EBP emphasis on evidence with high internal validity does not necessarily indicate any ecological validity, which arguably is why clinician expertise remains a valuable component – treatment decisions should always be informed by the wider context. This is particularly true given that clinicians - including CPs - are increasingly facing complex presentations with multiple, linear – and possibly contradictory - guidelines to follow. This arguably results in decisions being increasingly based on clinician judgement (Graham & Harrison, 2005).

When faced with complexity, how does the clinician decide which treatment is the best option? Thornton (2006) argues that the foundations for EPB is "good judgement". This relies not just on explicit guidelines, but also tacit knowledge – the unconscious accumulation of knowledge from experience - and implicit skills which cannot be discounted. This forms the "bedrock" of decision making, with the role of clinical judgement also recognised in NICE guidelines (2020). This definition of "good judgement" or "clinician judgement" is complementary, if not synonymous with the notion of practice-based evidence (PBE). PBE is the accumulation and synthesis of evidence by an individual over time within the wider context or specialism they are working within. Considering the prominence of requiring an evidence base, PBE is often considered inferior to EBP, though, considered in this light, it would appear to be an integral part of EPB. It is possible the weighting of which is considered more pertinent depends on the available evidence and complexity of the problem *alongside* the clinicians judgement of these.

Gabbay and le May (2004)'s ethnographic study exploring how clinicians in primary care apply their knowledge in practice provides support for the importance of clinician judgement and knowledge over guidelines in making decisions. When responding to challenges in everyday practice, clinicians were found to utilise "mindlines" or "guidelines in the head". These were formed through the amalgamation of a wide range of knowledge including existing guidelines and knowledge of the evidence base *alongside* tacit knowledge gathered through experience. This was then applied to the context they were working in. Clinicians would utilise this tacit knowledge and knowledge of others when faced with rapid decisions or complex situations – arguably their own accumulated PBE and others - in preference to clinician guidelines (Gabbay & le May, 2016). Additionally, they would go on to share this knowledge – or wisdom - with other clinicians and would seek out the knowledge – or wisdom of others - before consulting clinical guidelines even if the evidence was available. Consequently, mindlines are considered to be internalised, often tacit and flexible guidelines, collectively reinforced by others through the sharing and integration of knowledge at a local level (Gabbay & le May, 2011). Thus, it would seem in practice, clinicians place a significant amount of importance on their own and others knowledge – or PBE - over clinical guidelines. Arguably, unlike clinical guidelines, this knowledge can quickly be translated into practice (English et al., 2020).

The scientist-practitioner model integral to CP training has faced criticisms for similar reasons to EBP. Criticisms include elements such as the lack of consideration about integrating these components into practice both conceptually and operationally (Shapiro, 2002). The application of research into practice is often problematic as much is inapplicable or does not reflect the resources available. Additionally, it also relies on their being an available evidence base. Though there have been some attempts at gathering an evidence base regarding effective psychological interventions for those experiencing homelessness (Maguire, 2006), evidence is severely lacking.

This research argues that, as there are CPs working in homelessness services and given the lack of empirical evidence for such work, it is highly likely that they have accumulated knowledge through their own clinical practice and conversations with others. Consequently, it is likely that they have formed their own clinical mindlines (Gabbay & le May, 2011), applying these flexibly to the complexities they face within the homeless population and service structures. Considering Gabbay and le May (2011) findings, clinicians may place more value on the knowledge others have accumulated, as it is perceived to be more credible and applicable within their local context, compared to clinical guidelines. Furthermore, this credibility could partially be attributed to the level of complexity clinicians come across in the real world which cannot be adequately accounted for in guidelines (Gabbay & le May, 2016). Evidence for how PBE or mindlines can be utilised to guideline clinicians can be seen direct working in psychotherapy (Stiles et al., 2003) and psychological therapies (Evans et al., 2003) and a small evidence base for PBE used to inform indirect work (Kellett et al., 2020). Importantly, the term "good practice" rather than "best practice" guidelines has been chosen to acknowledge these guidelines use clinician PBE, not critically appraised research.

There is no "magic bullet" to address this practice-research gap (Langley et al., 2018, p. 1). The Delphi Method (Dalkey, 1969; Linstone & Turoff, 1975) supports the notion that expert knowledge is a valuable asset which can be utilised – particularly when there are gaps in the available evidence. It also allows for clinicians who are locationally disparate to share knowledge with others, creating a knowledge-sharing forum similar to that at the local level utilised by clinicians in Gabbay and le May (2004)'s study. This is particularly important given the relatively small but growing number of clinicians working in homelessness. The locational distribution of these clinicians means such knowledge-sharing forums may be limited. Additionally, Barth et al. (2016) attributes guideline non-compliance partially to a lack of awareness, alongside little familiarity or agreement with the content and lack of available resources for implementation. The Delphi method can overcome these in several ways; firstly, it utilises consensus building, seeking a level of agreement amongst the experts working in the field – in this case, CPs working within homelessness. Thus, providing the level of consensus is high, this would suggest CPs are more likely to implement the guidelines in context as they will be familiar with and will have endorsed the contents. Langley et al. (2018) argues that collective making – such as co-production and creation - can influence and support knowledge mobilisation through the active involvement of stakeholders. By involving those stakeholders who use the knowledge generated, this should increase ownership of the guidelines by the profession and increase credibility. Secondly, a Delphi is completed remotely. Therefore, it can facilitate a knowledge-sharing forum, supporting the concept of mindlines. Finally, given the lack of available resources which may hinder the implementation of guidelines, CPs working in homelessness are aware of what resources are available. Consequently, they are arguably more likely to make recommendations they have found to be operationally viable. Supporting this operational implementation of the guidelines is supported by the addition of clinical vignettes, providing clinicians with multiple ways in which the guidelines can be implemented. Additionally, utilising vignettes also seeks to mirror the way knowledge would be exchanged in coffee-room chats in local settings, where clinicians seek advice and share knowledge with others (Gabbay & le May, 2016).

This research did not seek to limit or set rules as to what knowledge would be seen as the "right" knowledge for inclusion, as found in other clinical guidelines. Instead, it sought to provide a forum where clinicians can express different forms of knowledge, which Langley et al. (2018) notes can help to support practical implementation. Consequently, this research sought to address a gap in the evidence by combining clinical mindlines and The Delphi Method to create a "product" which is valued, actionable in context, increasing its uptake and use (Langley et al., 2018). Finally, these guidelines are not intended to be the end of a conversation, rather an opening for a conversation about the lack of evidence. Afterall, identifying and exploring gaps in knowledge are crucial to our role as CPs in direct and indirect working.

2 Extended Method

2.1 Consensus building

Consensus building seeks to support decision making by synthesising existing knowledge rather than creating new knowledge (Black et al., 1999). Formal rather than informal consensus methods - such as the 'Interacting Group Method' (Van de Ven & Delbecq, 1974) - have been used within the healthcare sector since the 1950s (Black et al., 1999). It is often, though not always, used in areas where the empirical evidence base is lacking. Thus it relies on using the available information and wisdom of participants to inform the output (Black et al., 1999). One of the most notable examples of informal consensus processes used in UK healthcare is NICE. Formal methods of consensus are only implemented if consensus is not reached or if there is a lack of evidence in the area (NICE, 2020).

As there are a range of different consensus methods available, the chosen approach should be tailored to suit the question and way in which participants will interact (Carpenter, 1999; Halcomb et al., 2008). The three primary formal methods suggested by the World Health Organisation (WHO; 2014) for use in guideline development are; the Nominal Group Technique (NGT); the consensus development conference; and the Delphi method. Variations and hybrid approaches, containing aspects of each method also exist, such as the "modified NGT" (Black et al., 1999; Dalkey, 1969).

The Consensus Development Method, originally developed by the National Institute of Health in the US, has been modified and implemented in several international organisations (WHO, 2014). Experts convene over several days for face-to-face presentations of the available evidence by other experts and stakeholders in the field. Following this, the expert panel consider the question asked and seek to reach and produce a statement of consensus. There is no formal structure applied to how the consensus decision is reached (e.g., through voting), and no private decisions, with a chair present throughout (Black et al., 1999; Halcomb et al., 2008; WHO, 2014). Thus, this would be a more informal consensus method.

Comparatively, the NGT provides more structure to group interactions, making the method more formal. Prior to meeting, panellists individually record their ideas, all of which are then formally presented to the wider group by a facilitator for discussion in a face-to-face meeting. The facilitator provides structure to the group's interactions. Following discussions, panellists then privately vote on each idea, with judgements combined statistically to determine the groups consensus. This can take place over several rounds with discussions between each round. Structuring the interaction allows a space for equal consideration of all panellists' views, allowing a space for new ideas to be generated, with the potential to reduce dominant voices (Black et al., 1999; Hsu & Sandford, 2007; WHO, 2014).

2.2 The Delphi method

A classic Delphi, originally developed by Young and Hogben (1978), includes "anonymity, iteration, controlled feedback, a statistical group response and stability in response" (Hanafin, 2004, p. 5). Delphi's seek to facilitate structured communication and discussion to establish consensus, defined by Linstone and Turoff (1975) as "opinion stability", based on participant responses. The primary difference between the NGT and a Delphi is the reduced need for face-to-face contact required in a Delphi, as participants do not meet, remaining anonymous throughout (WHO, 2014). Delphi's are comparatively more accurate than unstructured groups (Yousuf, 2007) and more reliable than other structured consensus methods (Hutchings et al., 2006).

Despite considerable variation in how the Delphi method can be implemented, all follow a similar format: a panel of individual experts on the topic are recruited and, in a classic Delphi, are asked to provide some initial information or idea(s) via a questionnaire. Participant responses are then collated by the "facilitator" (in this case, the researcher) with all other participant responses. Thus, the process removes the need for a facilitator to chair discussions, removing this potential area of bias. A series of 'rounds' are used, whereby the collated participant responses are anonymised, and disseminated to all participants to consider their views on a carefully constructed survey. Each survey asks participants to indicate their feelings for each proposed idea on a Likert scale, alongside any additional feedback. Responses are then collated by the facilitator who then sends a summary form back to participants indicating the groups consensus level for each item. Each participant sees their response alongside the group consensus. If group consensus has not been reached, participants are then given the option during the next round to revise their rating(s) based on the groups feedback. This iterative process can last for several rounds until consensus is reached (Black et al., 1999). Considering the number of rounds is essential when implementing a Delphi study. Though as many as 25 rounds have been recording in Delphi literature, consensus has been shown to generally be achieved within two to three rounds, diminishing after three rounds due to increased attrition potentially due to factors such as participant fatigue (Thangaratinam & Redman, 2005; Walker & Selfe, 1996; Whitman, 1990; Worthen & Sanders, 1987; Yousuf, 2007). As Whitman (1990) notes, as fatigue increases, participants may be more likely to conform to end the process rather than reflect their views, reducing validity. This research used four rounds consisting of two survey iterations to refine panel views and achieve consensus. A third and final round was available to use for a final survey if consensus had not been reached. Considering the structured format, a Delphi could be seen as merely a way to collect data. However, Turoff and Hiltz (1996) warn against this, highlighting the insights gained through the process as more important than the sum of its parts.

2.3 Why a Delphi?

The Delphi method has been deployed to resolve problems, often in socially complex and uncertain areas (Donohoe & Needham, 2009), including guideline development. Whilst there are many examples of guideline development using a Delphi method (e.g. Byrne & Morrison, 2014; English et al., 2020; C. Kelly et al., 2008; Kelly et al., 2009; C. M. Kelly et al., 2008; Morrison & Barratt, 2010; Ross et al., 2014), given the range of consensus methods available, it was important the research team considered which would be most appropriate to fit the research question. Linstone and Turoff (1975) highlight a number of reasons as to why a Delphi was considered the most appropriate method of consensus building for this study including availability of data, practicalities of data collection and heterogeneity of participants. Firstly, the lack of evidence on how best to work in homelessness means analysis of data is impossible. However, though niche, due to the number of CPs working in the area, it is likely that there is increasing PBE which could be brought together and synthesised into a set of subjective judgements. Delphi’s have been highlighted as being particularly useful in helping to establish an evidence based by systematically tapping into and using the knowledge and expertise of individuals working in areas where evidence is absent (Minas & Jorm, 2010). The Delphi method explicitly values expert knowledge and expertise which complements the aims of this study – to create PBG derived from clinician experience. Secondly, the lack of face-to-face contact, and ability to readily utilise digital formats, particularly given the ongoing Covid-19 crisis, has reduced the processes cost and time. Additionally, completing this remotely reduces geographical limitations of the research, avoiding challenges of convening participants in one place. This is also particularly important given the number of CPs working in this area are few in number and likely to be geographically dispersed. Reducing the time commitment is also likely to increase participation, as it is unlikely that contributing to research will be part of participants job descriptions (Yousuf, 2007). Therefore, minimising disruption for the participants is paramount. Consequently, using the Delphi method provided a way of bringing together experts across the UK, minimising disruption, and reducing costs. Finally, the anonymity in the process can preserve the heterogeneity of participants. This is particularly important within such a small and likely homogenous group of clinicians, magnified by the lack of diversity in Clinical Psychology training (Turpin & Coleman, 2010). Controlling for and/or reducing group effects is a concern when using group-based methods to generate and synthesize data. Anonymising participants helps to reduce social desirability and conformity or "groupthink" (Janis, 1971), which may be present in other consensus methods. Groupthink asserts that groups adopt consensus seeking tendencies to avoid confrontation. This can result in alternative avenues being ignored, reducing critical thinking, and increases the probability that irrational or unwise decisions are made. Arguably, as the group see all responses, their responses may change to align with others views, resulting in some bias and groupthink within the process (Hasson et al., 2000). However, the anonymity in the Delphi method alongside its democratic nature seeks to minimise such variables, thus providing a space for challenging alternative viewpoints, resulting in "process gains" rather than "process loss" (Donohoe & Needham, 2009; Powell, 2003; Rowe & Wright, 1999). Additionally, though dependent on strategy employed and size of the group, group decisions have been found to be more accurate compared to individual decisions (Kattan et al., 2015; Miner, 1984). Surowiecki (2004) proposed in the book "*The Wisdom of Crowds*" that in groups of experts, increased group-accuracy depends on certain conditions. These include: increased diversity with heterogeneity; decisions being made independently with outside influence reduced; individuals being autonomous and decentralized; and aggregation (Jorm, 2015). The Delphi method includes many if not all of the conditions proposed by Surowiecki (2004). Arguably, it is unable to always reach the required diversity level, and that may be possible in this case. However, whilst this is a small and relatively homogenous sample, their range of clinical expertise will vary within the field of homelessness. Furthermore, given CPs have access to a wide range of psychological models and ways of working, arguably it is highly probable they are heterogenous in their approach.

2.4 Forming the panel

To ensure the relevant data is produced, all aspects of a Delphi must be carefully constructed, including panel selection and the question(s) to be asked (Donohoe & Needham, 2009). Delphi panels are formed by groups of experts in the subject area, adding to the methods credibility (Hanafin, 2004; Miller, 2001). As the output is predominantly a result of the panels ideas, particular importance should be paid to the panels selection, considered by some as the most important aspect of the Delphi process (Donohoe & Needham, 2009; Wheeler et al., 1990). However, there is little definition of what an "expert" is and this is debated within Delphi literature, with Hanafin (2004) identifying studies defining experts from “volunteers” to “informed academic and consultants”. Expert sampling is often selective rather than random, and therefore subject to researcher bias. Hasson et al. (2000) and Goodman (1987) both consider the inevitable bias when recruiting experts to the panel, such as those recruited having a vested interest in the output (Yousuf, 2007). Thus, to reduce bias, it is important that those selected are also able to maintain impartiality, ensuring information obtained accurately reflects their experiences, and perceptions. Hanafin (2004) asserts recruiting experts should be purposeful rather than random, hence the need for explicit, rigorous inclusion and exclusion criteria to define the parameters of the “expert”. This approach can also help reduce selection bias (Keeney et al., 2006). For this research, it was seen as important that those involved should not only have theoretical knowledge, but also a range of clinical backgrounds. In line with the practice-based focus of the research, this should encompass the population and service type and/or research experience in the area. Whilst “experts by experience” is often used to described those with lived experiences of mental health difficulties, in this instance, CPs are considered “experts by experience”. This is because they have and understanding of and experience being a CP in homeless services for both direct and indirect working (e.g., service development), which those with lived experience are unlikely to have. Further rationale for why homeless persons were not included in this aspect of the study is in section 2.5.

There is little guidance around the size of a Delphi panel, with some studies indicating that larger panels provide more stable outcomes (Jorm, 2015). However, Murphy et al. (1998) suggests that the increased reliability in panels which exceed 15 is small, and smaller panels have been suggested to be more reliable in homogenous samples (Briedenhann & Butts, 2006). Linstone and

Turoff (1975) note that increasing above 10 can generate a vast amount of material for the researcher to manage. Planning for attrition across rounds is also essential. High attrition rates in Delphi studies have been attributed to the length of commitment required, time between iterations and disillusionment with the process. Hanafin and Brooks (2005) guides researchers to anticipate attrition rates of between 16-28% per round (English, 2018). Preliminary research into the number of CPs working in homelessness prior to recruiting identified only around 15 CPs – though the research team agreed that, based on Maguire's (2015) figures and increased recruitment, it was probable this number was an underestimate. Despite this underestimate, it remains likely the numbers of CPs working in the area is small, considering those employed in statutory mainstream services are estimated to account for 80% of CP employment (Longwill, 2015). Therefore, due to the niche subject area and likely homogenous sample of this study, it was decided that we would seek to recruit 15-20 participants to form the expert panel. Attrition can be reduced through good communication about the process at the outset and throughout the process, and participants were emailed, wherever possible, with information regarding the timelines for the project, and were also sent reminder emails of upcoming deadlines for survey responses (Donohoe & Needham, 2009). Timings of the Delphi can also reduce attrition (e.g., avoiding school holidays) and planning should be made wherever possible to reduce the impact of such events (Donohoe & Needham, 2009). However, as the Covid-19 pandemic could not be anticipated and coincided with participant recruitment in February 2020, the research team agreed that recruiting ≥10 would be sufficient to provide stability and room for attrition, remaining above panel numbers advised by Donohoe and Needham (2009).

2.5 Consulting the Expert Citizen's

"Expert Citizens", also called experts by experience or service users, are increasingly being involved in research, providing lived experience of the issue being addressed (Barker & Maguire, 2017; Faulkner et al., 2019). Involving Expert Citizens is actively encouraged by the National Institute for Health Research (NIHR), asserting they provide valuable insights into the practical set up of research studies including the design, implementation, and evaluation, adding credibility and relevance to the research. The NIHR also notes that it is the democratic right of those who are affected by research to be able contribute and guide how it is undertaken, helping to empower those who will receive the service(s)(NIHR, 2012; Thompson et al., 2009). As CPs are considered the "experts by experience" for this research forming the expert panel, service users will be referred to as 'Expert Citizens'.

Whilst Expert Citizens have previously been involved in Delphi research (Byrne & Morrison, 2014; Law & Morrison, 2014), little is known regarding how best to utilise them in guideline development. Most commonly, service users are incorporated into the panel, with one of two representatives selected to provide input where possible. They may also be involved in the final review of guidelines through focus groups or questionnaires (van der Ham et al., 2014). However, there is no optimal way of including service users. Consequently, attention needs to be given to how service user involvement is adapted based on the guidelines subject area and population (Boivin et al., 2010; Boivin & Legare, 2007). A review of guideline development involving service users by van der Ham et al. (2014) indicates that involvement as early in the process is valued by professionals and service users. Recruitment and retention is a key barrier for incorporating service users into research, as service users may have limited interest or input into aspects of guideline development, viewing aspects of it as burdensome.

Given the above, it was important to consider how best to incorporate persons experiencing homelessness into the guidelines development. Considering the transient nature of the homeless population and limited conventional social networks pose challenges for continued engagement, high attrition rates are likely in this population. This often results in researchers being reluctant to include homeless persons in research (Forchuk et al., 2018; Hobden et al., 2011; Ojo-Fati et al., 2017; Strehlau et al., 2017). Considering the need for ongoing contact with participants, the time needed to take part during a Delphi and also the need for a location to send the survey to, the research team were conscious that this may mean involving Expert Citizens, in this instance homeless persons, may be problematic. Additionally, whilst some may be able to make specific contributions to good practice for relationship building, assessment, and therapy, many may not have had contact with a CP, meaning they are less likely to be aware of the support CPs can provide. Furthermore, they could not be expected to have an overview of the breadth of a CP role, particularly in indirect working or wider organisational support, meaning they would only have been able to input into limited aspects of the research. However, considering the already disempowered and stigmatised nature of the population, it was important to the research team that Expert Citizens were included in a way that was meaningful and appropriate.

Previous research has found that being creative alongside working with third party organisations to increase engagement and support with contacting participants, alongside being flexible in approach can support inclusion (Forchuk et al., 2018; Ojo-Fati et al., 2017). Involving Expert Citizens helps to reduce the power imbalance between CPs, researchers, and service users, enabling those traditionally excluded to be heard. Furthermore, Norman and Pauly (2013) note that excluding those impacted by homelessness risks important insights and solutions being missed. Considering the challenges of involving Expert Citizens in the Delphi, it was felt by the research team that an initial consultation group with Expert Citizens to explore their experiences would be most helpful. Exploring their experiences of mental health, homelessness and contact with CPs in a single consultation group reduced the time the Expert Citizens would have to commit to the project and could be arranged flexibly, at a time and location to suit them (Appendix G and Appendix H). Providing the CPs involved in this research with information derived from this consultation was completed with the aim that this would help them to hold the service user "in mind" when making their recommendations.

2.6 The Delphi process

2.6 Round One

Round One is often utilised as a 'scoping round' to explore the question (Donohoe & Needham, 2009), with the data captured used to inform future rounds (Gibson, 1998). Variations exist in how the first round of a Delphi is used. In a classic Delphi, it generally consists of a set of questions to obtain information and opinions about the research question from panel members to be explored in future rounds (Hsu & Sandford, 2007) – though modified Delphi's may use the first round to derive the questions and move straight on to survey iterations (e.g. Woodcock et al., 2020). Broad and narrow questions can be used. Use of narrow questions is increasing, often derived from a review of the current literature (e.g. Eubank et al., 2016). Broad questions allow a space for open exploration with panel members, increasing the amount of information obtained to inform the research question and future iterations of the Delphi (Hasson et al., 2000; Miller, 2001; Skulmoski et al., 2007). However, too little structure can result in vast amounts of data being generated, not all of which may be relevant to the research question (Hasson et al., 2000; Low, 2007). Arguably, not asking key questions derived from the literature at the start of the process may result in important information being unintentionally omitted, impacting on the validity of the output, a potential key weakness of the Delphi process (Linestone & Simmons, 1977; Miller, 2001). However, provision of information and/or a set of specific subject-related closed questions at the start is predicated on the notion that this literature is available. Within the area of homelessness, there is an inherent lack of evidence meaning a literature review would be problematic. The lack of available evidence is one of the key reasons why the Delphi was deployed in this study. Secondly, the aim of this guideline is to explore CPs practice-based experiences. Providing information derived from the literature would have reduced the probability of new knowledge being generated and shared amongst participants. Providing knowledge and/or using specific 'narrow' questions derived from the literature would also increase research bias. As Pannucci and Wilkins (2010) note, as bias is inherent, researchers should seek to reduce bias where possible through careful consideration of the study design and its implementation. Therefore, to reduce researcher bias and allow for both exploration and the collection of relevant data, semi-structured interviews, the most commonly employed qualitative research method, were used due to is flexibility and versatility (Appendix I; DiCicco-Bloom & Crabtree, 2006).

Considering the number of recommendations, Gargon et al. (2019) found that vast amounts of data in subsequent rounds increased the burden on panel members, impacting on attrition. Schmidt (1997) recommends panel members provide a minimum of six ideas to reduce the overlap between contributions. Given the considerations of researcher and participant burden, the research team agreed that panel members would be asked to contribute six ideas in total: three for direct working and three for indirect working (see Appendix K). The interview content generated from these questions were then used where possible in the vignettes accompanying the guidelines.

2.7 Round Two

Data from the initial round needs to be transferred into the subsequent survey round(s) and consolidated into a single list. As advised by Schmidt (1997), proposed guidelines which covered similar topics and had considerable overlap were grouped together. Additionally, Schmidt (1997) notes data is often reduced and/or mapped by the researcher in the initial round for the second round, compromising validity. To circumvent this issue, Schmidt (1997) suggests modifications should be member checked prior to the commencement of the Delphi. The introduction of such bias was reduced in this study by asking panel members to provide ideas in Round One which would be used verbatim in Round Two. Thus, no researcher interpretation was required from the first to the second round. However, to maintain credibility and trustworthiness of the output, member checking was completed during Round Three and Four (Birt et al., 2016; English et al., 2020).

The lack of guidance surrounding the implementation of a Delphi means there is little other than current convention to guide the amount of feedback collected from panel members during a Delphi. Two opportunities for anonymous feedback from other participants from Round Two were provided to influence panel member consensus in Round Three. Firstly, through the overall group consensus determined by percentages on the Likert scale for each guideline alongside the panel members response to each guideline, and secondly via an anonymous free text box for each guideline. Providing controlled, anonymous feedback provides panel members with additional insight and the opportunity to reconsider and refine their opinions, encouraging consensus (Keeney et al., 2010; Yousuf, 2007). Quality of feedback included is an important variable for consideration. Poor quality feedback comprised of minimal feedback of median responses rates excluding reasons for the panel members rating has been found to reduce accuracy compared to feedback which included the reasons for the panel members selection (Best, 1974). Consequently, this indicates that the more informative the feedback, the more influential it is likely to be (Rowe et al., 2005). Though panel members may choose to ignore the feedback, including all feedback for each item provides panel members with the opportunity to review and consider their responses. This is likely to improve the accuracy of the outcome. Additionally, doing so reduced the researchers influence on the Delphi's outcome, further reducing researcher bias on the consensus result.

All panel members were given the option of receiving the survey through either post or via email, and using both for all panel members has been found to increase response rate (Boulkedid et al., 2011). However, all panel member requested to be sent the surveys via email.

Determining consensus. Two primary methods of determining consensus are utilised; the percentage of panel response, with consensus levels determined as low as 60%, and measuring the interquartile range (Donohoe & Needham, 2009). Required consensus levels should be decided apriori, guided by the wider literature (Diamond et al., 2014). Literature indicates that consensus level should be decided based on the size of the panel – an individual's contribution in a smaller panel will hold more influence on the outcome compared to larger panels, where the power of an individual response diminishes (Hsu & Sandford, 2007; Jorm, 2015). Thus, larger panel may have lower consensus levels than smaller panels. Considering this, alongside the homogenous sample of clinicians, the research team decided percentages would be used. This was decided as they allow the most transparent way of communicating the level of consensus across the expert panel.

Likert scales. Likert-type scales are commonly used in research to quantify participants opinions on an issue, specifying their level of agreement. Inclusion of a Likert scale ensures that all participant contributions are weighted equally (Donohoe & Needham, 2009). Trevelyan and Robinson (2015) assert that, though commonly used in Delphi research, few studies consider how best to use the scale. For example, there is no guidance regarding the optimal number of response categories to use. Whilst there is no research addressing this issue directly in Delphi research, Lozano et al. (2008) notes the optimum number for reliability and validity is between four and seven. Additionally, a key critique of Likert scales is the inability to ascertain whether all participants perceive equidistance between each choice (e.g. 'Is important' and 'Is essential') (Bishop & Herron, 2015). Furthermore, participants may also moderate their responses by selecting the 'neutral' option, avoiding either extreme due to social desirability bias or because their answer may change depending on various factors. To mitigate this, researchers can choose to use the "forced choice" option, removing the 'neutral' point. This research used a five point Likert-response scale with a midpoint. As Chyung et al. (2017) highlights, omitting a midpoint to force-choice is not best practice, and the inclusion/exclusion of a midpoint should be considered depending on the research. Using a midpoint can increase validity (Adelson & McCoach, 2010) and misuse of a midpoint can be reduced by considering the clarity of the question(s) asked and providing sufficient response alternatives to the midpoint (Chyung et al., 2017; Matell & Jacoby, 1972; Presser & Schuman, 1980). In the case of this research, as it is asking panel members whether a guideline is or is not important, it seemed logical to provide an option which provided the option to remain neutral. This reduced the probability that panel members would instead choose not to respond to an item if forced and may have impacted on the survey and/or item response rate used to calculate consensus. As this research also sought to explore consensus, excluding a midpoint could be seen as the researcher forcing consensus, which may impact on the acceptability of the guidelines.

2.8 Round Three: providing feedback, modifying, and removing items

Little guidance exists around the modification and removal of items. Following feedback from Round Two, guidelines were amended to fit panel member feedback. In instances where the guideline had reached consensus but where minor amendments had been suggested (e.g., amendments to phrasing and grammar), panel members were not required to re-rate the guideline. In several instances, modification was significant, meaning guidelines were often combined with others to reduce overlap, and in one instance, the combining of multiple guidelines and creating a new modified guideline. All guidelines which were 'approaching consensus' or had undergone significant modification were included in Round Three for panel member feedback. Modifications were made when significant overlap was identified by the research team and/or multiple panel members, defined as two or more. All modifications were made by the primary researcher, who would then send these to the second and third to review independently and provide feedback. Conflicting opinions were resolved through discussion.

Though small in number, there were some instances of minority views suggesting amendments. The presence of these could indicate that the anonymity of the chosen methodology may have reduced the pressure for participants to conform. However, there is little guidance on how to handle minority view or "dissension" (Dalkey and Helmer, 1951), and such views may be ignored as it requires additional work for the researcher (Linstone & Turoff, 1975). Minority views should therefore be carefully addressed by the research team. Additionally, all amendments from Round Two were member checked in Round Three with the research explanation for the amendments alongside panel members feedback included to ensure feedback had been appropriately "mapped" (Schmidt, 1997). Panel members were required to re-rate guidelines which had undergone significant modification and could provide additional feedback. Feedback was included verbatim unless the comment indicated jeopardised the panel members anonymity – when this occurred, this part of the comment was redacted.

Similarly to English et al. (2020), guidelines were not removed from Rounds Three or Four if they had achieved consensus that they were not 'essential' or 'important' or had not achieved consensus (i.e. expert panel ratings were widely distributed across the scale). These were included to promote transparency, showing how guidelines had been amended, seeking to reduce the impact of researcher bias in the most likely area bias will arise – in the expert panels judgement (Skinner et al., 2015). Giving the panel all the available information in each round is thought to be the main influence in altering subsequent responses, as they are able to reassess their own responses in relation to the expert panel and available data (Hsu & Sandford, 2007). Therefore, by including all information regarding consensus including guidelines which had not reached consensus and would not be included alongside those which had reached consensus before inclusion may have helped participants to consider what was ‘missing’, thus honing their feedback.

2.9 Round Four

Following Round Three, all but one guideline had reached consensus. Given there had been modifications from Round Three, providing a final space for member checking the guidelines was particularly important. It was made clear modifications would not occur at this stage, as the research team was conscious of evidence of increase attribution over more Delphi rounds.

It was agreed that two clinical vignettes would be sought to accompany each guideline to provide examples of them in practice, supporting their practical implementation. Providing two examples shows how the guidelines can be implemented flexibly and creatively in different settings, while avoiding adding too much additional information. Where clinical vignettes could not be identified from the Round One interviews, the research team agreed the panel would be asked to provide vignettes in Round Four in the first instance. If any guidelines had less than two vignettes, then a member of the research team whose clinical background is in homelessness would contribute vignettes. For all vignettes, pseudonyms, and key identifiers (e.g., names of initiative or services) were removed to allow for participant anonymity, integral to a Delphi.

Feedback themes were identified and categorised by the primary researcher. Comments which contained multiple themes were grouped based on what was considered by the primary researcher to be the most prominent theme.

2.10 Quality criteria

There is no official methodological or quality criteria to assess a Delphi against (Hasson et al., 2000). Following a systematic review, Diamond et al. (2014) proposed a set of quality criteria based on how consensus had been applied operationally in Delphi studies. Similar to English et al. (2020), this quality criteria was applied to the study, guiding the design, application and reporting. The criteria, alongside the extent to which they were met can be found in table 13.

Table 13. Diamond et al.'s (2014) quality criteria applied to this study.

Criteria	Evidence of quality criteria in this study
Study objective	
Does the Delphi study aim to address consensus?	Yes
Is the objective of the Delphi study to present results (e.g., a list of statement) reflecting the consensus of the group, or does the study aim to merely quantify the level of agreement?	The objective of this study was to produce a set of consensus-based guidelines. This has successfully been produced, and the level of agreement has been evidenced, and can be found in the Appendices.
Participants	
How will participants be selected or excluded?	Inclusion criteria was been adhered to, which included the following: • Qualified and HCPC registered Clinical Psychologist • Is currently or until recently has been working

	clinically with the target population • Have ≥1 year of experience working with the target population • Must currently be involved in either direct work (which includes working directly with clients and/or supporting staff working directly with clients) and/or research work with the target population • Have access to a computer and the internet
Consensus definition	
How will consensus be defined?	≥80% agreement by respondents that an item is important or essential, and ≥70% for approaching consensus.
If applicable, what threshold value will be required for the Delphi to be stopped based on the achievement of consensus?	N/A
What criteria will be used to determine when to stop the Delphi in the absence of consensus?	The Delphi would have been stopped if none of the items had achieved the consensus level i.e., if all had <80% consensus following Round Two. A maximum of three rounds were used.
Delphi process	
Were items dropped?	Yes, following the second and third round.
What criteria will be used to determine which items to drop?	If consensus has not indicated that the item is important or

	essential OR if items are identified as overlapping. In these instances, guidelines will be combined with others where overlap is evident.
What criteria will be used to determine when to stop the Delphi process or will the Delphi be run for a specific number of rounds only?	The Delphi will run for a maximum of Four Rounds. The first round will be the initial ideas round consisting of a semi-structured interview. The second and third will consist of surveys to reach consensus. Providing consensus has been reached, the Fourth Round will be to seek feedback on the research output.

2.11 Epistemological position

This research was approached from a Critical Realist perspective. Critical Realism places emphasis on the importance of considering ontology, drawing attention the understanding of the nature of knowledge before we can consider the enquiry. It posits itself between constructionism and empiricism, asserting that, though there may be an objective truth, human knowledge only captures a small amount of this reality or truth (Fletcher, 2017). There are three “truths” in critical realism, leading to the assertion that the world is multidimensional; there is the objective empirical truth, the actual of what occurs but is not always experienced, and the “real”, which generate the phenomenon (McEvoy & Richards, 2006). The latter is not openly observable, but truth can be inferred using theory and empirical methods. Given the combination of multiple “truths”, in critical realism, all truths have the potential to be valid, as they are grounded in a specific context, worldview and perspective (Maxwell, 2011). Furthermore, given there are enduring process and structures that are “known”, these can act as points of reference which theories can be tested against (McEvoy & Richards, 2006).

Critical realism lends itself well to this research question for two reasons: Firstly, the definition of the term “homeless” varies across countries, alongside economic, cultural and social contexts (Kellett & Moore, 2003; Toro, 2007). This suggests that there are multiple contextually specific shared realities or alternative truths, lending itself to a social constructionist perspective. Secondly, the research question is looking to identify what is considered “good practice” by CPs working in the UK. CPs have access to lived experiences of direct and indirect working which they can critically reflect on and evaluate. This suggests there is the possibility that both an individual and shared truth – or understanding of what constitutes good practice - may be found, lending itself to empiricism. In essence, there may be multiple alternative truths, but the possibility of a shared truth would suggest there is the possibility of one reality being found. Furthermore, specifying the UK context acknowledges that specific contextually-dependent structures exist which they can “measure” the success of their subjective experiences against, such as their experiences of social norms and structural mechanisms.

The Delphi method is well suited to this blending of epistemological positions and type of enquiry. It fits neither the definitions of a qualitative or quantitative methodology, arguably placing it primarily as a mixed-method approach, classically seen as holding predominantly opposing ontological and epistemological (McEvoy & Richards, 2006). Critical realism acknowledges strengths for each position; for example, whilst positivist endeavours isolate elements, reducing the multi-dimensional complexity posited by Critical Realism, it can provide methods for comparison and reliable descriptions, as seen in the use of the Likert scale. Qualitative, interpretivist methods can provide information on perceptions and lived experiences, though some interpretivist methods isolate these experiences away from underlying social structures (McEvoy & Richards, 2006). As the Delphi method capitalises on human experience and interaction, valuing expert opinion and seeking to establish consensus, it would appear reductionist in nature, indicating that there is a single reality which individuals rely on (Black et al., 1999; Hanafin, 2004). However, the acknowledgement of a set of realities which can be modified by others views through the iterative Delphi process indicates that there are multiple realities with no single truth (Donohoe & Needham, 2009; Engels & Powell Kennedy, 2007), implying a more constructivist epistemological basis. Though, as Engels and Kennedy (2007) note, the outcome of a Delphi is constructed through interactions within a group which results in both an agreement of shared realities. Therefore, it suggests that there is the potential for a shared “truth” based on individual clinician experiences which, though contextually specific, can be identified. Similarly, though the concept of clinical mindlines clearly has links to social constructionism (Gabbay & le May, 2016), given the information shared by clinicians is accepted into other clinicians tacit knowledge, this would suggest that there is some commonality. Consequently, this indicates that there is an element of an objective truth in the shared knowledge, which is then subjectively applied in context.

Finally, critical realism incorporates the notion of researcher bias, which whilst controlled for wherever possible in a Delphi, is inherent. Considering the primary researcher completed the initial interviews and modified the output across several rounds inherently means that their opinion and therefore world view was incorporated into the guidelines. Thus, unlike reductionist research which reduces the researchers world view in the output, this research actively acknowledges the researchers view will have influenced the output given the need to act of qualitative feedback.

3. Extended results

3.1 Demographics

Individual demographic profiles have not been included. This is to maintain panel member anonymity due to the relatively small number of CPs working in homelessness in the UK. One panel member chose not to provide demographics, whilst another provided only partial demographic information.

Despite representation from around the UK, the group remained relatively homogenous, with the majority considering themselves 'white British' (73%), reflecting the lack of cultural diversity in the profession in the UK (Hall, 2006; Turpin & Coleman, 2010). Conversely, the contributors did not mirror the CP workforce regarding gender, with nearly an equal amount of females and males contributing (Longwill, 2015). The majority of panel members were between 30-39 years old and identified with various religious backgrounds. Of those who responded, 64% had been working in the area for between 1-9 years. All but one were working clinically with the population, whilst three were also engaged in research. Finally, data was not collected on whether panel members were working in statutory or non-statutory services.

3.2 Participant responses across the Rounds

Panel member input across the Rounds can be found in table 14. During Round Two, three panel members did not provide a rating for all direct guidelines (P002, P005 and P006). One panel member (P006) did not rate any indirect guidelines, agreeing to provide input during Round Four due to other commitments. P002 and P005 did not provide a rating for six indirect guidelines. For Round Three, P002 did not provide a rating for one direct guideline.

Table 14. Panel member contributions across the rounds.

Panel member	Round One	Round Two	Round Three	Round Four
1	✓	✓	✓	
2	✓	✓	✓	✓
3	✓	✓	✓	
4	✓	✓	✓	✓
5	✓	✓		✓
6	✓	✓		✓
7	✓	✓		
8	✓	✓	✓	✓
9	✓	✓	✓	
10	✓	✓	✓	
11	✓	✓	✓	✓
12	✓			
Total in percentage (*N*=)	100% (*N*=12)	92% (*N*=11)	67% (*N*=8)	50% (*N*=6)

3.3 Feedback across the rounds

Across both Rounds, more feedback was received for the direct guidelines than indirect (Table 15. Further breakdowns of feedback per guideline across Rounds Two and Three can be found in Appendix J). Feedback reduced from Round's Two to Three for both the direct and indirect guidelines, though there were less guidelines to provide feedback for overall in Round Three, alongside reduced respondents. Feedback contribution by panel members was relatively consistent across the rounds, though one panel member's feedback reduced significantly from Round Two to Three (P002, see Table 15). One provided no feedback in Round Two but provided comments in Round Three. Conversely, another provided feedback during Round Two, but none for Round Three.

Feedback themes were broadly similar across the rounds. The highest number of comments in Round Two for both the direct (Table 16) and indirect guidelines (Table 17) were classed as non-specific comments which did not state a specific position in relation to the guideline – for example, stating how the guideline related to their current role. The second highest in Round Two for both direct and indirect guidelines were suggested amendments to phrasing, followed by overlap identified with other guidelines. Again, these reduced in Round Three, though amendments to phrasing continued to receive high levels of feedback, as did overlap identified for the direct guidelines. Feedback regarding disagreement with aspects of the guidelines reduced across the rounds, as did comments regarding lack of clarity. Only one guideline across the two rounds polarised opinion in both ratings and feedback, which related to working in the NHS (see Appendix L for Round Three survey including Round Two results).

There were very few comments containing direct conversation between panel members, with only two in Round Three for the direct guidelines. Both of these were positive, voicing support for a panel members suggested amendment. Few comments were made directly to the researcher, with only one explicitly voicing disagreement regarding the researchers amendment from Round Two to Round Three. Finally, feedback relating to whether the guideline was not a guideline drastically reduced between rounds. Three panel members commented on this, with two responding only to Round Two. Despite providing this feedback, two of these panel members during Round Two intermittently provided a rating of 'important' or ‘essential’ twice for the direct guidelines and four times for the indirect guidelines.

Table 15. Number of comments contributed by panel members for each Round.

Panel member	Direct Round Two	Indirect Round Two	Direct Round Three	Indirect Round Three
1	8	6	6	6
2	30	32	4	1
3	3	0	10	9
4	0	0	6	1
5	18	10	No response	No response
6	8	Did not respond to this part of the survey	No response	No response
7	13	6	No response	No response
8	32	28	13	9
9	22	19	15	3
10	1	1	0	0
11	10	0	7	2
12	No response	No response	No response	No response
Total	145	101	61	31

Table 16. Direct guideline feedback based on the main theme identified in the panel members feedback.

Direct guidelines	Round Two	Round Three
Number of respondents	11	8
Total number of comments	145	61
	Main theme identified in comment	
Feedback themes	Number of comments per theme	Number of comments per theme
Agree with guideline	7	4
Comment containing views (not specifically specifying agreement or disagreement with guideline)	40	16
Disagreeing with the entire or part of the guideline	13 (5 are for 1 guideline which reach consensus to not be included in the guidelines)	4
Suggesting lack of specificity to homelessness	7	1
Disagreement with language used	7	2
Multiple messages in guideline	7	1
Issues relating to guidelines clarity, confusion, vague or lack of understanding	9	2
Overlap identified	20	9
Comments on other participants feedback		2

Suggested amendment to guideline phrasing	25	19
Comment stating the guideline is a ‘guidance’, ‘advice’, ‘statement’, or comment indicating that the guideline is not a guideline	7	1
Other	3	-
Disagree with researchers amendments from Round Two	N/A	0
Agreeing with researchers amendments from Round Two	N/A	0

Table 17. Indirect guideline feedback based on the main theme identified in the panel members feedback.

Indirect guidelines	Round Two	Round Three
Number of respondents	11	8
Total number of comments	101	31
	Themes	
Feedback themes	Number of comments per theme	Number of comments per theme
Agree with guideline	8	3
Comment containing views (not specifically specifying agreement or disagreement with guideline)	37	14
Multiple messages in one	1	
Disagreeing with the entire or part of the guideline	12	2
Disagreement with language used	-	1
Suggesting lack of specificity to homelessness	-	1
Overlap identified	13	2
Comments on other participants feedback	-	-
Issues relating to guidelines clarity, confusion, vague or lack of understanding	5	1
Suggested amendment to guideline phrasing	17	5

Comment stating the guideline is a 'guidance', 'advice', 'statement', or comment indicating that the guideline is not a guideline	8	-
Other	-	-
Disagree with researchers amendments from Round Two	N/A	1
Agreeing with researchers amendments from Round Two	N/A	1

3.4 Asking specific questions

In two instances, the researchers felt it necessary to gather additional feedback from the panel on the guidelines. The first concerned two direct guidelines (25 and 26, table 2) the researchers thought may overlap as did one panel member in Round Two. Therefore, the researchers asked panel members to re-rate these, considering the potential overlap. In Round Three, this elicited feedback regarding overlap between these guidelines and another, with amendments to wording suggested. Whilst consensus was reached for both guidelines, for one it reduced across rounds. As a result of feedback, these two guidelines were modified. Aspects of each were combined with other guidelines highlighted in the panel member feedback to reduce overlap.

The second instance concerned a need for clarity on a guideline's meaning. Guideline 7 (table 5) following Round One was "Encourage curiosity" (see table 2 for original guideline). In Round Two, the guideline achieved consensus, though one comment queried the guidelines clarity, particularly whether the guideline referred to the clinician, other staff, or the client. After discussing, the researchers agreed that, though the guideline would be included as it had achieved the required consensus level, panel members who rated the guideline as ‘essential’ were asked to provide feedback and clarity. As requested, all respondents to Round Three who had rated guideline 34 as ‘essential’ in Round Two provided feedback. Following this feedback obtained in Round Three, the guideline was amended to incorporate this feedback.

3.5 Guidelines which did not reach consensus

Following Round Two, two guidelines – one direct and one indirect – did not reach consensus to be included (Appendix L). The direct guideline achieved only 40% for inclusion, with 60% of panel members indicating the guideline was either ‘not important’ or ‘not at all important’. None of the respondents selected the ‘neutral’ option. Feedback indicated differences in opinion, with some highlighting advantages of working outside the NHS, and others providing examples of structures they consider to support their practice, such as clinical governance.

3.6 Comments and amendments to vignettes during Round Four

Due to increasing attrition and only one guideline ‘approaching consensus’ which overlapped with another guideline, the researchers agreed to use this final Round to member check the guidelines. Guidelines were circulated with accompanying vignettes, providing panel members the opportunity to give general feedback regarding the guidelines and provide vignettes where indicated (see Appendix M). Panel members were informed comments would not be actioned regarding amendments to guidelines unless multiple panel members raised the same issue(s), and the researchers agreed with the suggested changes. The research team made this decision as there would be no way to member check the guidelines following this fourth and final round. Therefore, whilst three comments were made by two panel members regarding amendments, none were actioned as they related to different guidelines (see Appendix M for Round Four results, containing panel member vignettes and comments). Following agreement from the research team, two vignettes were amended following one panel members feedback; one (direct guideline 26, table 11) had one vignettes final sentence deleted due to repetition, and the second (indirect guideline 2, table 12) was modified to provide clarity.

Feedback from panel members was collected at the end of each of the direct and indirect guideline sections. Three provided comments: two for the direct guidelines and one for the indirect guidelines. Comments for the direct guidelines related to the value of the vignettes in support CPs apply the guidelines in practice, whilst the indirect acknowledge the breadth of the guidelines, and highlighted their importance (see Appendix N for the final guidelines and accompanying vignettes).

4. Extended Discussion

4.1 Direct working categories

4.1.1 Individual work

NICE guidelines are primarily created for use in the NHS which has specific service structures and access to a range of available resources. Additionally, they are created using specific populations and are generally diagnostically specific (NICE, 2020; Petticrew & Roberts, 2003). Thus, their relative absence in these guidelines may reflect their reduced applicability to the complexity that CPs experience when working with homeless persons, often needing to refer to multiple competing guidelines. Consequently, their absence may echo the research into barriers in applying EBP guidelines (Graham & Harrison, 2005).

Arguably, the lack of representation of the SMD population whom are experiencing homelessness in EBP guidelines generally could be – at least in part - attributed to the absence of a high-quality evidence-base. This seems to be particularly relevant for individual psychological work. Evidence is emerging suggesting specific therapies such as CBT can be effective in reducing depression and substance misuse in homeless youths (Wang et al., 2019), and reducing offending behaviour (Maguire, 2006). However, Wang et al.,'s (2019) review found the studies identified were of low or very low in methodological quality, with bias being a risk in the majority. Furthermore, the effectiveness of specific interventions may be dependent on how they are adapted to fit the SMD population, particularly given the need for flexibility seen in the guidelines. For example, participants were provided with accommodation for the duration of Maguire (2006)'s intervention, which may have been a key component. Given the lack of evidence, it is clear that further high-quality research needs to be completed, exploring the efficacy of specific psychological interventions and adaptations required for this population.

4.2 Indirect working categories

4.2.1Approaching systems change

Despite the lack of available evidence demonstrating efficacy (Wells & Tickle, 2020), trauma-informed approaches feature heavily in the guidelines, as do concepts associated with TIC, such as co-production. Considering the prevalence of trauma in the homeless population, its inclusion is logical. However, given PIEs prominence in the literature and its similar focus on trauma, it is surprising that this is not also referenced to a similar extent. Reasons behind this may relate to the differing levels of flexibility behind concepts. Given the breadth of different types of homeless services and lack of resources, implementing all aspects of a PIE may be unfeasible, though implementing some aspects – such as the trauma-informed element(s) (e.g., training) – may be more accessible.

4.3 Guidelines which did not reach consensus

Considering divergence in opinion is normal within groups, Linstone and Turoff (1975) and Donohoe (2009) argue items which do not reach consensus are just as important as those which do. Division of respondents for the direct guideline relating to working for the NHS was clear. Data on the number of CPs working in homelessness and the division of labour between statutory and non-statutory services is currently unavailable. Furthermore, this research did not collect demographics on where panel members were employed and therefore cannot draw direct conclusions regarding panel member employment and the Delphi results. However, given the nature of the homeless sector and number of non-statutory service providers, whilst some specialist NHS services do exist (e.g., Leicestershire Partnership NHS Trust's "Homeless Mental Health Service"), it is highly probable at least some of the panel members work with and in other non-statutory services and organisations. Thus, the nature of the guidelines phrasing – emphasising that CPs should be employed by the NHS – does not appear to reflect the panel opinion and experience, nor the current structure of homeless service provision.

5. Critical reflections, considerations for implementation and recommendations for future research

5.1 Demographic data

The absence of demographic data on the type of service panel members were currently working in and drawing experience from is a clear limitation. Omitting this data reduced the ability to draw further inferences from the data.

5.2 Attrition and inconsistent contributions

Despite efforts made to reduce attrition - such as providing flexibility around holidays - attrition rates increased across the rounds. Only four panel members consistently contributed, and one only contributed to Round One. Panel members input was also inconsistent, with two providing vignettes in Round Four who did not respond to Round Three. In one instance, this related to time commitments. The reasons behind the second panel member's lack of contribution to Round Three are unclear.

Reducing contribution across rounds could be partly attributed to panel members being unable to accommodate the research into their existing workloads. This was communicated to the researcher from several panel members across the rounds. This further supports Newman and McKenzie (2011) research, suggesting a lack of support for the indirect research-based components of a CPs role (Newman & McKenzie, 2011). However, it is unclear whether this is due to a lack of understanding, value, or available resources. Alternatively, dissolution with the process due to a lack of understanding in the aims and processes may have reduced interest in the project over time (Yousuf, 2007). Some evidence for this can be found in panel member feedback. The three panel members did not rate every guideline stated that multiple guidelines were “vague” or “not a guideline” and two of these did not respond to Round Three.

Explicitly highlighting to panel members at the start of the process that the parameters of the output were going to be defined by panel members may have mitigated this impacting on attrition. However, this appeared unlikely to be the primary cause given one panel member continued to contribute throughout, and all three contributed to Round Four, suggesting all endorsed the guidelines. Furthermore, all panel members - including those who did not formally contribute to Round Four - provided informal positive comments via email regarding the guidelines value. Therefore, the reasons for reduced contributions remain largely unclear.

Given the flexibility of the Delphi method, consensus levels could have been adjusted across the rounds to account for varying response levels. However, as none of the ratings for establishing consensus of either the consistent or inconsistent contributors included were outliers, this is unlikely to have impacted on the results. Furthermore, given the democratic nature of the Delphi process, seeking to reflect panel input in the output and reduce researcher bias (Linstone & Turoff, 1975), all data was treated the same and included for consideration. This was also the case for panel members who endorsed a guideline, whilst also providing suggestions for modifications, negative feedback or questioning the guidelines validity (e.g., the guideline not being a guideline). The research team took the presence of a Likert scale rating to mean that the panel members endorsed the contents of the guideline. However, this is an assumption and the discrepancy between feedback and rating highlights the limitations of utilising a Likert scale in research. Modifying the Likert scale to improve transparency or providing further guidance to panel members on how the Likert scale would be interpreted may have enabled panel members to provide consistent qualitative and quantitative responses. Data may have been managed differently had there been the presence of outliers, as the mean – a measure of central tendency – can then be pulled – particularly in smaller panels - to reflect minority views, moving away from consensus (von der Gracht, 2012).

5.3 Facilitating communication

The Delphi utilises anonymity, proposing this reduces group think (Janis, 1971) and the influence of extraneous social information, creating a space for alternative opinions and discussion. This is considered to support panel members focusing on item content and 'good' feedback across rounds, which influences panel opinion (Rowe et al., 2005), reducing panel member bias (Skinner et al., 2015). Despite this space being provided, there was very little communication between panel members, apart from endorsing other panel members comments regarding amendments to phrasing. Furthermore, whilst including feedback during iterative processes has been found to improve accuracy (Rowe et al., 2005), there appeared to be little impact of comments on panel members future responses across rounds. This may be because the panel themselves were relatively homogenous in their views. Alternatively, it may have been that, despite anonymity, whilst panel members did express a range of opinions, they may not have felt able to directly disagree with other panel members feedback. Additionally, though improving accuracy, the extent to which the feedback itself is the causal mechanism for improved accuracy is inevitably limited by the iterative nature of the process. The time between rounds and change of opinion made may be the result of the panel member reflecting on their own input and previous feedback, rather than others (Rowe et al., 2005).

Similarly, there was little communication directly to the researcher, with only one of these disagreeing with the researchers amendments. Again, the reasons for this remain unclear. It may be that panel members felt the researcher would not listen to their feedback, and therefore did not directly address them. Alternatively, it may be that the lack of comments was reflective of panel members support of the researchers amendments. Feedback does support this hypothesis given the reduction in comments relating to overlap and modifications across the rounds, and general positive feedback received for the output.

5.4 Decision making and modifications

The lack of guidance on how best to conduct a Delphi and how to approach decisions and modifications provides flexibility in its application. However, this places additional emphasis on the need for the researchers to consider how best to reduce bias inherent in a Delphi (Donohoe & Needham, 2009).

Whilst some Delphi’s extract data considered relevant by the research team from initial interviews to form survey items (Thangaratinam & Redman, 2005), this research requested panel members provide these initial items. Using first order constructs – the panel members own words (Malpass et al., 2009) - removed the need for further analysis of items, reducing researcher bias. As highlighted by English et al. (2020) whose study informed this research, keeping the guidelines in their original form allowed them to be more readily linked back to the practice-based examples from Round One, acknowledging the value of PBE. Furthermore, requesting panel members to suggest items increases participant ownership of the product, increasing its credibility (Langley et al., 2018).

A clear weakness of the Delphi is the risk of surveys being open to researcher bias and manipulation (Skinner et al., 2015). There are no guidelines available on how to modify items across survey rounds. Modifications sought to reflect feedback from panel members. However, given modifications were made by the primary researcher who has their own beliefs and values – recognised as an important factor to consider when approaching research from a Critical Realist perspective - it is inevitable that they will have had some influence on the output. Furthermore, there is the possibility that some amendments were not acted upon, as these require more input (Donohoe & Needham, 2009; Linstone & Turoff, 1975). For example, decisions around whether to act on the panel members comment disagreeing with an amendment was subjective. However, given that all amendments were discussed amongst the research team, it is hoped that this will have helped to manage the primary researchers bias in the process. Furthermore, the presence of an objective measure of consensus determined apriori will have reduced bias in the process, with panel members determining the level of importance of a guideline.

Decisions regarding what constitutes a minor or major modification – whilst decided by all the research team – inevitably impacted on the extent to which panel members were able to provide further feedback on the survey items. For example, panel members were unable to provide further comments for guidelines which were considered to have undergone ‘minor’ modifications. Efforts were made to maintain transparency across rounds, such as providing panel members with information on how guidelines had been modified. Unlike some Delphi literature which may remove survey items from future rounds depending on the level of consensus achieved (Howarth et al., 2019), we chose to include all survey items in the output disseminated to panel member. This increased transparency and reduced the possibility of the research team inadvertently forcing consensus by influencing panel opinion. Furthermore, as the primary researcher is not an expert in the area, though this reduces bias by providing some distance from the contents, it may also mean important points were missed. Given a member of the research team has considerable clinical experience in the area, it is hoped this has largely been mitigated.

Finally, whilst guidelines were member-checked during Round Four, panel members were not given the opportunity to propose further modifications to items modified following Round Three. This includes the only guideline which was ‘approaching consensus’. Efforts were made to provide transparency in this round, including information in the appendices regarding amendments. The output received positive feedback via survey responses and informal email correspondence from panel members, indicating they endorsed the final product, supporting their credibility (Birt et al., 2016).

5.5 Impact of the Expert Citizens

Considering this research focused on those who are most excluded, the research team sought to include service users in a meaningful way. Whilst information from the Expert Citizen consultation group was given to panel members for consideration, only one panel member directly commented on the value of this information informally in their correspondence. Furthermore, none directly mentioned the impact this information had had on their interview responses. Therefore, it is difficult to ascertain the impact the extent to which the service users voice was considered in panel member responses.

5.6 Commonality of concepts

Overlapping concepts can be found across the guidelines. For example, indirect guideline 20 (see table 12 or Appendix N) could also fall under the direct guideline theme “Multi-agency working”. Reasons for this could be attributed to differences of opinion in what constitutes direct and indirect working. This may have been circumvented by the researcher providing further guidance on the definitions of direct and indirect working, possibly using those in BPS (2012) guidance on activity for CPs. However, this project sought to enable CPs to determine which knowledge was ‘right’ for the output, with the hope this would increase useability, ownership for and credibility of the output (Langley et al., 2018).

Additionally, many aspects of the “approach” theme, such as focusing on the relationship, providing flexibility, and considering trauma histories can be seen throughout the majority of the direct guidelines. Overlap in content can also be found in other areas such as “Relationships with and Support for Staff”. Some of this overlap is arguably important. For example, the way a CP approaches working with this population is – based on panel member input – a crucial component of direct work. Furthermore, whilst overlap is present in other areas of the guidelines, the emphasis of each guideline is slightly different. For example, indirect guidelines 1 and 2 (table 12) focus on different components of relationships with staff; safety and good practice. Thus, whilst further rounds may have further reduced overlap, important distinctions can still be found.

5.7 Subjectivity and good practice

The definition of what constitutes ‘good practice’ is subjective rather than objective. Considered from a Critical Realist perspective, given the lack of input and corroboration from service users and staff, it could be argued that these guidelines can only represent a shared clinician-specific view of what constitutes good practice. However, considering the CPs contributing to this research have generated subjective experience in contexts shared by staff service and service-users, it is hoped that they will shared at least some of these ‘truths’. Furthermore, given the shared UK context, CPs will have access to the same structures to measure their successes against, providing a way to objectively measure success (e.g., ability to obtain accommodation). Nevertheless, given the possibility for multiple alternative-truths, views of what constitute good practice may be different, hence the need for future research to explore this further.

5.8 Guidelines or guidance?

The Oxford English Dictionary defines the word guideline as "a general rule, principle, or piece of advice" (Oxford English Dictionary 2015). Thus, whilst clinical guidelines - such as those produced by NICE (2021) - focus on using directive guidance, these are not the only type of guideline. Furthermore, given the evidence regarding the use of clinical guidelines in practice when presented with complexity, they may not always be the most helpful. This research sought to give the expert panel the ability to select the type of guidance they felt would be most helpful in supporting their work, seeking to increase the useability and ownership on the output. Furthermore, as decisions should be made to reduce the impact of researcher bias where possible (Pannucci & Wilkins, 2010), providing guidance on what the guidelines 'should' look like would introduce bias into the process. Furthermore, by telling CPs what their knowledge 'should' look like implies there is a known causal 'truth', aligning to empiricism, countering the epistemological position. Critical Realism respects their being multiple perspectives and realities. Therefore, by telling panel members what is 'right' would dismiss their own lived experiences and knowledge of shared societal structures. Furthermore, as consensus was reached, this would suggest that there is a shared underlying and unknown causal mechanism which all CPs are working within and are able to measure success against. Therefore, the flexibility present in these guidelines reflects the epistemological position.

It may, however, have been helpful to provide panel members with information on the expectations for the output prior to commencing the research. Providing this may have supported their understanding of what the process was seeking to achieve – to capture what CPs working in homelessness discern as good practice guidelines. Given the feedback regarding lack of specificity reduced, and the clinical vignettes received praise for supporting implementation, is it argued the reduced specificity with accompanying vignettes will support application in a range of services. This flexibility should reduce constraints on implementation which may accompany other clinical guidelines, such as lack of available resources (Sadeghi-Bazargani et al., 2014).

5.9 Donations

To thank panel members for participating, each were given a £10 donation to give to a homeless charity of their choice. If no charity was specified, a £10 donation was given to Framework.

5.10 Dissemination and implementation

A four stage framework has been proposed by the Medical Research Council to use when developing complex interventions (Craig et al., 2008) consisting of the following stages: development, feasibility and piloting, evaluation, and implementation. Whilst linear in presentation, the order of the phases is determined by the intervention being developed and implemented. Whilst this research focuses solely on development, thought should be given to implementation, to reduce the transition period between research to practice (Proctor et al., 2009).

Given these guidelines have been created using PBE, it could be argued that much of the feasibility and piloting stage has been completed by CPs. Craig et al. (2008) notes that for complex interventions, the evaluation and implementation may also coincide and take place in a range of settings. Information regarding the product and any results should be disseminated to as wide an audience and possible. Additional research should be promoted to support and monitor the implementation process.

Considering the output from this research, it is probable that the evaluation of these guidelines will occur alongside implementation. Therefore, the initial stage of facilitating this process is through the dissemination of the intervention. To support this, the Division of Clinical Psychology in the British Psychological Society – the largest representing body of CPs in the UK – were contacted to explore publishing the guidelines. In addition, Homeless Link, was also contacted with a similar request. It is hoped that publication by such bodies will encourage institutional support for the guidelines, promoting implementation (Appendix O).

Barriers to implementing evidence generated from research – be that PBE or EBP – have been identified. Sadeghi-Bazargani et al. (2014) found lack of available resources – including a lack of institutional support, inadequate facilities and lack of resources or equipment - was the primary barrier to the implementation of guidelines. To navigate this, they suggest that extra resources are provided, or alternative low-cost strategies are explored. Considering the lack of available resources in the homeless sector, it is unlikely resources can be easily increased. Thus, it was important for the research team to consider how these barriers can be overcome. To some extent, the lack of specificity of the guidelines do lend themselves to easier implementation, as they can be tailored to fit the services and resources available. However, this is also likely to impact on the interventions evaluation, as it reduces the probability that outcomes can be compared across services.

Another barrier to generating and implementing EBP is the lack of time staff have available to dedicated to the evaluation of evidence translated into practice (Sadeghi-Bazargani et al., 2014). Given CPs have the knowledge and skillset to systematically apply and evaluate evidence in practice, it is crucial time is allocated and protected to facilitate this (Sadeghi-Bazargani et al., 2014). It is possible that, services with high demand and reduced resources may struggle to see value in this indirect work. Publication of the guidelines by the organisations contacted will provide institutional support and credibility for the guidelines, supporting CPs in promoting the need for this protected time with managers and commissioners.

5.12 Clinical, policy, governance, and future research

These guidelines identify the needs of those facing SMD, which have previously been largely unrecognised by Clinical Psychologists. Identifying these provides crucial information regarding where the profession’s efforts should be placed to best support this population. Thus, they provide the foundations to guide future policies at both an organisational and wider systemic level across the sector, creating the foundations for the accountability of the adequate provision of care to be measured against. Consequently, they promote improved standards of consistent practice. Whilst this clearly points to improving the standards of care provided to the service users, they also promote the provision of adequate support and training to staff, with a view to promoting the wellbeing of staff as well as the service users. Furthermore, they also highlight to services and commissioners the need for research and service development to be incorporated into CP workloads, which as discussed in section 1.15, may be mediate by perceived value and level of support for this type of work within services. Ultimately, generating increased research evidence in the field should further improvements in service quality and provision.

The lack of evidence related on how best to work with the SMD population – both from a direct and indirect perspective - has been highlighted throughout this work. Given that these guidelines are – to the authors knowledge – the first guidelines to have been created for CPs working in this area, they both highlight and provide multiple avenues which urgently require further exploration.

There is a distinct lack of research in the area relating to the efficacy of individual psychological interventions with the SMD population. Generating evidence may begin to highlight what is effective, alongside how interventions may need to adapted for this population. This will provide CPs and commissioners with further knowledge of the resources required to support effective interventions.

Despite PIE being recommended throughout the homeless literature, divergent views were expressed in this research. Consequently, future research should seek to explore CP opinions of PIEs in homeless services. Further exploration of this may also uncover previously unidentified barriers to implementations in different services and settings.

There has been no independent assessment to establish whether the good practice suggested by CPs is indeed effective in practice, improving outcomes. Thus, additional research should collect organisational, staff and service user views on their experiences of the guidelines, with particular emphasis and/or exploration placed on their ability to improve outcomes. Furthermore, whilst the guidelines are formed by CPs working across the UK in a range of settings, future research should also explore their utility across different settings. Exploration of this may highlight potential barriers to their implementation which have yet to be identified through this research. Publication of service case studies detailing the guidelines implementation and evaluation would also be welcomed, adding to the evidence base, and would provide services with examples to support their own implementation.

Considering these guidelines utilised expert opinion, it is hoped that, within the context of the mindlines paradigm (Gabbay & le May, 2016), that they will be more accessible to CPs across the sector. This is, however, an assumption. Therefore, it may be equally as useful to explore whether guidelines capitalising on this phenomenon does improve uptake compared to other guidelines.

5.13. Reflections

This section contains my reflections on my experience completing this research. It is not intended to cover all aspects of the research's development and undertaking. Instead, I reflect on key aspects I feel have been important in my journey through this project.

When I started the Doctorate in Clinical Psychology, I knew the research project would be an integral component. Having always lacked confidence in my research abilities, I felt I 'just needed to get through it', wanting to focus more on developing my clinical skills which I considered a strength, rather than develop my research skills, which I felt would add little to my ongoing development. On reflection, I perceived these as two very separate areas, and had never truly considered the positive contribution completing research could have on my development as a reflective scientist-practitioner.

On approaching the topics selection, I was guided by two factors: choosing an area of interest and finding a topic which used a methodology I felt capable of undertaking. For the former, I knew working with complexity had always interested me, which I attribute to my ongoing curiosity and desire to challenge myself and further develop, which was one of the key reasons for me applying for this programme. Furthermore, I knew I would prefer to focus on research supporting CPs in their roles, rather than completing research directly with service users. This was partly due to my interest in systems level work and desire to understand and support the commissioning of services on qualifying. However, it was also a pragmatic one, deciding that research involving clinicians would likely reduce barriers for ethical approval, and would reduce potential difficulties with recruitment and retention. For the latter, as I had little research experience, I had little knowledge both qualitative and quantitative methodologies, and on reflection lack confidence. I did, however, recognise value in both methodologies and the types of information they collected, seeing them as complimentary in aiding understanding. This recognition of value complimented the Delphi method and my chosen epistemological position – critical realism. This project fulfilled both of these factors, supporting Clinical Psychologists in an area of complexity, using a mixed-methods approach. Additionally, considering other trainees had completed similar projects for other populations, my perception was that much of the projects design had already been 'tested' by others. Thus, considering my lack of confidence in research, this topic felt less anxiety provoking than others which required more attention to the projects conception and design. Therefore, whilst I initially explored a few topics, this project was ultimately the one which caught and held my attention.

Reviewing the literature and realising how disempowered homeless persons are in society fostered a growing interest in the area, resulting in a desire to include the service users voice in the research. This change in perspective I believe was the first indication that I was beginning to feel emotionally connected to the research, fostering a sense of responsibility for the output. On reflection, I hypothesise that I initially saw myself as an 'outsider' in the research process – often associated with quantitative methodologies - possibly linked to my desire to manage my anxiety. On reflection, I think these feelings of emotional connection were the first glimpses of me starting to identify with the 'insider' positioning – associated with qualitative research - as the research began to elicit my own lived experience and values associated with my role as a Trainee Clinical Psychologist. Ross (2017) argues the dichotomous position of the insider-outsider status is an oversimplification. It assumes a binary position which the researcher is fixed to throughout the research process. Furthermore, it does not account for the impact of additional unintended variables influencing the researcher and does not explore the potential for the researcher to be positioned along an insider-outsider continuum (Ross, 2017; Song & Parker, 1995). This dichotomous positioning does also not appear to compliment mixed-methods approaches, for which the researcher may struggle to sit comfortably in either the 'outsider' or 'insider' positioning, such as the Delphi design. Consequently, this would suggest some methodologies encourage or require the researcher to straddle both positions. When consider my own positioning throughout this process, I see myself as moving along this continuum depending on what was required of me, using supervision to guide me when nearing towards either end of the continuum. Considered in the context of this continuum, in hindsight, I believe this desire for including the service users reflects my need to connect with others and understand their experience which I value in my clinical work, and one which I – prior to this research – had not consciously identified as also being possible in research. Therefore, I began to move along the continuum, beginning to align with the 'insider' position. On reflection, I believe this straddling of the continuum supported the outputs quality. However, this was also incredibly challenging to manage as a researcher, particularly given the impact of bias on the Delphi process. Thus, supervision and using the research team to discuss ideas and the reasons behind decisions became increasingly important throughout the process.

The expert citizen consultation group was also a key area of initial decision making on the project's design and on reflection, was the first sign of me starting to take ownership of the project. However, due to the barriers discussed in this research, it became clear that involving those with lived experience in the Delphi process would not be possible. Whilst finding this disappointing, through discussions with my supervisor, we agreed to consult a group of expert citizens at the start of the process. We hoped obtaining and sharing information on their lived experiences to the panel members would provide a space for their voice to be heard. I approached this consultation with enthusiasm, but with an 'outsider' view, moving away from the 'insider' end of the continuum. I saw myself attending this group as an information gathering exercise to support the panel members, with little acknowledgment of how this would impact on myself as a researcher. However, hearing their personal stories of their experiences was incredibly valuable, and further increased my sense of responsibility for the guidelines, wanting the output to be helpful and meaningful for those it was intended to support. I believe meeting the expert citizens also helped me connect with the expert panel members during the initial interviews, enhancing my ability to empathise, supporting relationship building – an advantage associated with the 'insider' position (Ross, 2017). Therefore, whilst I cannot draw concrete conclusions on the extent the panel members held in mind the information obtained from the expert citizens when making their recommendations, I can account for the impact it had on myself when approaching the project from this point onwards. Consequently, I see the involvement of service users through the initial consultation as a real strength of this research, and an event which drew me back towards the 'insider' position.

Whilst this growing feeling of responsibility and alignment to the 'insider' position was largely positive and something I am glad was present, this also increased my anxiety. Initially, the anxiety I experienced due to my lack of confidence was managed through reducing my feelings of ownership and aligning towards the 'outsider' position. This was supported by the major design decisions - such as the selection of the methodology and subsequent structure of the survey rounds – already being decided by the methodology and informed by previous work. Therefore, whilst my feelings of responsibility and ownership were gradually increasing, I often deferred to my supervisor for decision making, reducing my anxiety. My lack of knowledge of the Delphi process, however, meant that I did not realise that, whilst the method and structure had largely been decided, there would be a significant number of decisions integral to the output that would have to be made by the primary researcher. My first experience of my anxiety increasing was the following the first survey round, where amendments were required in line with panel member feedback. I found this daunting, and, on reflection, naively expected my primary supervisor to walk me through the process. However, whilst extremely supportive, helping me modify the first few guidelines during supervision to support my initial learnings, I was then left the modify the vast majority of these myself prior to sending on to the rest of the research team to check. The ownership now clearly fell on me to determine the amendments for each guideline – the key output of this research. Though my reflections may – up until this point – suggest that I would shy away from this, fortunately my enjoyment of complexity and taking on a challenge allowed me to push past this anxiety. In hindsight, this suggests that my lack of confidence in the 'research arena' may be more related to my lack of experience and knowledge. Thus, I believe having to take ownership of the process helped me build my confidence in my own abilities in undertaking research.

It is at this point that I turn to my epistemological position. When I initially chose critical realism as the paradigm to approach this research, I did so because it resonated with me. I have always valued all types of knowledge, and, whilst I think I am more drawn to social constructionism – as can be seen by my tendency be draw towards the 'insider' position' - I also see value in pragmatism, believing there are tangible ways we can measure 'success'. Thus, this paradigm seemed to reflect my values, and compliments the research question. Valuing all knowledge, combined with my growing feeling of responsibility and feelings associated with the 'insider' positioning however, made making amendments to the guidelines particularly challenging. I was keen to continually reflect all panel member's views in the amendments and avoid my own biases where possible, resulting in me finding modifications anxiety provoking. This became particularly apparent when there were – though few in number – instances of conflicting feedback, such as Likert scale ratings not reflecting qualitative feedback, dissenting voices, or differing viewpoints. This was one of the greatest challenges I have faced in this research and is also one I suspect is inherent in a Delphi given the lack of guidance on modifications. It also very much highlighted my lack of confidence in my own research and decision making skills. I also, however, see this as the most valuable experience I have taken from this process, which will support my personal and professional development. Though this was challenging to work through, my confidence in my research skills increased throughout the process as I moved through each Round, as did my trust in the research process. Furthermore, I began to see my anxiety – though uncomfortable – as a strength, allowing me to approach the modifications ethically and with reflection, taking the time to work through and consider all panel member opinions, whilst holding in mind my own biases and their potential impact on the modifications. Supervision was also invaluable in supporting me in managing the straddling of the insider-outside divide, with both my supervisors supporting me to reflecting on my modifications, provide alternative views and opinions, helping me to maintain a more objective view, thus reducing bias. On reflection, though initially hesitant to take ownership of the project, I have moved through from the initial anxiety and acknowledgment of the need to take ownership, to embracing it, seeing it as both a way to facilitate personal growth, and also contribute support to a field I feel increasingly passionate towards.

Managing this insider-outside positioning has also been important during the writing up of this research. Given the difficulties persons experiencing homelessness have spans so many arenas, I have struggled at times to consider what is and is not important for inclusion. Again, I feel this aligns to my tendency to align to the 'insider' positioning, wanting to ensure the complexity of this population is accounted for and all potential realities and structures accounted for and understood. I feel that this draw for inclusion has been the result of the project eliciting my identity as a CP, and increased identification with the research project. Similarly, supervision has supported this, helping me to reflect on whether I am sitting to far along the insider-outside continuum. However, as I reach the end of this project, I believe this has become easier, with my harnessing my anxiety, utilising it to draw attention to and explore key issues. Without this anxiety, I may have continued to adopt an 'outsider' position by distancing myself from the research. This is likely to reducing the probability of me questioning the decisions I was making, increasing the probability of my own bias unknowingly impacting on the decisions I made for each guideline.

Whilst completing this research has increased my skills as a researcher through increasing my knowledge about the general research process and a new methodology, the most important aspect for me has been acknowledging the impact research can have on the researcher. It has shown me the importance of having an emotional connection with the research – and potentially my propensity to move towards the 'insider' position. Though this is something to be managed, I believe that despite the challenges associated with this, it ultimately has enhanced this project's quality and subsequent output. It has increased both my reflective capacity when approaching research and reframed my understanding of my research-related anxiety, seeing it as a way to support the research process, instead of a barrier. This reflective capacity is also a key component of my clinical work – and thus has highlighted the benefit of me utilising these same reflective skills and strengths to support research. Therefore, it has shown me that clinical and research related work are not separate, but are truly interrelated, with transferable skills and learning which can be utilised to support development in both. Consequently, I feel this research has supported my professional development, increasing my alignment to the reflective scientist-practitioner identity associated with CP. This growth was completely unexpected and unintended but has – over time and on reflection – been very much welcomed, having increased my confidence and desire to continue exploring research on qualifying. Completing this project has reaffirmed my desire to support CPs through the completion of research, particularly in areas where there is a lack of evidence, such as homelessness, to support them in their roles and improve outcomes.

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Appendices

Appendix A. Ethical approval and subsequent approval of amendments to the project.

University of Nottingham
UK | CHINA | MALAYSIA

DPAP Committee

05/02/2021

Supervisor: Danielle De Boos

Applicant : Jennifer Wells

Project: Project Id Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'

yours

David Daley

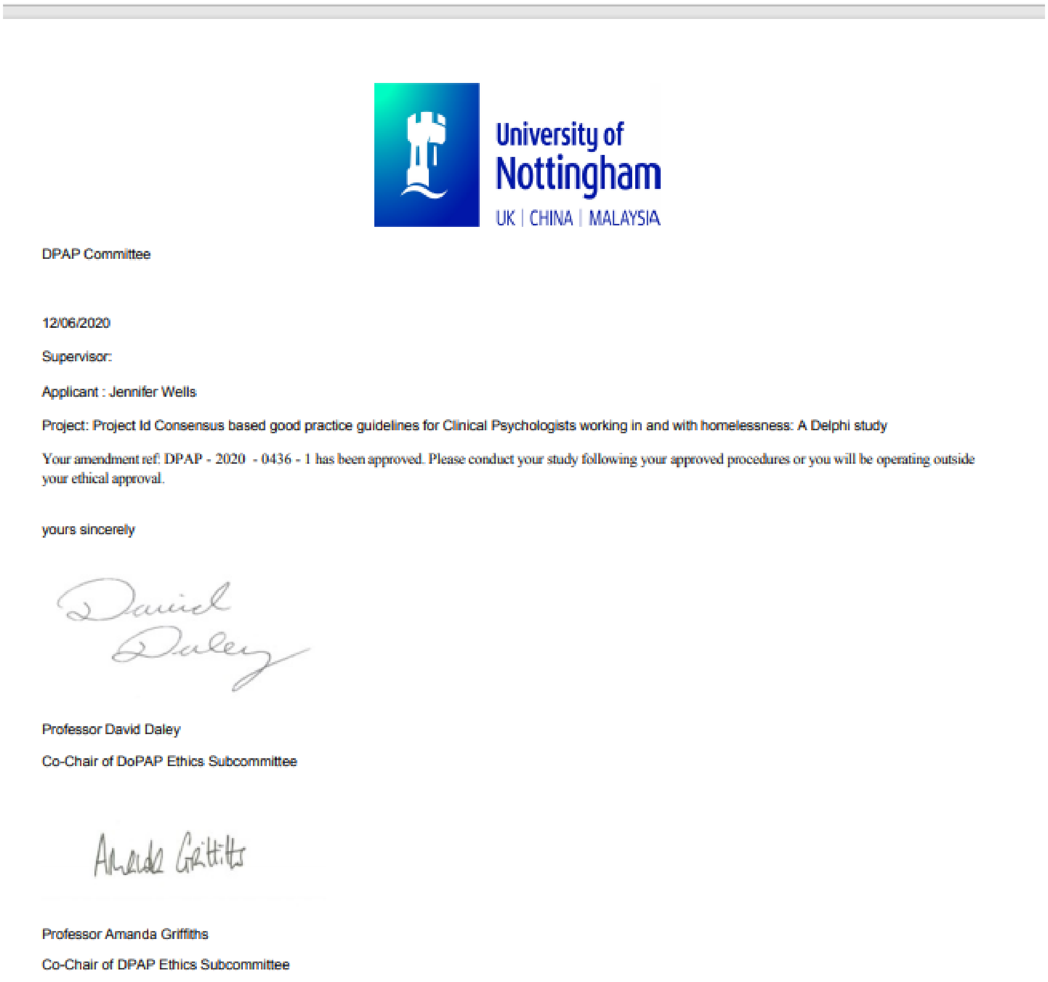
Professor David Daley

Co-Chair of DoPAP Ethics Subcommittee

Amanda Griffiths

Professor Amanda Griffiths

Co-Chair of DoPAP Ethics Subcommittee



University of
Nottingham
UK | CHINA | MALAYSIA

DPAP Committee

12/06/2020

Supervisor:

Applicant : Jennifer Wells

Project: Project Id Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Your amendment ref: DPAP - 2020 - 0436 - 1 has been approved. Please conduct your study following your approved procedures or you will be operating outside your ethical approval.

yours sincerely

David Daley

Professor David Daley

Co-Chair of DoPAP Ethics Subcommittee

Amanda Griffiths

Professor Amanda Griffiths

Co-Chair of DPAP Ethics Subcommittee

Appendix B. Panel Member Participant Information Sheet.

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW

Division of Psychiatry & Applied Psychology

Project Title: Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Researcher/Student: Jennifer Wells, msxjw19@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Ethics Reference Number: DP–P - 2020 - 04–6 - 3

We would like to invite you to take part in a research study about developing a set of recommendations to support Clinical Psychologists working in homeless services. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?

The aim of this research is to explore and identify the ways Clinical Psychologist approach working within homelessness, for both direct (one-to-one) and indirect working (staff support, service delivery and organisation). The primary objective is to produce a set of guidelines to help inform Clinical Psychologists with individuals experiencing homelessness.

It is possible that interview data may also be subject to secondary analysis to examine key themes relating to providing a clinical psychology service for people experiencing homelessness. This would be done by members of the team and another trainee clinical psychologist, bound by the same guidelines and policies as the current project. All data would remain anonymous.

Why have I been invited?

You are being invited to take part because you are a Clinical Psychologist who has experience and / or a special interest in working with individuals experiencing homelessness. We are inviting 15-20 participants like you to take part.

Do I have to take part?

It is up to you to decide whether to take part. If you do decide to participate you will be asked to sign a consent form and complete a demographics questionnaire. If you take part, you are free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will I be asked to do?

If you choose to take part, the research will last approximately one year, with a maximum of four stages. The study will use a Delphi process, which is a methodology of using interviews followed by surveys with a view to developing consensus among a group. Initially you will take part in a one-to-one interview with the primary researcher. This will last a maximum of 90 minutes and can take place at a location which is convenient to yourself, face-to-face, over the telephone or via Skype. There may be a geographical limit for face-to-face interviews and can be discussed if this option is selected. This interview will be arranged for a date and time of you choosing in early 2020. This interview will also be recorded by the researcher.

For subsequent phases your contribution will involve responding to a survey, which you will receive via email. You will be requested to fill out a survey in a Microsoft Word document and return the document, either via post or email to the primary researcher within two weeks of receiving it. A reminder email may be sent if a response has not been received within 10 days. You will receive the first survey in within a few months of the interview and then another a few months later. A fourth survey may be sent out, depending on the responses to previous rounds. if there are a number of survey items which are in the ‘approaching consensus’ category.

The study would be terminated if survey responses clearly indicate that consensus cannot be reached. If this occurs, an email will be sent out informing all participants.

Each survey should require roughly 20-30 minutes to complete. You will not be required to meet with the researcher following the initial interview.

Will the research be of any personal benefit to me?

Participating will give you an opportunity to reflect on your work and share your views on good practice. It is hoped that the latter inform the future practice of clinicians working within homelessness services, including yourselves. This has the potential to positively impact on the staff teams and service users accessing the services.

Are there any possible disadvantages or risks in taking part?

Taking part in this research will take up approximately 6 hours of your time. It is highly unlikely that you will experience any distress during the interview, as you will be asked to speak about your professional practice, with a particular emphasis on good practice.

What will happen to the information I provide?

All participants’ responses from rounds 2 – 4 of the Delphi process, excluding the data collected from the initial interviews, will be made known to all other participants, but in all cases will be anonymous. Participants will be given a unique reference number, which will remain confidential during and after the study completion. Direct quotes may be used from the interviews and surveys in subsequent publications, though these will remain anonymous. Initial interviews will be audio recorded, therefore by consenting to this study, you are consenting to having your interview recorded.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

Your contact information will be kept by the University of Nottingham for 1 year after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in a particular area of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel may put you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons or agencies. This would be first discussed with you.

We will follow ethical and legal practice and all information will be handled in confidence.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry1@nottingam.ac.uk who will pass your query to the Chair of the Committee.

Although highly unlikely, in the event that something does go wrong and you are harmed during the research and this is due to some'ne's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

What will happen if I don't want to carry on with the study?

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses.

What will happen to the results of the research study?
Participants will be contacted via email with the results of the study when it has been finalised and with details of any subsequent publications. Following the studies completion, participants will be emailed the results of the study.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and is being funded as part of my DClinPsy training, by NHS Health Education East Midlands (HEEM).

Who has reviewed the study?
All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham Faculty of Medicine & Health Sciences Research Ethics Committee.

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Appendix C. Panel Member consent form.

PARTICIPANT CONSENT

STUDENT RESEARCH PROJECT ETHICS REVIEW

Division of Psychiatry & Applied Psychology

Project Title: Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Researcher: Jennifer Wells, msxjw19@nottingham.ac.uk

Supervisor: Dr Anna Tickle, anna.tickle@nottingham.ac.uk

Ethics Reference Number: DPAP-2020-043-6-3

• Have you read and understood the Participant Information?	YES/NO
• Do you agree to take part in an interview that will be recorded and participate in a survey about working in and/or with homelessness?	YES/NO
• Do you know how to contact the researcher if you have questions about this study?	YES/NO
• Do you understand that you are free to withdraw from the study without giving a reason?	YES/NO
• Do you understand that for rounds 2 – 4 of the Delphi, once you have completed the study and submitted your anonymous questionnaire studies, the data cannot be withdrawn?	YES/NO
• Do you understand that once you have been interviewed for round 1, it may not be technically possible to withdraw your data unless requested within two weeks?	YES/NO
• Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?	YES/NO
• Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?	YES/NO
• I confirm that I am 18 years old or over	YES/NO

Signature of Participant ………………………………………… Date ……

Name (in capitals) …………………………………………

This consent form will be detached from the completed questionnaire and stored separately. Your answers will not be identifiable.

Appendix D. Expert Citizen Participant Information Sheet.

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Researcher/Student: Jennifer Wells, msxjw19@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, Anna.Tickle@frameworkha.org; Dr Danielle de Boos, Danielle.deboos@nottingham.ac.uk

Ethics Reference Number: DP–P - 2020 - 04–6 - 3

We would like to invite you to take part in a research study help develop a set of recommendations to support Clinical Psychologists working in homeless services. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?

The aim of this research is to explore and identify the ways Clinical Psychologists approach working within homelessness services, both working directly with service users as well as indirect working, with staff in services. The primary objective is to produce a set of guidelines to help inform Clinical Psychologists working with individuals experiencing homelessness.

Why have I been invited?

You have been invited to take part because you have lived experience of being homeless, and may have received support from a homeless service and/or a Clinical Psychologist working in or with a homeless service.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You may change your mind about being involved at any time, or decline to answer a particular question. You are free to withdraw at any point before or during the study without giving a reason.

What will I be asked to do?

If you choose to take part, you will be asked to attend one focus group which will last no longer than 90 minutes. This will be facilitated by Jen Wells, the researcher, and have no more than 9 other persons with lived experience of homelessness. Up to a month before attending the focus group, you will be sent the questions that will be discussed at the group to help you to reflect on them and prepare for the discussion. During the focus group, each question will be discussed by the group. The discussion will be audio-recorded and anonymous notes will be taken. These notes will then be summarised into a series of bullet points for each question, and sent to a maximum of 15-20 Clinical Psychologists with a special interest in providing psychology services to people experiencing homelesses, who are also taking part in this study. The answers provided by you are intended to help the Clinical Psychologist focus on individuals' needs when considering their recommendations to other psychologists.

Will the research be of any personal benefit to me?

Participating will give you an opportunity to share your views on good practice in homelessness services, particularly in relation to psychological support. This has the potential to positively impact on the staff teams and service users accessing the services. You will also receive a £10 'Love to shop' voucher to thank you for your participation.

Are there any possible disadvantages or risks in taking part?

Taking part in this research will take up approximately 2 hours of your time, including roughly 30 minutes prior to the focus group to review the questions. It is highly unlikely that you will experience any distress during the focus group.

What will happen to the information I provide?

The focus group will be recorded and notes will also be made by the researcher. These will then be summarised anonymously under each question for the Clinical Psychologist also taking part in the research to review prior to their contribution. Direct quotes may be taken from the focus group, but any information that could identify you will be removed.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

Your contact information will be kept by the University of Nottingham for 1 year after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing anonymous research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and further develop understanding of the area being researched. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel may put you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons or agencies. This would be first discussed with you unless there is very good reason not to.

We will follow ethical and legal practice and all information will be handled in confidence.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

At the end of the project, all raw data (original recording, consent forms and information about you) will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere

If you have any questions or concerns, please don’t hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?

If you have any queries or complaints, please contact the student’s supervisor/chief investigator in the first instance – this would be Dr Anna Tickle, Clinical Psychologist with Opportunity Nottingham / Framework. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology’s Research Ethics Sub-Committee adrian.pantry1@nottingam.ac.uk who will pass your query to the Chair of the Committee.

Although highly unlikely, in the event that something does go wrong and you are harmed during the research and this is due to some’ne's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

What will happen if I don’t want to carry on with the study?

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses.

What will happen to the results of the research study?
Participants will be contacted with the results of the study via email when it has been finalised and with details of any subsequent publications. Following the studies completion, participants will be emailed the results of the study.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and is being funded as part of my DClinPsy training, by NHS Health Education East Midlands (HEEM).

Who has reviewed the study?
All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham Faculty of Medicine & Health Sciences Research Ethics Committee.

Further information and contact details
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Appendix E. Expert Citizen consent form.

PARTICIPANT CONSENT

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Researcher: Jennifer Wells, msxjw19@nottingham.ac.uk

Supervisor: Dr Anna Tickle, Anna.Tickle@frameworkha.org; Dr Danielle de Boos, dannielle.deboos@nottingham.ac.uk

Ethics Reference Number: DP–P - 2020 - 04–6 - 3

Please read the statements below and circle yes or no and sign the form at the bottom.

If you have any questions, please feel free to contact the researcher to discuss these further.

• Have you read and understood the Participant Information?	YES/NO
• Do you agree to take part in a focus group that will be recorded and participate in a survey about working in and/or with homelessness?	YES/NO
• Do you know how to contact the researcher if you have questions about this study?	YES/NO
• Do you understand that you are free to withdraw from the study without giving a reason?	YES/NO
• Do you understand that once you have attended the focus group, it may not be technically possible to withdraw your data unless requested within two weeks?	YES/NO
• Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?	YES/NO
• Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?	YES/NO
• I confirm that I am 18 years old or over	YES/NO

Signature of Participant ……………………………………… Date ……………..
Name (in capitals) ………………………………………

This consent form will be detached from the completed questionnaire and stored separately. Your answers will not be identifiable.

Appendix F. Questions from Expert Citizen Consultation.

Please can you tell me about your experiences of contact with homeless services.

Have you experienced mental health difficulties whilst in homelessness services? If so, please can you briefly describe how these difficulties impacted on you when you were homeless.

Did you meet with a clinical psychologist whilst homeless?

If so, please tell me about what it was like to work with a clinical psychologist.

Did you feel that those supporting you while you were homeless took into account your psychological wellbeing and needs? If so, in what way. If not, what could they have done differently to support you psychologically?

If you could change one thing about the support you received for you mental health difficulties when experiencing homelessness, what would it be?

What advice would you give to clinical psychologists who want to support people experiencing homelessness and related needs?

Prompts – what might it be important for clinical psychologists to keep in mind about the impact of homelessness on somebody's mental health?

How might clinical psychologists need to adapt their approach from 'mainstream' mental health services to best support people experiencing homelessness?

Appendix G. Collated information from Expert Citizen consultation for Panel Members during Round One

Round One: Information Sheet

(Version 4.0: 24/03/2020)

Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Definition of terms

Homelessness

'…a household has no home in the UK or anywhere else in the world available and reasonable to occupy. Homelessness does not just refer to rough sleeping' (Public Health England, 2018).

Multiple and Complex Needs (also referred to as Multiple Disadvantage)

Individuals who experience two or more of the following (The National Lottery Community Fund, 2019):

- Homelessness
- Record of current or historical offending'
- Substance misuse
- Mental ill health

Expert citizen

An individual with experience of multiple needs who contributes this experience locally and / or nationally to raise awareness of and improve provision for others facing multiple needs'

Additional information

A number of expert citizens who have experienced multiple disadvantage have been approached to discuss their experiences of receiving psychological support when homeless and what they do / would value from clinical psychologists working with people experiencing homelessness. A summary of the information from this focus group can be found below.

This material is for consideration only and should only inform rather than being explicitly included in your responses. It is important that whilst this information in considered, you apply your own clinical experience with direct and indirect working and psychological knowledge in the interview.

References

Public Health England. (2018, November 2). Homelessness: applying All Our Health. Retrieved from https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

The National Lottery Community Fund. (2019). *Fulfilling Lives: Supporting People with Complex Needs.* Retrieved from https://www.tnlcommunityfund.org.uk/funding/strategic-investments/multiple-needs

EXPERT CITIZEN FOCUS GROUP

Information on Attendees

- **Four people contributed to the focus group. All were male and were self-selecting.**

1) Please can you tell me about your experiences of contact with homeless services.

"I was homeless in and out of custody. I needed somewhere to stay to get that connection, but I managed to get it through (service). Initially it was a really big headache and I got the impression that I was being left with, that there wasn't much accommodation. The worst thing is coming out of custody, you know, you've been in an institution where you've been used to that kind of institute and then you're put in a predicament when you're being released from that kind of institute with nowhere to go and you're in no better position…street homeless basically and I ended up back in custody and a referral was done to an organisation to you know…get that kind of support. I was homeless for…it's got to be about 3 years…it was like never ending, constantly in and out each time. I was actually sent from prison to an agency who's supposed to cater for homeless people…now what I was told when I left custody is there's a bed space for you. I turned up at this place…there were basically three of us that turned up and we were basically told I don't know what the prisons have told you but the truth is the place has actually been allocated just for one of you so two of you have been sent here unnecessarily so why the prison services have sent you here we don't even know but the prisons were trying to make out like...and that was a big issue to be honest with you because I was like…basically I got to the point where I ended up back in prison because of that scenario. There was nowhere to go."

"I've been to hostels twice when coming out of prison. Once coming out it was alright I didn't get it until the day I got out literally as I was leaving the jail with my discharge papers…and about three weeks before I got out I filled out some benefit forms and then the day before I got out I had to go and see the governor and the doctor who see if you're fit enough to leave prison and then I said to them 'I got nowhere to live you know' and I'm signing my discharge papers and there saying 'they'll have somewhere for you tomorrow don't worry about it'. So the next day I got out and I still don't have anywhere to go for me, so on the way to Nottingham I had to be at my placement for 1 o'clock which was never going to happen so I phoned my probation officer and told them I was going to be late and they said 'we aren't even expecting you' so I said 'listen I'm getting out of prison and I've got nowhere to live'. When I got to probation was in probation for about 4 hours and they got me a place in [names hostel]. [Hostel] was expecting me all the time but probation didn't know it. Another time I come out of prison I was homeless and my mum said I could come home but me and my mum don't get on…so I stayed there for a bit and I went down to the council and I said 'yeah I'm homeless' and they said 'where are you staying at the moment' and I said 'I'm stopping on my mum's sofa' and they said 'well you're not homeless then'…they said you have to present yourself homeless so I said how do I do that then…and they said well you'd have to be homeless, living on the street, and we have to have somewhere where we can come to you in the early hours of the morning and check up on you and all the rest of it. So, I leave my mum's house, find a graveyard for three days and tell them where I was. So they had to come and see me there 2 or 3 times in the morning, give me tea and stuff before they would say I am homeless and then they said you can go to the (temporary accommodation provider)…Housing Aid told me I'm not homeless living on my mum's sofa…the first time I left prison to [names hostel], I was the type of prisoner where they have to worked out of prison instead of being discharged…

(1. Please can you tell me about your experiences of contact with homeless services continued...)

…see I’ve never spent a full year out of prison from the age of like 13 so I can’t be discharged out of prison any more I have to be processed out and that was the only reason I got it, because the government has already got X amount of money allotted to me so I’m not homeless and [names hostel] already knew about that but probation service didn’t know about that…but yeah like if you’ve got a certain type of criminal record the government automatically throw money at you, and I didn’t even know that until I got to [names hostel]. The second…I went to YMCA, filled out a load of forms, left my phone number and two days later they phoned me and said yeah come. It all happened so fast they put me straight in to shared accommodation so I didn’t have to do the hostel part in the (service provider) and be surrounded by…I was trying to stay clean so it was a good move but even though I was down there I was there for 3.5 years waiting for a council place, they lost my forms twice, were checking to see if I had ASBO’s…they check every reason not to give you it but I just stayed cool and in the end I got one”

“…I was in a building quite like the (hostel)…unfortunately events happened, and I got evicted…I was basically given notice. Now it involves some things that didn’t involve me but because it was on the landing…they then had to find another place for me. Now when I got to this other place I was basically told you can only be here for 6 months…it was like they put a thing where within this 6 months…I felt like I’d just been put there, you know you can stay here for this long but I also felt like any time they could come along and basically have gone it’s time for you to move on here’s your notice sorry or used an excuse basically to get you out the place. So, it didn’t feel very safe that was a worrying factor because you always had that niggling thought you know what if they just come and decide to end your tenancy”

“So I was made homeless after being sectioned 3 times, on the second time the only contact that I had was (accommodation provider) and (community homeless support service) and I know from coming out of the section I was put in the [names hotel] which is a B&B with nothing, it had a bed, no kettle, it was a bed, nothing else in the room. So, I came out of that, into that. So, the first thing I pretty much did was use…I’d had a month during section not using…I came out and basically relapsed straight away, ended up in hospital that night…came back out the next day back to [names hotel]. Fortunately, I’d got with (community homeless support service), I was seeing a worker…who met me at the property and then took me to Housing Aid…Housing Aid had put me in [names hotel] and I was trying to get something through (community homeless support service)…”

2. Have you experienced mental health difficulties whilst in homelessness services? If so, please can you briefly describe how these difficulties impacted on you when you were homeless.

“I’ve been diagnosed as being bipolar type 1 and that’s due to…well I’m not going to say that's due to homelessness, but I’ve experienced that whilst being homeless. It’s definitely impacted most areas of my life to be honest. I saw [Clinical Psychologist] and [hostel] and I know that it was really beneficial, but if I had of had that at [a previous hostel], ‘cause I was talking to the staff at [names hostel] and saying to them you know I’m an artist and my room will get messy, it’s a studio to me, so they kind of were down with that so I continued to fill my room with stuff that I was working with. Consequently, I did get into a point with psychosis and smashed everything to pieces. I was arrested and evicted from [names hostel]. [Researcher prompt] So it resulted in you losing your housing? *Yes. Yeah. I didn’t know I was bipolar to be honest, so I just thought I was living a creative process. So yeah definitely it’s impacted me. Plus, you’re right in the middle of addiction…although I was using, I was trying to manage my habit but a lot of people were using mamba. Probably out of 15 rooms 10 of the people there were using mamba. And I managed for quite a while before I started using mamba. So consequently I managed to stop using the amphetamine but then started using mamba and alcohol. I guess it’s my way of medicating. And I can manage things. You know years ago I was addicted to heroin and crack 15 years ago and I did well to get off those…people refer to mamba as though it’s the same thing as you know, smack – it’s not”.*

“…You can score 100 yards north east south and west outside those hostels. It’s mad that they can put somebody in [names hostel] or [names hostel] with a drug problem. Temptation is put right there. [Researcher prompts] So if you were in a place that was less temporary you might not want what? *If there was more support.* [Researcher prompts] So if you felt like the accommodation was less temporary and less worrying then you’d be less likely to use? *Yeah of course. If all the circumstances were right, then yeah, you’re right. But the circumstances, all of them are wrong. They are 100% wrong for a person like a [names hostel] and [names hostel]”.*

“…You’ve got to say I’m choosing recovery, you can be firm with that but having said that it’s that one day when I’m thinking ‘oh’ or it’s someone saying ‘do you want a pipe?’ and I’m going I’ve not done it for a long time and it’s free so go on then. It’s there. Temptation is there and too much for recovery”.

“ do they look at actually putting people in shared accommodation with the same needs? Because I’ve been in housing where there’s so much in difference between you know that environment that it can cause big…more than it actually resolves it and you end up going around in the circle…so you are put in a position where something happens and you end up losing accommodation or just can’t live there…do they think about how people relate to each other rather than just putting people in a situation where it could just go topsy-turvy? [Research prompts] So it feels like the environment that people get put in they don’t take in to account the individual which then can make other difficulties worse? *Yeah that’s right”.*

“I’ve seen them put Muslims with non-Muslims in shared accommodation, so the kitchen and bathroom is shared. So they are waking up in the morning and there is egg and bacon and the Muslim is coming down and he’s proper, proper fuming he’s like”

3) Did you meet with a clinical psychologist whilst homeless? If so, please tell me about what it was like to work with a clinical psychologist.

"...It was someone else who was separate from drugs and alcohol and mental health who seemed to be …you know for me it was positive. [Researcher prompt] So you met her on your own? *Yes, yeah, I did. In [names hostel].* [Research prompt] So she gave you things to help you stop using but it sounds like she gave you a space to talk?…*yeah it was and yeah it was somebody…I've had quite a lot of therapy and counselling before so it was similar to counselling but it wasn't the same. It was more practical; I'd say that was the thing that was different.* [Research prompt] And was that…when you say different…was it what you needed at that time or…? *Erm yeah I saw her for a bit, and I found that er, yeah it was useful"*

"…I am going to look at it slightly differently. Because of my mental state…because of how I was at that time, regardless of how much this person was trying to help me, mentally because I was…she was helping me, I knew that but within my own self, it just felt like it was just…am I really getting through, is she…is the person perceiving what I'm trying to you know, say, are they really kind of getting what I'm trying to express how I'm feeling. And I know you're doing your job and kind of getting insight into me, but this is how I…and to me it just felt like my head was in a shambles. So really at the end of the day I was just kind of sitting there thinking what is this person actually going to do for me, you know, can this person really help me? [Research prompt] Can they really understand me? *Yeah, can they understand what's really going on here. It was one of those scenarios and I can remember kind of walking out feeling yeah that was good but what has it really done for me because my head was still…I felt like I needed something else more than just that. Like I needed some other extra little bit of…that was it, but I needed something else.* [Research prompt] So you said you felt good when you left… *Well I felt confused as well at the same time. Kind of like can she really understand what I'm trying to…or am I just talking to somebody and they're just going to sit there and listen and go 'yeah'. I'm not saying that happened, but it could've been that scenario where they say 'yeah yeah yeah' but inside they are thinking I really don't understand the situation so I'm just going to have to sit here and let you offload.* [Research prompt] so did you think she didn't understand you or was it more a worry that she was never going to understand this? *I think it was more worry that she might not be able to comprehend what I was trying to fully…and I think that was a fear factor.* [Researcher prompt] And do you think they ever managed to get to that point? *Yeah I think they did, I think because now…I got impression that she's a genuine person and she went away and spent, you know not all night but maybe just a bit of time thinking what can I really…to me that's a genuine person and there's others out there who would've said yeah yeah yeah your files there now get out the door I'll see you next week. That was not going to help my situation.* [Researcher prompt] So she kind of gave you the time without the pressure of 'well you've got to be better in 6 months'? *Yes, thank you, you've just answered that right"*

(3) Did you meet with a clinical psychologist whilst homeless? If so, please tell me about what it was like to work with a clinical psychologist continued)

"Yeah I am in contact with [Clinical Psychologist]. They put me in contact with a doctor for medication and mental health and [Clinical Psychologist] has sorted that out for me, she's got me a social worker as well. This is all come about because of my voice in my head, my mental health, self-harming and drug use. So, what she's trying to do is she's trying to get me in with the doctor to give me medication for it. But what I said was you'll still put me on medication won't you and I'm already on drugs, I'm taking me drugs and you'll be pumping me up with more. And he goes oh we'll help you. But I said I don't want that, I want to speak to people to talk to people about it, oh he'll be alright, he will help you. So, it's up and down at the moment with me. So, I'm not getting that support even from a psychologist…If you pump me with medication and whatever, that's not going to help me. That's just going to pump me full of drugs. **[Researcher prompt] So you don't feel like people are listening to you?** ***No, they are not".***

4) Did you feel that those supporting you while you were homeless took into account your psychological wellbeing and needs? If so, in what way. If not, what could they have done differently to support you psychologically?

"Maybe a little bit controlling…some of them…it felt like a little bit of them in my position...I'm talking that they felt maybe they had that little bit more of an edge that "we can control", that "we can run this place and you will bow". **[Researcher prompt] So you felt they were a little bit higher than you?** ***Yes, and you felt a bit suffocated with it".***

"What I find in a lot of these places is that they are actually against you having your own meds…I've been in hostels where they ask what meds you're on and we need to take your meds off you. You can't do that, there prescribed to me from my GP. Oh but there's a factor of if you're in a 'bad space' one day, how do we know. So there's all that conflict. So what are they going to do, bring in a doctor to monitor it as we don't know if that person is able to monitor their meds on their own"

"I've been to a few hostels like that, and what they do is give you a space and lock with a combination for your meds and the first time you mess that up they take them away from you"

"They always adopt the carrot and stick. When they want to get you to do something, they do it".

5) If you could change one thing about the support you received for your mental health difficulties when experiencing homelessness, what would it be?

"My worker. If I wasn't happy with her then I'd ask for a change. If I felt like I wasn't getting anywhere, and I am in that position at the moment. This person always seems to be off sick anyway so what's the point in having them as a worker"

"My worker"

"I want someone with experience over academics".

[Research prompt] So a change in you your worker would help to make you feel…*"more confident, more supported"*

"The workers, they need to strike a balance, without being too personal but remaining professional. It's a balance."

"I must admit, I'm surprised that there isn't a place where you could go…other than say, [names hostel], because you've got your hostel dwellings but there's no kind of place…there could be a place that (homelessness service provider) have set up which is specifically for people with complex needs or multiple disadvantages"

6) What advice would you give to clinical psychologists who want to support people experiencing homelessness and related needs?

"Maybe some additional training and role plays…using people who are homeless, be realistic, not using actors. Actually call people in who are in these situations"

"Shadowing somebody like an outreach worker for a morning to see what it's about. You know you've got the different types of homeless people you know"

"You can get someone with lots of training, but you need someone whose had experience. You've got to know that they have got mental health issues, they're not just homeless. I don't think it's even 99% I think its 100%, if he's homeless he's got mental health problems. Even if he's got drug problems, it's also mental health problems. So mental health problems goes with all of them. You've got to know that; you can't just look at him being homeless and what homelessness is doing to him".

"Homelessness is not just not having a roof over your head, it's a hell of a lot more. Some people have got pride out there and solidarity going on!"

"There's a community… They're (the homeless community) defensive, but they're united in that defence. Alright they're defensive, but they've got reason to be defensive".

Other key points from focus group were:

- **Access to psychology support has sometimes felt too late.**

- **Understanding the impact of the environment, e.g. access to substances, lack of consideration of diversity when placing people in shared accommodation.**
- **Individuals can feel victimised by housing systems and controlled by hostel staff.**

- **Practical tools given in therapy might be more beneficial than just listening.**
- **You can make use of clinical psychology even when you are using substance or drinking.**
- **Recognition that staff at support services are stretched, and the impact that this can have on services users e.g. the changes they experience when interacting with staff when staff are 'feeling the pressure' of high caseloads.**

Appendix H. Supplementary figures (figures 3-6) of guideline modifications across the Rounds.

Figure 4. Round Two results for the direct working guidelines.

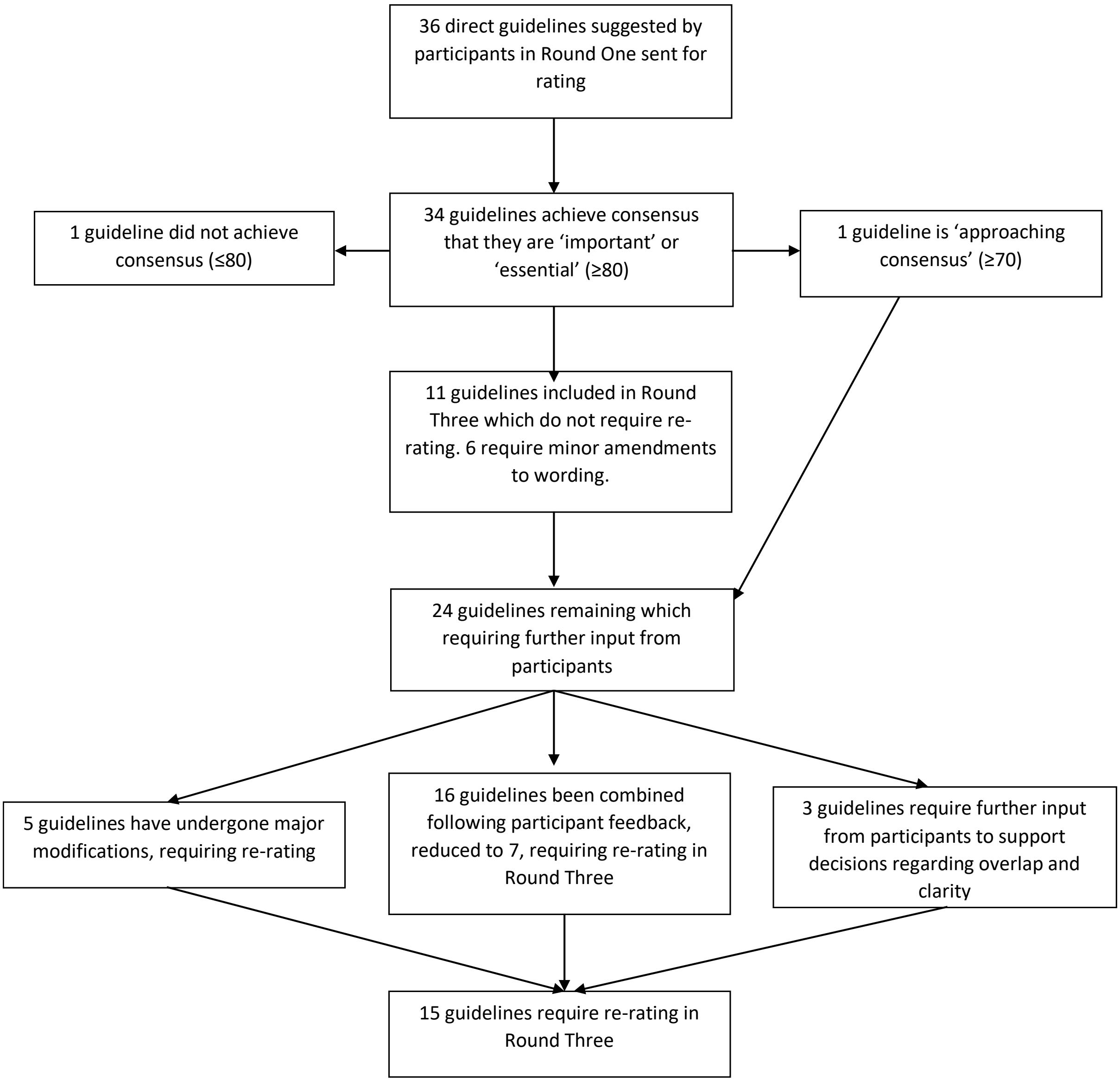


Figure 5. Round Two results for the indirect working guidelines.

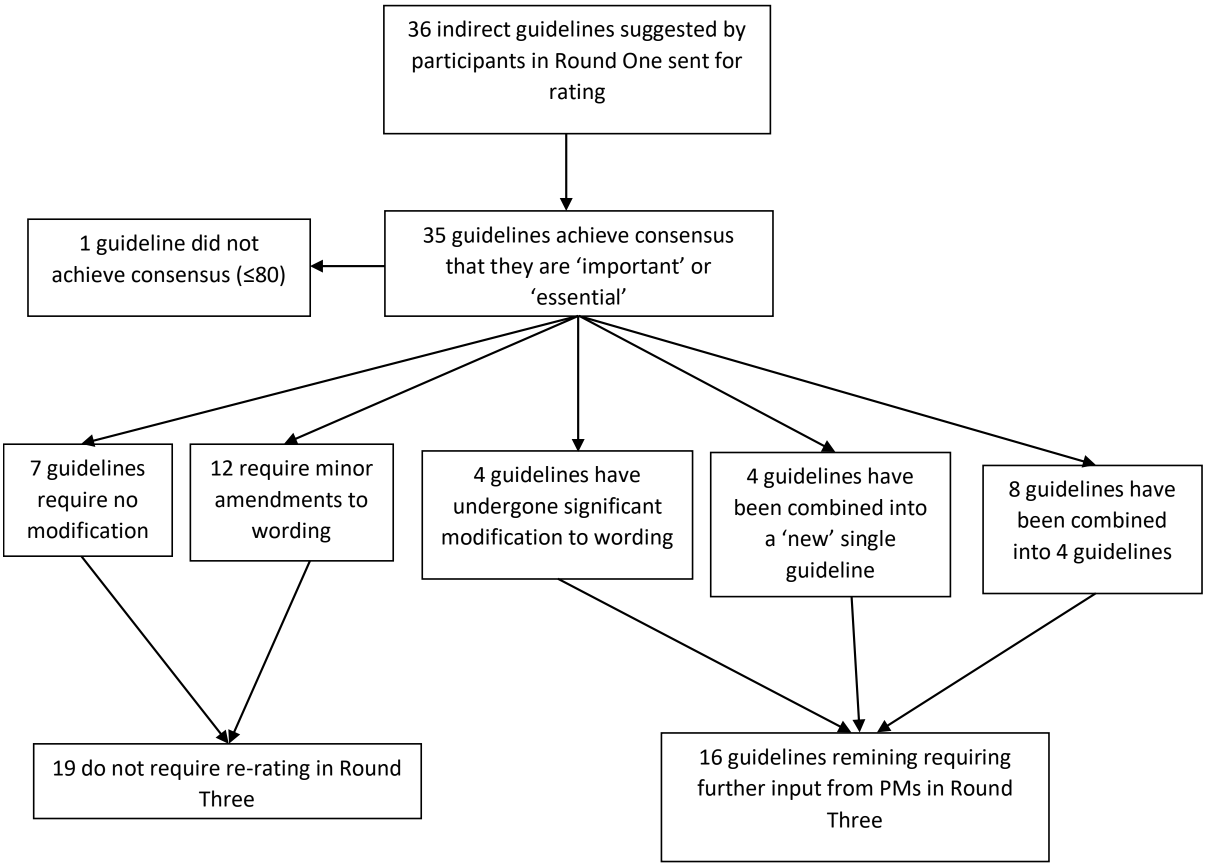


Figure 6. Round Three results for the direct working guidelines.

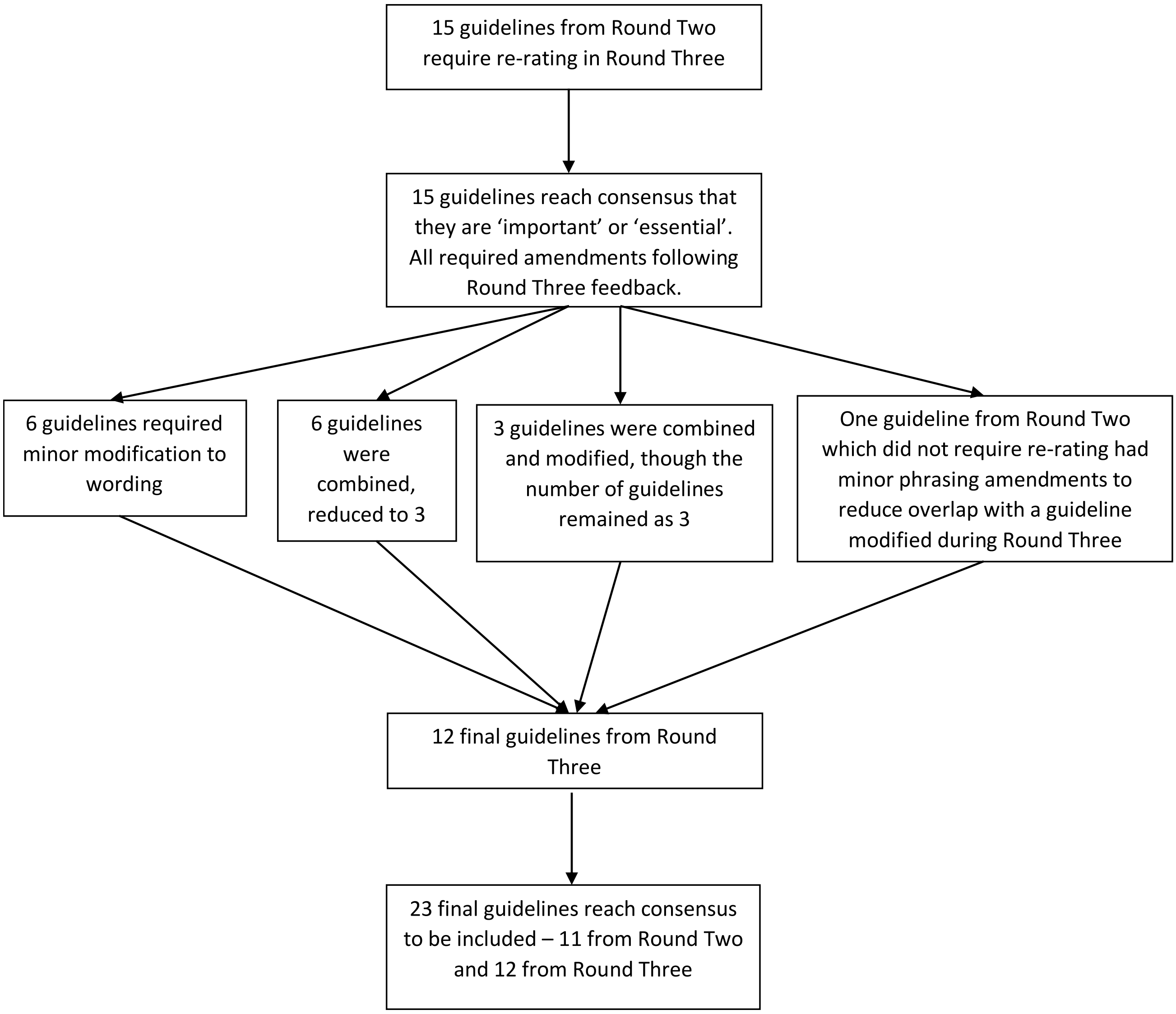
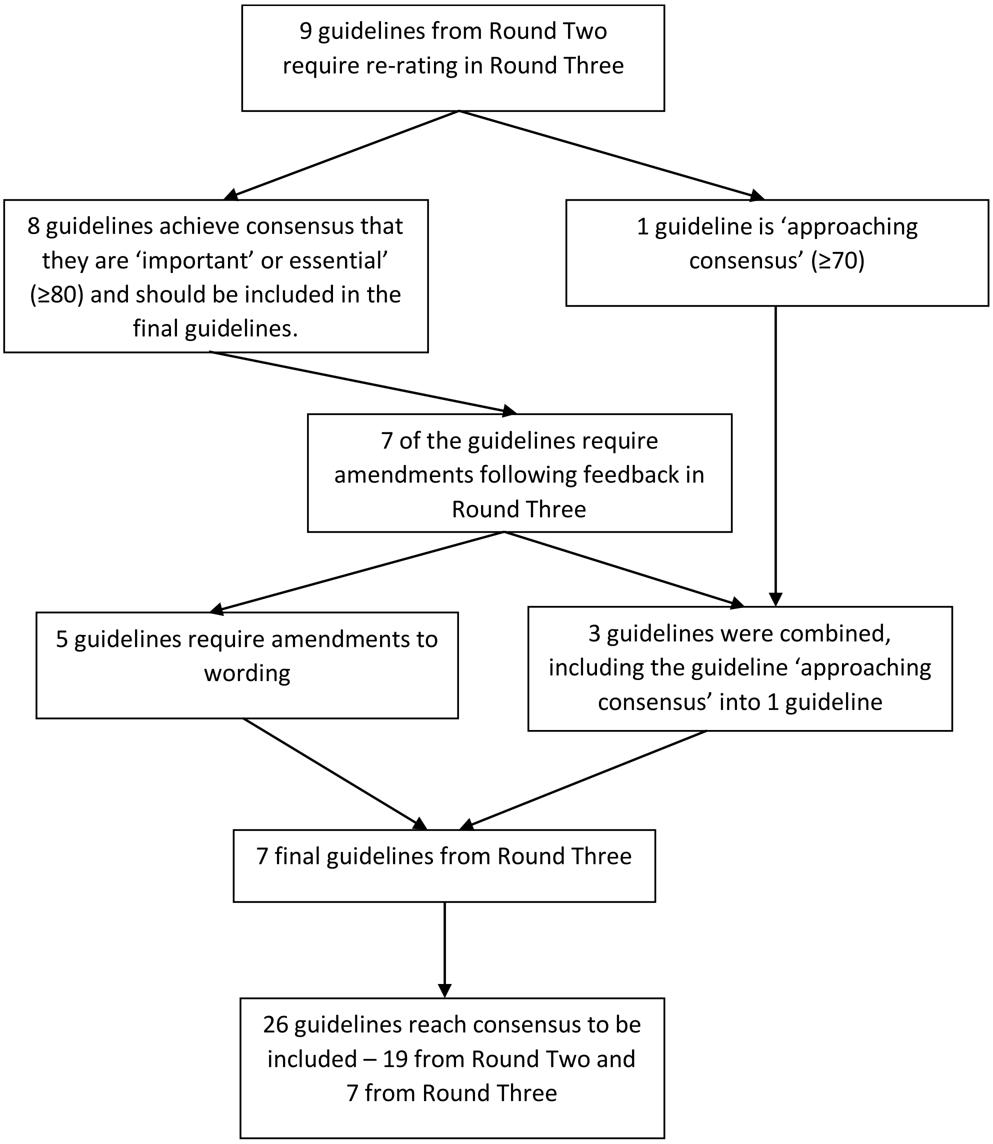


Figure 7. Round Three results for the indirect working guidelines.



Appendix I. Round One interview questions.

Thank you for taking part in this research. I will begin by asking you about your views on good practice in direct clinical work and then about any indirect work you do, for example with staff in hostels or service development. Do you have any questions before we start?

Direct work Can you start by briefly telling me about your current role in terms of settings and population? Why are you working in this area/what interests you about this population?

In what way(s) is this population unique when compared to working with other populations?

Do you find you have to adapt your practice to fit this population and if so, how?

Prompts: do you make adaptations to when and where you see people?

How do you adapt the 'pathway' of referral through to discharge?

Do you have specific exclusion / inclusion criteria? If so, what?

Which psychological/therapeutic models do you draw on in your clinical work?

Can you give an example of your work that you consider to evidence good practice for somebody experiencing homelessness and what might be termed multiple complex needs?

Prompt: What supported your practice in this example?

Did you receive feedback that helped you to view this as good practice?

Do you face ethical dilemmas in relation to this population? If so, what are they and how do you work to manage them?

Do you actively engage in self-care? Are there any specific self-care needs to consider when working with this population?

Prompts throughout: Please can you give me a specific example of good practice in relation to this?

Can you tell me some more about that?

Is there anything we have not said about direct clinical work that you think is important?

Based on our discussion so far, can you suggest three potential ‘guidelines’ for clinical psychologists working with people deemed to have multiple complex needs?

i.

ii.

iii.

Indirect work – hostels, service development and delivery

What indirect work do you do within the services? e.g. formulation, consultation, service development.

Can you tell me about an example of indirect or service development work that you consider to be good practice.

Prompts: What feedback did you get that suggested this was good practice?

What outcomes were there?

What types of psychological frameworks do you think are best placed in services to support homeless people? Please explain why you think this is the case.

What do you see your role as in hostels?

How do you think working with the population impacts on members of staff working in the team? Can you give me specific examples of good practice from your work with staff teams?

What do you think your role as a Clinical Psychologist is in service development? Can you give me an example of good practice in service development work within your role?

What do you see as the challenges involved in indirect working in these types of services?

Is there anything we have not said about indirect work that you think is important?

Based on our discussion so far, can you suggest three potential ‘guidelines’ for clinical psychologists working indirectly in services for people considered to have multiple complex needs?

i.

ii.

iii.

Thank you for taking part in this interview. After all interviews have been completed, the recommendations made my all participants will be collated and sent out for feedback to all participants.

Appendix J. Panel member feedback per guideline.

Table 18. Number of comments received for each guideline in Round Two.

Direct guideline number[1] Round 2	Number of comments
1	6
2	2
3	6
4	5
5	4
6	7
7	4
8	2
9	5
10	4
11	5
12	5
13	4
14	4
15	6
16	5
17	7
18	5
19	4
20	5
21	3
22	4
23	1

24	5
25	2
26	2
27	4
28	2
29	2
30	4
31	5
32	5
33	4
34	2
35	2
36	3
Total	145

Indirect guideline number Round 2	Number of comments
1	3
2	2
3	3
4	2
5	2
6	3
7	4
8	2
9	3
10	4
11	3
12	3

13	2
14	3
15	3
16	4
17	4
18	3
19	1
20	3
21	2
22	3
23	3
24	4
25	3
26	2
27	2
28	3
29	3
30	3
31	4
32	3
33	3
34	2
35	2
36	3
Total	101

Table 19. Number of comments received for each guideline in Round Three.

Direct guideline number[1] Round 3	Number of comments
2	5
3	5
8	4
9	3
11	2
13	3
16	4
18	4
20	4
25	4
26	2
27	4
30	6
33	4
34	7
Total	61
Indirect guideline number Round 3	**Number of comments**
3	4
7	2
12	4
14	6
16	3

17	4
21	2
24	3
New guideline	3
Total	31

Appendix K. Round Two survey with all panel member guidelines.

Direct working guidelines

Guidelines relating to flexibility and adaptations

1. ***Be flexible in your hours and the amount of work you will do. Do not stick to standard protocols.*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

2. ***Be flexible in your approach.*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

3. ***The co-locations of services - psychological therapies are taken to the point of need, located in familiar settings and locations, and going out to where homeless people find themselves (e.g. hostels, day centres, streets).***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

4. ***Meet the person physically where they are at. Having a person centred approach, encouraging all opportunities to engage and acknowledge the context you are working in.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

5. ***Be accessible and available so that people can reach you, working where they are and feel comfortable and be visible to the homeless community.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

6. ***Get out of the consulting room and meet service users where they are, being flexible and more relaxed about therapeutic boundaries particularly at the pre-treatment phase. Without this, other parts of the work will not proceed.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

7. ***Be flexible - do not expect the work to stick to a predetermined route. Things may throw you off the way and it is important to journey alongside someone.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating to the relationship

8. ***Prioritise relationship building and be flexible***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

9. ***Be mindful of the interaction between trust and attachment. A complex attachment can be formed between you and your client.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

10. ***Consider the likely trauma histories of service users you are working with, appreciating engagement is likely to be a long process as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc .***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

11. ***Attend to the relationship e.g. listen, kindness, power dynamic.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

12. ***Engagement - be prepared to spend longer engaging someone. Use supervision to manage any rejection or suspicion you face.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

13. ***Pay attention to endings as much as beginnings.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relation to assessment, formulation and understanding

14. ***Formulation is key and sometimes the most basic are the best. Sharing it collaboratively is essential, making them something more than just a 'label'***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

15. ***Trauma is highly prevalent in this population (both historic and current/repeated patterns of trauma). Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

16. ***Maintain active hope by grounding your formulation in the social/economic/political context and a systems-thinking stance***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

17. ***They should be screened for brain injury at some point even if it is not the first thing you do. It can be critical to aid understanding.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

18. ***Be aware of the high prevalence of cognitive and neurological problems and how therapy may need to be adapted. Include cognitive difficulties in formulations, as these can contribute to the breakdown of placements and impact on social and day to day functioning.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating therapeutic work

19. ***Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies. It is important to recognise that you may retraumatising them during interventions so you need to recognise the impact of trauma on an individual.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

20. ***To eliminate and discard the hierarchy of needs, working with the pre-contemplation stage is critical. You have to work with where the person is at regarding their sense of self, motivation, and values.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

21. ***Acknowledge the wider context that the person is in at an individual level, not just offering 1-2-1 therapy. Using an approach flexibly to do the work needed at that time.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

22. ***It is important that goal setting has to be done collaboratively. It may need to be guided by the professional but the individual needs to lead the process to some extent.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

23. ***Make use of integrated models of psychology, paying attention to attachment and theories of motivation.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

24. ***Approaches to direct work should be trauma-informed Psychologically Informed Environments (PIEs) and encompass all elements that come with this (e.g. building relationships, helping people connect and feel empowered, strengths-based, recognise the impact of trauma on an individual and avoiding re-traumatisation).***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

25. ***Adaptability, flexibility and creativity are essential, you are never going to be doing manualised treatment. Consider what model fits the person and think of how to adapt it***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

26. ***Think carefully about what your role should be with this person and what adaptations you need to make to your practice.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

27. ***People are likely to present with multiple difficulties (including dual diagnosis/substance misuse). Do not exclude someone from psychological therapy because of their presenting difficulties. Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g. motivational interventions) that can help people to make changes to substance use and engage with other services. Work creatively to do this and following the relevant guidance (e.g. NICE guidance for dual diagnosis and substance misuse) can support this work.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating to direct working and the wider system

28. ***Clear communication is key with everybody. Be clear with everyone - the service user and others - about the direct work you are completing. This includes - the boundaries, what I am doing, this is why and this is how I have come to understand this person and what we can offer.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

29. ***Promote good multi-agency working especially when working with complexity and risk.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

30. ***Clinical Psychologists should not work in isolation from colleagues in social services and housing. They should be part of an integrated team but the make-up will be dependent on the local circumstances.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

31. ***Even in direct work, work as both a Clinical Psychologist and a care co-ordinator to work effectively with the whole system.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

32. ***If you are doing direct work with people experiencing homelessness, be employed by the NHS.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

33. ***Be co-located and embedded within the multidisciplinary team.*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Other guidelines relating to direct working

34. ***Encourage curiosity.*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

35. ***Have a realistic sense of optimism, having a sense of it being worth trying even with a deep level of complexity.*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

36. ***Have strong self-awareness and reflective practice, whether this is through journaling, supervision etc*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Other comments:

Indirect working guidelines

Guidelines relating to staff wellbeing

1. ***Pay attention to the trauma staff will have experienced. Many will have come into this because of their own past and present experiences.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

2. ***To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential, including training, reflective practice, consultation, consistent team approaches and debriefs.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

3. ***Attending to the emotional impact of the work on colleagues is an important starting point. Trauma Informed Care provides a 'universal precaution' approach which can be used with staff as well as service users. The work is potentially traumatising for staff many of whom also come with trauma backgrounds.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

4. ***The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

5. ***Be mindful of the stress and pressures that staff (e.g. outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be. Staff may not have the supervision and training that we would like them to have.***

Type 'x' in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

6. ***Providing a space for validating workers' emotional reactions/toll of the work and understanding behaviour.***

Type 'x' in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating to working within the existing staff teams / systems

7. ***To recognise the skills, beliefs, and ways of working already in the system and prioritise these.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

8. ***To offer something practical and useful other people can see e.g. offering reflective groups and case discussion and consultation to add value.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

9. ***Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes. Ensure that consultation is useful to care planning, not only theoretical.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

10. ***Build relationships and partnerships as everything you are doing is through the staff. Emphasise good practice, consider evolution not revolution.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

11. ***Model and reinforce the skills that you want to develop within systems and staff groups.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

12. ***Work from a position of building capacity (e.g. through formulation) and developing existing strengths in staff teams.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

13. ***Learning and building up therapeutic and practical skills, giving people a sense of control.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

14. ***Clinical Psychologists should be involved as far as possible in providing support and mentoring for frontline staff.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Other indirect working guidelines

15. ***Think about your language and how you explain things in a way to staff that is accessible, interesting, and more than just common sense.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

16. ***Try to pay attention to the night workers, as it is likely that there will be a lack of consistency in approach.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

17. ***It is important to make sure your indirect work is led by service user involvement and feedback.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

18. ***Creating opportunities to be present or available if you cannot be physically present. Showing a willingness means you can understand challenges in different services if you are not able to be in a service all the time.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

19. ***Contract work as transparently as you can. Ensure all including senior managers are involved, have authorised, and support the work.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

20. ***Clinical Psychologists should be involved in ensuring that initial needs assessments consider relevant psychosocial factors.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating to research and generating an evidence base

21. ***Use and share the available evidence base and any additional evidence generated as much as possible, with the recognition of the context that they were developed in. Consider what are you going to do with what you have.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

22. ***Consider how to take what you have done and share it more widely in the organisation, how to develop the evidence base, and how to influence wider societal norms to develop more helpful narratives around homelessness.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

23. ***Clinical Psychologists should be a source of guidance and expertise on the evaluation and research of services.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

24. ***Contributing to the evidence base of effective ways of working with this population to influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

25. ***Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating to organisational and/or system development/change

26. ***Develop psychological formulations and understanding of what is happening within teams or organisations (using any model) in order for organisations to understand how they are influencing the service users and the different levels within the service. This offers space for the organisation to think about what they do.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

27. ***Service level structures (e.g. PIE, TIC) are really useful to help guide the work. It cannot just be about individual therapy; we need to be promoting system change.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

28. ***Working towards and contributing to the development of PIE both locally (e.g. training, reflective practice) and PIE as a concept.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

29. ***Psychologically Informed Environments leadership and service design: thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

30. ***Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector to work in a way which is PIE and TIC (trauma informed care) informed.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

31. ***Setting up specialist services for homeless people is not sufficient. Inclusivity needs to be promoted within the wider system (e.g. local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

32. ***Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

33. ***Think about how your indirect work can become part of the system. Not seeking to create an entirely new initiative which has minimal chance of survival. Doing with people and organisations rather than doing to.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guidelines relating to working with other agencies

34. ***Working to bring different services together and to proactively support the needs of people with multiple complex needs.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

35. ***Remember to tell stories as these can motivate people to work together. People often remember these and will help to draw in multiple agencies.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

36. ***Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible. People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the service-user.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Other comments:

Appendix L. Round Three survey circulated including Round Two results.

Direct working guidelines which consensus for inclusion has been reached

Guidelines relating to the relationship

10. ***Consider the likely trauma histories of service users you are working with, appreciating engagement is likely to be a long process as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc .***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2:					100%
How you answered in Round 2:					

Comment:

- This is the 'most' essential guideline in this section.
- Much better than no9, more specific
- This seems like advice.
- Very well articulated and inclusive. Similar to my comments in 8. 'With people with histories of trauma, disrupted attachment and those who have had negative experiences of the system it can be hard to trust and for a therapeutic alliance and open themselves up to psychological contact. Slow steady building of the foundations of a relationship is vital'

Guidelines relation to assessment, formulation and understanding

14. ***Formulation is key and sometimes the most basic are the best. Sharing it collaboratively is essential, helping the individual to feel valued, making them more than just a 'label'.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2:				45%	55%
How you answered in Round 2:					

Comment:

- I agree but I’m not sure that this is any more relevant to a homeless population than others.
- Supporting a person to feel valued, and more than just a label.
- I would stick to the first sentence. But needs to be a definition of basic. I would add ensure the formulation is connected to a persons social graces and political context.
- I have seen shared formulations powerfully shift how a team around someone understands, responds and supports an individual leading to increases in empathy, tolerance and effectiveness in the staff team and sustained accommodation and positive engagement and outcomes for the client. This can be powerful in group reflective practice or individually.

15. ***Trauma is highly prevalent in this population (both historic and current/repeated patterns of trauma). Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2:					100%
How you answered in Round 2:					

Comment:

- Comments 15, 16 and 18 account as being the ‘most’ essential guideline in this section. **A formulation should maintain active hope by being grounded in the social/economic/political context within which the person finds himself but also takes into accounts his/her/they historical context which may have included traumatic histories compounded by further trauma and or cognitive and neurological problems.**
- Again, I would have thought that this isn’t specific to homeless people, there are many other groups who are highly traumatised that clinical psychologists work with and we should be doing this with all of them
- Not that clear as a guideline but do agree with what saying
- Guideline might be : Assess a person’s trauma history and current likelihood of being traumatised.
- Trauma has been said to precedes, perpetuates and maintains experiences of homelessness and only by recognising and working with the individual on this can this shift.
- I would phrase this a little differently…..awareness of trauma in this group of people should guide everything you do…rather than /assessing for it. What we need to do is facilitate the person to tell their story….how power has affected them…how they have managed…etc …collaborative formulation from the beginning.

Guidelines relating to therapeutic work

19. ***Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies. It is important to recognise that you may retraumatising them during interventions so you need to pace the sessions carefully, allowing the service user to control what is discussed.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2:				20%	80%
How you answered in Round 2:					

Comment:

- I like this but might be quite service dependent, seems to be coming from the position of a ‘PIE/therapeutic community’ position.
- I agree except I feel like the end of the last sentence (after the word interventions) should say pace the sessions carefully taking a position of ‘influential but not directive’ allow the service user control over what is discussed.
- This seems more like advice.
- Graded model of care coming slowly into contact with people is vital. This may be covered by relationship building and flexibility points.

22. ***It is important that goal setting has to be done collaboratively.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2:			10%	10%	80%
How you answered in Round 2:					

Comment:

- Again not sure that this is specific to homelessness.
- Everything should be collaborative
- Stick to first sentence. – goal setting is conducted collaboratively and you can provide evidence of this.
- Why does it need to be guided by professional…..? It should be collaborative…..

23. ***Make use of integrated models of psychology, paying attention to attachment and theories of motivation.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2:				40%	60%
How you answered in Round 2:					

Comment:

- Making use of attachment theory is vital and utilising a model or method of working that fits with that particular client. This doesn't have to be integrative for me but considered informed by a good formulation and plan.

24. *Approaches to direct work should seek to apply the frameworks of Trauma-informed and Psychologically Informed Environments (PIEs) where possible, encompassing all elements that come with this (e.g. building relationships, helping people connect and feel empowered, value-based, recognise the impact of trauma on an individual and avoiding re-traumatisation).*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	10%	80%
How you responded in Round 2:					

Comment:

- This is the 'most' essential guideline in this section.
- Though I don't necessarily agree with "strength-based" as this can individualise the work and often what is absent but implicit in 'strength' is the persons 'weakness'. This positions the psychologist in a place of judgement (or others, who determines what is a strength or weakness?) . I prefer "value-based" helping to bring forth the persons values and supporting these to be the basis from where the person can develop or increase their motivation.
- I agree that direct work should be trauma-informed, but not necessarily via 'PIE's' – there is potential to work with actually homeless people in other settings, or other people in temporary accommodation.
- Like this one
- Guideline might be – make sure you are up to date with how to apply trauma informed and psychologically informed environment frameworks to your direct work.
- Fundamental in all that we do. Most important criterion for me. These frameworks encapsulate all of the other key elements mentioned above about

ways of working and PIE specifically was developed for work with UK homelessness populations.

Guidelines relating to direct working and the wider system

28. ***Clear communication, within the boundaries of consent, is key with everybody. Be clear with everyone - the service user and others (e.g. those involved in the person's wider network including family, friends, GP etc.) about the direct work you are completing. This includes: the boundaries, what I am doing, this is why and this is how I have come to understand this person and what we can offer.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				50%	50%
How you responded in Round 2:					

Comment:

- Guideline: Within the boundaries of consent, communicate regularly with all involved in a person's network including family, friends, GP.
- Boundaries and communication – inherent challenges in the work that can slip due to the nature of the work. Important to keep holding this in mind.

29. ***Promote good multi-agency working across professionals especially when working with complexity and risk. Coming together regularly, including with the client, is vital.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in round 2:				10%	90%
How you responded in round 2:					

Comment:

- What is the definition of good multi-agency working.
- Often there are lots of professionals involved and coming together regularly including with the client is vital

Other guidelines related to direct working

35. ***Have a realistic sense of optimism, having a sense of it being worth trying even with a deep level of complexity.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How the panel responded in Round 2:					

Comment:

- Guidance rather than a guideline.
- Holding the hope

36. ***Have strong self-awareness and reflective practice, for example through journaling and/or supervision.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- Don’t like the term ‘journaling’!
- Reflexive rather than reflective.
- I would say e.g. and lose etc. – make a sentence unfinished and therefore ambiguous.
- Supervision and reflective practice is vital.

Direct working guidelines which require re-rating

Guidelines relating to flexibility and adaptations

Guideline 2 has been combined with guidelines 1 and 4. Please rate the following guideline:

2. ***Be flexible in your approach for example working hours, implementation of protocols and how and where you engage people: having a person-centred approach, encouraging all opportunities to engage.***					
	Type ‘x’ in one box This guideline is…				
	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comments:

1. *Be flexible in your hours and the amount of work you will do. Do not stick to standard protocols.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel answered in Round 2	20%		10%	50%	20%
How you answered in Round 2					

Comment:

- There are too many different points being made here – I assume this relates to taking a flexible approach. But I don’t understand what being flexible “in…the amount of work you will do” means. There also needs to be self-care and boundaries in our work, so I would reject this.
- These are two different things. I’d agreed strongly with flexibility in hours. However the amount of work and protocols are more about safety and self-care.
- This needs to be done at the same time as remaining boundaried
- I strongly agree with most of that but think you have to be careful with amount of work too, so don’t burn out. Prefer ‘be flexible in your hours. Don’t stick to standard protocols’.
- The way this is phrased could be taken as signing your rights away as an employee. Everyone should have contracted hours and a manageable job plan.

If this guideline is about the ability to work outside of traditional Monday to Friday 9 – 5 p.m. office hours, whilst this can be helpful, I would advise against guidelines that may unintentionally discriminate against some people being able to be in post e.g. people who provide care to others.

Not sticking to standard protocols may be a separate point and could refer to models of intervention or service delivery. A formulation based approach might be an alternative suggestion.

- Important but retaining some boundaries as vital (just wider boundaries than standard!)

2. ***Be flexible in your approach.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			9%	9%	82%
How you responded in Round 2:					

Comment:

- Overlaps with number 1, but is more vague, I prefer number 1
- Using creative means of initial engagement such as going for walks, gardening, having cups of tea, working slowly to build trust and establish a working alliance, short sessions, activity or games based sessions, considering the location of where sessions are held.

4. ***Meet the person physically where they are at. Having a person centred approach, encouraging all opportunities to engage and acknowledge the context you are working in.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- I agree with these points but, although seem broadly related, need to be separated or better organised to combine with others.
- Not sure what the first bit of this means.
- Over laps with number 3 and 5, I prefer 5
- More than one point here, I would separate each point and then see what overlaps or is the same as other guidelines. Not sure what is meant by acknowledge the context you are working in.
- Essential but very similar to 3. I prefer 3 wording and breadth it covers

Guideline 2 has been combined with guidelines 3, 5 and 6. Please rate the following guideline:

3. ***Using outreach and in-reach approaches - psychological therapies are taken to the point of need by being accessible and available so that people can reach you by being located in familiar settings and locations, and going out to where homeless people find themselves so you are visible to the homeless community (e.g. hostels, day centres, streets).*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

3. ***The co-locations of services - psychological therapies are taken to the point of need, located in familiar settings and locations, and going out to where homeless people find themselves (e.g. hostels, day centres, streets).***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				9%	91%
How you responded in Round 2:					

Comment:

- This is the 'most' essential guideline in this section. In doing this it's important to adapt your approach, it may take 7-8 sessions to build a rapport with an individual, but best to be slow and steady to do it right; as opposed to following a structure which wont work.
- This wording is a bit confusing. Are you simply saying that we should offer an outreach model of work? If so, I agree strongly.
- Overlap with 4 and 5, I prefer 5
- Really like this one
- I would assume co-location of services means services that are physically based together rather than what is offered to a service user/service. As a phrase psychological therapies taken to the point of need doesn't make sense. I would emphasise psychological interventions of which therapies is one kind of psychological intervention to support the unique skill set of clinical psychologists. I would suggest 'take an assertive outreach or in-reach approach, providing work where the person is'
- This has led to notable outcomes across a range of different services offering psychology to homeless people. Co-location of services at point of need to build trust on someone's own terms in their own environment or a place that is familiar and feels as safe as possible. This works well in LOCATION REDACTED and LOCATION REDACTED leading to a 90% engagement rate in contact with psychology.

5. ***Be accessible and available so that people can reach you, working where they are and feel comfortable and be visible to the homeless community.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				45%	55%
How you responded in Round 2:					

Comment:

- Is an overlap with 3 and 4, but I prefer 5
- There's two points here allowing people to come to you as well as going to them as covered earlier.
- Essential but very similar to 3. I prefer 3 wording and breadth it covers
- Similar to 4

6. ***Being flexible and more relaxed about therapeutic boundaries particularly at the pre-treatment phase. Without this, other parts of the work will not proceed.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				50%	50%
How you responded in Round 2:					

Comment:

- You need to be flexible but still holding your professional therapeutic boundaries is important.
- I think the last bit of this is unhelpful as it suggests no alternative is acceptable.
- Don't like the language of 'treatment' but I do think it's important to get out of the consulting room
- Unsure about the boundary part – I think you need to be very aware of boundaries due to the complexity of clients as well as needing to have more flexible approach from traditional therapy.
- I think the assertive outreach/in-reach approach is addressed earlier.The reference to a consulting room implies psychologists are therapists (part of what we do) so I would drop that. Being relaxed with therapeutic boundaries is not quite right - I think this may be referring to working in a consulting room. Therapeutic boundaries are essential and we need to adhere to HCPC guidelines. Which models of service delivery we use is what helps engagement and these models of service delivery are likely to be trauma informed. Also the guidelines may give the impression we are working alone and we are more than likely to be engaging service users through or with others. So maybe a guideline related to working at the pre-contemplation stage of change or be prepared to use a variety of approaches to engage a person in psychological interventions – this last I would mark as essential.

- This is vital. I feel this could be encompassed under flexibility Q2 and this Q6 be a good description of that flexibility criterion. Being a person first, building the relationship as the foundation for further therapeutic work.
- Think 4/5/6 could be combined

Guidelines relating to the relationship

Guideline 8 has been combined with guidelines 7. Please rate the following guideline

8. *Prioritise relationship building and be flexible. Do not expect the work to follow a pre-determined route. Things may throw you off the way and it is important to journey alongside someone*

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

7. ***Be flexible - do not expect the work to stick to a predetermined route. Things may throw you off the way and it is important to journey alongside someone.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				9%	91%
How you responded in Round 2:					

Comment:

- I'm getting a bit confused now. This reads like an aide memoire rather than guidelines.
- Overlaps with 3, 4 and 5, I prefer 5. But maybe these can be rolled into one? I like the journey analogy
- This might be a guideline referencing work once engagement has been established. I think this is more a stance than a guideline.
- Covered by 2 & 6

8. *Prioritise relationship building and be flexible*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				18%	82%
How you responded in Round 2:					

Comment:

- This again comes under flexibility but perhaps is the reason why we need to be flexible. Maybe I would remove flexible here as you are flexible in more ways than the relationship and this is an item in itself. With people with histories of trauma, disrupted attachment and those who have had negative experiences of the system it can be hard to trust and for a therapeutic alliance and open themselves up to psychological contact. Slow steady building of the foundations of a relationship is vital.
- Get to know the person – their strengths – this is the work ….you can build a relationship just by consistently saying hello

Guideline 9 has been combined with guideline 12. Please rate the following guideline:

9. ***Be mindful of the interaction between trust and attachment. A complex attachment can be formed between you and your client. Use supervision to discuss and reflect on how best to manage the relational dynamic (e.g. rejection or suspicion from the service users). DNA's and re-referrals may be part of the engagement process.***

Type 'x' in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

9. ***Be mindful of the interaction between trust and attachment. A complex attachment can be formed between you and your client.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	40%	50%
How you responded in Round 2:					

Comment:

- Clearly this is essential but I don’t like the wording of the second sentence.
- May / not can. Also need to think about endings and balance issues of connection, attachment, and boundaries.
- No specific enough, complex attachments are common, but this doesn’t tell the practitioner whether that is a good or bad thing and what to do about it. Don’t like the word client.
- This is perhaps a hint towards expect to be rejected. There’s critiques of attachment theory including not being particularly culturally sensitive. What do we want people to do about attachment other than think about it internally. Would a guideline be regularly discuss and reflect on attachment in supervision and how this influences intervention?
- Interesting point. Good to include. E.g. Thinking about boundaries, pulls and pushes within the dynamics, pressures and needs stemming from lifelong deprivation.

12. ***Engagement - be prepared to spend longer engaging someone. Use supervision to manage any rejection or suspicion you face.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- Again needs to be included within a wider context.
- Yes, specifically DNA’s and re-referrals can be seen as part of the process of engagement
- Engagement….Use supervision to manage the relational dynamics that may come up (i.e. rejection or suspicion)
- Use supervision to discuss and reflect on any rejection or suspicion you experience from the service user.
- Great. Engagement does take time. On average we found that service used took 4 months of informal engagement to begin to come to regular planned psychology appointments. The use of supervision and team support can help with the work and this process.

Guideline 11 has been amended based on the comments by participants. Please rate the following amended guideline:

11. Be attentive to your therapeutic relationship and be aware of relevant power dynamics. Reflect on this regularly in supervision, with colleagues and with service users. Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

11. ***Attend to the relationship e.g. listen, kindness, power dynamic.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	10%	80%
How you responded in Round 2:					

Comment:

- I agree with these points but it is unclear. I assume it refers to your therapeutic relationship? If so it should state e.g. Be attentive to your therapeutic relationship and be aware of relevant power dynamics. These sorts of statements also need to be expanded to clarify why this particularly important to this population (obviously we should be doing this in therapy with everyone).
- Too vague, we should always do this with whoever we work with
- Not well worded
- Would a guideline be regularly reflect and discuss in supervision or with colleagues and with service users where possible what you actively do to develop your relationship, and what they do that helps this too? And a similar guideline re power?
- Essential. Probably covered by other items. Power is something in and of itself to be aware of. V important

Guideline 13 has been amended based on the comments below. Please rate the following guideline:

13. ***Pay attention to endings as much as beginnings. Actively doing this with staff and service users such as by devising care plans for the end of the work from the beginning can help to work through the feelings of rejection and withdrawal service users may experience, but these can be powerfully worked through given time.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

13. ***Pay attention to endings as much as beginnings.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			9%	18%	73%
How you responded in Round 2:					

Comment:

- (if a little obvious!)
- Important, but we should always be doing this in our therapeutic work, homeless or not
- Turning this into a guideline – something like when devising care plans plan for the end of the work from the beginning.
- Great point. Maybe even more important. Homeless clients have so many disrupted attachments and unresolved and sudden losses often starting early in life and throughout. It can be helpful to help clients and staff teams around them to have an eye on this from the start/early in the work. Giving lots of time to work towards this and bearing likely rejection and withdrawal which may come but can be powerfully worked through given time.

Guideline 16 has been amended based on the comments by participants. Please rate the following amended guideline:

16. It is important to *maintain active hope as this is essential in improving outcomes, especially when the individual and others in their system may have lost this. Grounding your formulation in the social/economic/political context and a systems-thinking stance can help contextualise this.*

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

16. ***Maintain active hope by grounding your formulation in the social/economic/political context and a systems-thinking stance***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			19%	45%	36%
How you responded in Round 2:					

Comment:

- I agree with the underlying points, but not sure that taking a systemic perspective will naturally promote hope. I would separate these two points. It is essential to hold onto hope (especially when the individual and others have lost this). And separately, it is essential to recognise wider systemic factors, but don't always interlink.
- I love this
- Not sure about linking hope to formulation. Formulation is about a shared understanding of how someone has come to be as they are and how this understanding influences the intervention. This might also be a nod to looking for evidence of change however small they may seem. 14. probably covers this – although not hope. A guideline re maintaining hope may be – discuss and reflect how you feel about the work with colleagues and supervision and if feeling hopeless make a plan of how you might become more hopeful – only because research says hope is important for service users and staff for good outcomes
- Interesting. Active hope is vital. I don't do this a lot in terms of the grounding of the context but have seen it done helpfully.
- Perhaps we could include and raise this type of consciousness as you collaboratively formulate

Guideline 17 has been combined with guideline 18. Please rate the following guideline:

18. ***Be aware of the high prevalence of cognitive and neurological problems and how therapy may need to be adapted. Include cognitive difficulties such as brain injury and intellectual disability in formulations, as these can contribute to the breakdown of placements and impact on social and day to day functioning. Assessments exploring these should be informed by the service user's needs.***

Type 'x' in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comments:

17. ***They should be screened for brain injury at some point even if it is not the first thing you do. It can be critical to aid understanding.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			19%	36%	45%
How you responded in Round 2:					

Comment:

- Comments 15, 16 and 18 account as being the 'most' essential guideline in this section. **A formulation should maintain active hope by being**

grounded in the social/economic/political context within which the person finds himself but also takes into accounts his/her/they historical context which may have included traumatic histories compounded by further trauma and or cognitive and neurological problems.

- I work with young people so this is less of an issue than likely to be in adult homeless services.
- Screening for brain injury and cognitive difficulties can be key for some people, but not everyone. There needs to be rationale for these assessments. I would suggest the point below is more appropriate. Also don't like 'They' in this (I'm sure taken from a wider context). I'd adjust wording to say 'cognitive problems' such as brain injury, learning disability…
- Screened and then if positive for probable brain injury care plans should be adjusted accordingly and referrals to appropriate services considered. A separate guideline would be to screen for communication difficulties and then the response as above.
- I think this should be done if it indicated (presentation, history). Leading on specific screenings around head injury or trauma should be done with caution and informed by client needs. Not the core foundation of the work for me but an important element of working with the multiple complex needs of the clients and addressing them on an individual by individual basis. Much like when learning disability or dementia assessment is indicated. Both already very common in the population. But I would not be screening everyone for them.
- I would re-phrase… to consider the likelihood of brain injury…discuss what this means..how it might explain some of the challenges….consider more formal assessment but be led by the person….

18. ***Be aware of the high prevalence of cognitive and neurological problems and how therapy may need to be adapted. Include cognitive difficulties in formulations, as these can contribute to the breakdown of placements and impact on social and day to day functioning.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				27%	73%
How you responded in Round 2:					

Comment:

- Comments 15, 16 and 18 account as being the 'most' essential guideline in this section. **A formulation should maintain active hope by being grounded in the social/economic/political context within which the person finds himself but also takes into accounts his/her/they historical context which may have included traumatic histories compounded by further trauma and or cognitive and neurological problems.**
- Over laps with no 17, and I prefer this one because it is more specific
- Similar to 17
- It is important to be aware of this and it inform your formulation, assessment plan and interventions where indicated. Important teams are aware of the signs and features and needs associated with different presentations.
- I think this is linked to trauma awareness stance…..the impact of trauma (of different types) on the brain and relationships….talk about this with the person….with staff…help people use this to respond reflectively and preventatively

Guidelines relating therapeutic work

Guideline 20 has been combined with guideline 21. Please rate the following guideline:

20. ***Working with the pre-contemplation stage is critical, - you have to work with where the person is at regarding their sense of self, motivation, and values. The way you work with a service user should be approached flexibly, be that through 1-2-1 work or alternative, to do the work needed at that time.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

20. ***To eliminate and discard the hierarchy of needs, working with the pre-contemplation stage is critical. You have to work with where the person is at regarding their sense of self, motivation, and values.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	10%	80%
How you responded in Round 2:					

Comment:

- I like this but seems to have cut off the initial point – not sure what 'to eliminate and discard the hierarchy of needs' means.
- Love this
- I don't really understand what the first part of this one means.
- Several points in one. I would say essential to disregard Maslow's hierarchy of needs when planning psychological interventions.
- Important to work with where someone is at not those labelled as ready and motivated for therapy as may be the case in more traditional psychotherapy services.

21. ***Acknowledge the wider context that the person is in at an individual level, not just offering 1-2-1 therapy. Using an approach flexibly to do the work needed at that time.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				40%	60%
How you responded in Round 2:					

Comment:

- Seems repetitive.
- Important. Sometimes joint or group work has been good engagement, but we have tended to get best results from 1:1 and people progressing on to that as a result of flexible initial engagement.
- I think work with the system/staff is often more effective…..

Guidelines 25 and 26 may overlap. Please re-rate the following guidelines:

25. *Adaptability, flexibility and creativity are essential, you are unlikely never to be doing manualised treatment. Consider what model fits the person and think of how to adapt it*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				10%	90%
How you responded in Round 2:					

Comment:

- Although I would take out the word never – you may be doing manualised treatment for example when I worked in a GP Practice for the homeless for some patients I did use standardised approaches that might be used in any outpatient psychology clinic. Homeless people are not a uniform population in any sense.
- Also covered in flexibility criterion 2 but here it is emphasising what is needed for psychological therapy and that is very relevant here.

Type ‘x’ in one box

This guideline is…

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

26. ***Think carefully about what your role should be with this person and what adaptations you need to make to your practice.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				40%	60%
How you responded in Round 2:					

Comment:

- Duplication of no25 and no 25 is better
- Important to consider the network of professionals, whose role is what, boundaries, who is best placed, how you can help, how has the best relationship, how we adapt our practice to meet the needs of the client (eg briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work)

Type ‘x’ in one box

This guideline is…

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

Guideline 27 has been amended based on the comments by participants. Please rate the following amended guideline:

27. ***Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse). Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g. motivational interventions) that can help people to make changes to substance use and engage with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g. NICE guidance for dual diagnosis and substance misuse) that can support this work.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

27. ***People are likely to present with multiple difficulties (including dual diagnosis/substance misuse). Do not exclude someone from psychological therapy because of their presenting difficulties. Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g. motivational interventions) that can help people to make changes to substance use and engage with other services. Work creatively to do this and following the relevant guidance (e.g. NICE guidance for dual diagnosis and substance misuse) can support this work.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:		10%		50%	40%
How you responded in Round 2:					

Comment:

- This is covered by25 and 26
- Guideline might be: Do not reject offering an intervention because someone has an addiction.
- Important to consider exclusion and inclusion criteria and be as inclusive as possible. We have no fixed exclusion criteria in our homeless psychology services. This helps reduce further risk of people falling through the cracks between services and perpetuating unmet need.
- I would add critical review NICE guidelines and whether they fit for this group of people – seek supervision and other psychologists…practice based evidence…..

Guidelines relating to direct working and the wider system

Guideline 30 has been combined with guideline 31. Please rate the following guideline:

30. ***Clinical Psychologists should not work in isolation from colleagues in social services, housing and healthcare. They should be part of an integrated team but the make-up will be dependent on the local circumstances. Consider working as a care co-ordinator to work effectively within this system.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

30. ***Clinical Psychologists should not work in isolation from colleagues in social services and housing. They should be part of an integrated team but the make-up will be dependent on the local circumstances.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:					100%
How you responded in round 2:					

Comment:

- This is the ‘most’ essential guideline in this section.
- Agree but not great guideline
- Also could include health. It is assumed clinical psychologists are ‘health’ but in homelessness services and working with the third sector the psychologist may be a ‘lone’ worker and not represent health or be integrated with health at all.
- As above. Service Silos create further social exclusion

31. ***Even in direct work, work as both a Clinical Psychologist and a care co-ordinator to work effectively with the whole system.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				50%	50%
How you responded in Round 2:					

Comment:

- Obviously depends on whether someone already has a CC!
- Yes, but I think this is covered better by no 30
- Agree but prefer other guidelines
- Although care -co ordinator may need to be defined to suit different service models.
- Would be interesting to explore what ‘working as a psy’ means and what ‘as a care coordinator’ means…..I think this is about re-conceptualising CPs roles….

Guideline 33 has been amended based on the comments by participants. Please rate the following amended guideline:

33. ***Be co-located and embedded within the multidisciplinary team. If an MDT is not available, think how you access the network of services working with these groups offering multiple disciplines.*** Type ‘x’ in one box This guideline is…				
Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

33. ***Be co-located and embedded within the multidisciplinary team.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			20%	50%	30%
How you responded in Round 2:					

Comment:

- This depends on the service – within a team such as mine (CMHT providing outreach to homeless people) this is essential (rather than a separate outpatient psychology service). But many psychologists/therapists won't work within MDT's. I would suggest being embedded within the team and play a central role in the person's system.
- More specificity would help. Co-located and embedded within the homelessness sector but employed within the NHS would be better.
- This is very very helpful but not essential. We have managed as a psychology services but definitely valued times when we have had psychiatry, art therapy in the team and when working closely with SALT, SW, nursing etc. If an MDT is not available think how you access the network of services working with these groups offering multiple disciplines
- I think it is about building strong relationships with the networks and doing that creatively….thinking about systems change….rather than 'fitting' into the system…sometimes it is useful to be a little outside as long as you are supported

Other guidelines relating to direct working

Considering the comments, can those who rated this guideline as essential expand on their responses, providing specificity as although it was rated as important or essential by most participants, the research team are concerned about including it in its current form due to the lack of clarity / specificity.

34. ***Encourage curiosity.***					
	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			11%	33%	56%
How you responded in Round 2:					

Comment:

- This is too vague – does this mean for other workers, therapist, service-user? I suppose I would normally encourage curiosity in trainees/other junior staff. But not specific to homelessness.
- Guidance rather than a guideline.

PLEASE PROVIDE COMMENT REGARDING SPECIFICITY:

Direct working guidelines which will not be included in the final guidelines

32. ***If you are doing direct work with people experiencing homelessness, be employed by the NHS.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:	30%	30%		20%	20%
How you responded in Round 2:					

Comment:

- Arguably some clients prefer to access psychology via charities because of their past negative experiences or rejections from statutory services. NHS also has a lot of specific barriers to resources, which charities can be more flexible about. Arguably the NHS can be worse for employees and homeless populations than voluntary sector.
- There can be benefits to working within NHS systems, but I can't see why people cannot offer psychological interventions from the voluntary/charitable sectors.
- Ideally yes but if not possible, you can still do really important work – strong relationship with NHS is essential thoughx
- I have found this vital in offering containment, clinical governance, working on referral pathways and helping to address some of the difficulties homeless people have had in accessing NHS services historically, particularly mental health services.
- I think being employed by NHS has strengths and also significant challenges…..

Indirect working guidelines for which consensus for inclusion has been reached

Guidelines relating to staff wellbeing

2. ***To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential. Clinical Psychologists should provide training, reflective practice, consultation, consistent team approaches and debriefs.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				10%	90%
How you responded in Round 2:					

Comment:

- Guideline: Clinical Psychologists should provide …..
- Very important and rounded point.

4. ***The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- Guideline: Use a process consultancy model of engagement with staff teams.
- nice

5. ***Be mindful of the stress and pressures that staff (e.g. outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be. Meet staff where they are at considering what they would find helpful, as staff may not have the supervision and training that we would like them to have.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				22%	78%
How you responded in Round 2:					

Comment:

- Guidance
- It is important we are mindful of our difference and privilege (support, training, roles, working hours) in approaching the work and expectations on staff. Meet them where they are at in terms of what they would find helpful.

6. ***Clinical Psychologists should provide a space for validating workers' emotional reactions/toll of the work and understanding behaviour.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	30%	60%
How you responded in Round 2:					

Comment:

- Not enough on it's own without systemic and strategic work across agencies

- This is clearly important, but I'm not sure that clinical psychologists are always the best placed people to do this – it depends on what our role is in relation to the team.
- Guideline: Clinical Psychologists should provide …similar to number 2

Guidelines relating to working within the existing staff teams / systems

9. ***Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes which are evaluated. Ensure that consultation is useful to care planning, not only theoretical.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				50%	50%
How you responded in Round 2:					

Comment:

- Several points in one. Guideline: Evaluate outcomes or use PDSA cycles.
- Even when focusing on process. Formulation and understanding it is helpful to work with teams to think 'what now?'
- I wonder if it is always possible to mark/define what is useful? I would be interested in the goal being learning rather than outcome

10. ***Build relationships and partnerships with staff who are key to much of what we do. Emphasise good practice, consider evolution not revolution.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:		10%		20%	70%
How you responded					

in Round 2:

Comment:

- I think it is too strong to say that ‘everything you are doing is through the staff’ (may well be providing direct interventions).
- Not everything we can do is through the staff, there is a lot of direct work we can do, but yes, partnerships and relationships are key
- Guidance. Although not everything you do is through others.
- The partnership is the work, they create the psychologically information environment and have far more contact with and knowledge of the clients.

11. ***Model and reinforce the skills that you want to develop within systems and staff groups.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- Walk the talk
- By being onsite or co-located or spending time with teams t allows you to model the approaches you are encouraging with them and in your observed contact with clients.
- Some skills you cannot teach…they need to be internalised….become part of the culture…this can only happen over time

13. *Learning and building up therapeutic and practical skills with appropriate supervision, giving people a sense of control and fostering Psychologically- and Trauma-Informed environments.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:		10%		50%	40%
How you responded in Round 2:					

Comment:

- I'm wary of giving skills to staff labelled 'therapeutic skills' because they are not, nor should they be, therapists. Too often I meet staff who have a small amount of training in a therapeutic technique and then want to practice it on a very vulnerable group of people with no supervision.
- Being aware of power imbalances and giving people we work with control is important in all the work we do whether with staff or service users.
- Guideline: In collaboration with teams develop a programme of staff development that fosters TIC and PIE.

Other indirect working guidelines

15. ***Think about your language and how you explain things in a way to staff that is accessible, interesting, and more than just common sense. Doing so will help to prevent staff feel disempowered.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				20%	80%
How you responded in Round 2:					

Comment:

- This is the 'most' essential guideline in this section.
- Be engaging, down to earth and accessible is key. Not too theoretical or making staff feel disempowered.
- Have a staff critical friend who will give you honest feedback….

19. ***Contract work as transparently as you can. Ensure all including senior managers are involved, have authorised, and support the work.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	30%	60%
How you responded in Round 2:					

Comment:

- Contract work as inclusively as you can

20. ***Clinical Psychologists should be involved in ensuring that team screenings and initial needs assessments consider relevant psychosocial factors.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				70%	30%
How you responded in round 2:					

Comment:

- Guideline: Ensure team screenings and assessments include a psychological framework/model.
- Where indicated and possible. Supporting staff teams to develop these teams and understanding can also mean they can lead on holding this in mind as well. May not need to be the psychologist only
- Upskilling staff to do this overtime

Guidelines relating to research and generating an evidence base

25. ***Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.***					
	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				60%	40%
How you responded in Round 2:					

Comment:

- Creating a community of practice
- As above.
- This is very helpful and supportive. It really helps me feel connected and held by a lovely network of peers.

Guidelines relating to organisational and/or system development/change

26. ***Develop psychological formulations and understanding of what is happening within teams or organisations and share with organisations in order for organisations to understand how they are influencing the service users and the different levels within the service. This offers space for the organisation to think about what they do.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	40%	50%
How you responded in Round 2:					

Comment:

- This is the 'most' essential guideline in this section. I would extend this comment to local homeless sector systems.
- Take out ***using any model*** and replace with and share with organisations

31. ***Setting up specialist services for homeless people is not sufficient. Inclusivity needs to be promoted within the wider system (e.g. local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				40%	60%
How you responded in Round 2:					

Comment:

- Important but perhaps slightly unrealistic!
- The first sentence is very important
- Advice
- Also valuable to be working to deliver a range of specialist services and accessible inclusive mainstream services that will work with homeless clients

32. ***Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	30%	60%
How you responded in Round 2:					

Comment:

- This is put better by the other statements in this section
- Repetitive
- Important may repeat an earlier point

33. ***Think about how your indirect work can become part of the system. It is not always about seeking to create an entirely new initiative which has minimal chance of survival. Doing and planning with people and organisations rather than doing to.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				60%	40%
How you responded in Round 2:					

Comment:

- Would love to keep the last sentence of this!
- Guideline:I would suggest plan with others how your direct and indirect work can be sustained and developed by the system.
- Some new initiative work but working with existing systems also vital

Guidelines relating to working with other agencies

34. ***Working to bring different services together and to proactively support the needs of people with multiple complex needs, bridging the gaps between services that service users can fall between, helping to address service exclusion***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in round 2:					

Comment:

This is working between systems.

Partnership multi-agency working is the true way to bridge gaps between services that clients fall between and to address service exclusion.

36. ***Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible. People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the service-user.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				40%	60%
How you responded in Round 2:					

Comment:

- This is the ‘most’ essential guideline in this section.
- Advice/guidance
- My fav of the joint working criteria that overlap some what

35. ***Remember to tell stories for both direct and indirect work as these can motivate people to work together. People often remember these and will help to draw in multiple agencies.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			20%	30%	50%
How you responded in Round 2:					

Comment:

- Tell stories for both direct and indirect work.
- Nice point. I don’t do this enough.

Indirect working guidelines which require re-rating

Guidelines relating to staff wellbeing

Guideline 3 has been combined with guideline 1 and amended following comments. Please rate the following guideline:

3. Demonstrate that services are Trauma-Informed. ***Attending to the emotional impact of the work on colleagues is an important starting point. Trauma-Informed Care provides a 'universal precaution' approach which can be used with staff as well as service users. The work is potentially traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

1. ***Pay attention to the trauma staff will have experienced. Many will have come into this because of their own past and present experiences.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- This is the ‘most’ essential guideline in this section.
- This is a valid point, but we won’t necessarily know what traumas staff may have experienced. I would suggest something more like… Be mindful that staff may have also had challenging backgrounds. Staff may have come into their roles because of their own experiences of homelessness or other related past experiences. Remain aware that this work could bring up particularly difficult memories and feelings for staff. (Or point 3 below!)
- High prevalence of lives experience. Important to be mindful of staff needs, impact of work and variety if support structures needed.

3. ***Attending to the emotional impact of the work on colleagues is an important starting point. Trauma Informed Care provides a 'universal precaution' approach which can be used with staff as well as service users. The work is potentially traumatising for staff many of whom also come with trauma backgrounds.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- 1, 2, and 3 overlap and I think 2 is best
- Guideline: Demonstrate that service development is trauma informed.
- Excellent point. Complimentary to 2 and better than 1 which is replicates in some ways. .

Guidelines relating to working within the existing staff teams / systems

Guideline 7 has been combined with guideline 8 and amended based on comments provided by participants. Please rate the following amended guideline:

7. ***Clinical Psychologists should assess the service context in which they work, recognising and acknowledging the skills, beliefs, and ways of working already in the system and prioritise these. Offer what is meaningful and practical to the people and services you work with (which maybe reflective groups, case discussions and consultations in order to build capacity).***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

7. *To recognise the skills, beliefs, and ways of working already in the system and prioritise these.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	50%	40%
How you responded in Round 2:					

Comment:

- This is the ‘most’ essential guideline in this section and add … *in doing so offer what is meaningful to the people and services you work with (which maybe reflective groups, case discussions and consultations in order to build capacity*
- Also important to acknowledge ***skills, beliefs, and ways of working*** which are not present
- Clinical Psychologists should assess the service context in which they work.
- Build on existing knowledge and validate experience and ways of working.

8. ***To offer something practical and useful other people can see e.g. offering reflective groups and case discussion and consultation to add value.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				60%	40%
How you responded in Round 2:					

Comment:

- Guidance. Guidelines covered above.
- These are often appreciated and feel like something for the teams as well as clients

Guideline 12 has been amended based on the comments by participants. Please rate the following amended guideline and provide comment on what you believe 'capacity' refers to:

12. ***Work from a position of building capacity by sharing knowledge and discussing ideas (e.g. through formulation) and developing existing strengths in staff teams.***

Type 'x' in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

12. ***Work from a position of building capacity (e.g. through formulation) and developing existing strengths in staff teams.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				33%	67%
How you responded in Round 2:					

Comment:

- I think this needs more development – to me 'capacity' alone seems to vague and has connotations with an individual's capacity to make decisions.
- Yes, it's always important to work with the strengths of the people you are supporting we are rarely beginning from scratch
- We must not position ourselves as the key holders…this is about sharing ideas/knowledge and upskilling….

Guideline 14 has been amended based on the comments by participants. Please rate the following amended guideline:

14. Where appropriate, *Clinical Psychologists should be involved as far as possible in providing support for managers and frontline staff. Mentoring for frontline staff should also be considered.*

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

14. *Clinical Psychologists should be involved as far as possible in providing support and mentoring for frontline staff.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:		10%	10%	40%	40%
How you responded in Round 2:					

Comment:

- I think this depends on the service, sometimes mentoring from someone’s own professional group would be more helpful e.g. a nurse being mentored by a more senior/experienced nurse.
- Yes, this is important, but I’m not sure this is specific enough.

- This can be very helpful – supporting staff development. But it can also be helpful to support managers who then support and mentor the staff team

Other indirect working guidelines

Guideline 16 has been amended based on the comments by participants. Please rate the following amended guideline:

16. ***In relevant contexts, develop your interventions collaboratively with all staff including those working on shifts at night and domestic workers to promote consistency of approach.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

16. ***Try to pay attention to the night workers, as it is likely that there will be a lack of consistency in approach.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	30%	60%
How you responded in Round 2:					

Comment:

- Where relevant to the service – I think this needs more context (presuming this point refers to supported accommodation e.g. a ‘PIE’)
- Night workers and domestic staff can be missed when making interventions relating to the setting; however, they can also be ‘culture carriers’ so missing them can have significant consequences.
- Guideline: Develop your interventions with all staff including those working on shifts at night to promote a consistency of approach.
- Night workers get little support and access to clients in day time or overlap with day staff, team approaches, training or reflective practice. I would soften the language here as it sounds quite critical of the night staff rather than the service structures. We have done work offer night staff evening training, scheduling for them to come on rota in the day every month or two to attend reflective practice, attend debriefs, have more overlap with the day staff team, and get clinical supervision by psychologists offered early in the morning or in the evening.

Guideline 17 has been amended based on the comments by participants. Please rate the following amended guideline:

17. ***Where possible and appropriate, indirect work should be led by service user involvement and feedback. Be creative and flexible in your approach to this, implementing a range of methods to work co-productively e.g. through focus groups, surveys, informal verbal feedback.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

17. ***It is important to make sure your indirect work is led by service user involvement and feedback.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	30%	60%
How you responded in Round 2:					

Comment:

- I think this depends on what indirect work. For some types of indirect work this will be extremely pertinent, but in other situations staff feedback might be more important.
- It is essential, but there needs to be flexibility about what counts as service user involvement. In the service I work in I find it hard to justify staying in touch with service users who are now housed because the service is commissioned for people who are homeless. However, when someone is homeless, they often have more important things to prioritise that volunteering to be a service user activist. Service users have also told us that they do not want to meet in a group (because of risks from other service users), so with both of these things we have had to be very creative about how we involve service users.
- Guideline: Implement a variety of methods to work co-productively and seek service user feedback in developing services.
- Where this is possible its very important and works well.

Guideline 21 has been combined with guidelines 23 and 24 and amended based on comments provided by participants. Please rate the following amended guideline:

21. ***Clinical Psychologists should allocate time to research and evaluation. As well as seeking out opportunities to promote and complete research, they should be a source of guidance and expertise for staff, working collaboratively on research and evaluation projects whenever possible.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

21. ***Use and share the available evidence base and any additional evidence generated as much as possible, with the recognition of the context that they were developed in. Consider what are you going to do with what you have.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- Ensure clinical psychology roles have time allocated to research and evaluation
- Guidelines (although this is in a job description): Keep up to date with research. Engage in research. Disseminate research.

23. ***Clinical Psychologists should be a source of guidance and expertise on the evaluation and research of services.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			10%	30%	60%
How you responded in Round 2:					

Comment:

- Q24 is better and covers this
- Guidance. Is in job descriptions although may not be supported by job plans.
- I think they should be involved….but how could we share this ‘power’ there are different ways of creating evidence/doing research …we are not the authority…we should be partners

24. ***Contributing to the evidence base of effective ways of working with this population to influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- This is the ‘most’ essential guideline in this section.
- Combine with Q2
- Guideline: Belong to a national group of clinical psychologists.
- This is my fav of these evidence-based points. I think this covers the range of ways this is important (encompasses 21, 22 too). Sharing the developing evidence-base has been vital in developing clinical psychology in homelessness as a profession and also growing our service. We have seen it having a real impact on the way services are design and delivered.

Guideline 22 has been combined with guideline 24 and amended based on comments provided by participants. Please rate the following amended guideline:

24. *Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community. Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness.*

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comment:

22. ***Consider how to take what you have done and share it more widely in the organisation, how to develop the evidence base, and how to influence wider societal norms to develop more helpful narratives around homelessness.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				22%	78%
How you responded in Round 2:					

Comment:

- Q24 is better and covers this
- Guidance.
- Sharing the developing evidence-base has been vital in developing clinical psychology in homelessness as a profession and also growing our service. We have seen it having a real impact on the way services are design and delivered.

24. ***Contributing to the evidence base of effective ways of working with this population to influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				30%	70%
How you responded in Round 2:					

Comment:

- This is the ‘most’ essential guideline in this section.
- Combine with Q21
- Guideline: Belong to a national group of clinical psychologists.
- This is my fav of these evidence-based points. I think this covers the range of ways this is important (encompasses 21, 22 too). Sharing the developing evidence-base has been vital in developing clinical psychology in homelessness as a profession and also growing our service. We have seen it having a real impact on the way services are design and delivered.

The following guideline is a merging of guidelines 27 – 30. Due to the level of change needed to bring them all together into one guideline, this is a new guideline. Please rate this guideline:

NEW GUIDELINE PROPOSED. ***Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector. Service level structures such as Psychologically Informed Environments (PIEs) and Trauma-informed Care can be really useful to help guide the work, for example by supporting thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work. It cannot just be about individual therapy; we need to be promoting system change.***

Type ‘x’ in one box

This guideline is…

Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential

Comments:

27. ***Service level structures (e.g. PIE, TIC) are really useful to help guide the work. It cannot just be about individual therapy; we need to be promoting system change.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				11%	89%
How you responded in Round 2:					

Comment:

- Guidance.
- Vital as said earlier.

28. ***Working towards and contributing to the development of PIE both locally (e.g. training, reflective practice) and PIE as a concept.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:		10%		30%	60%
How you responded in Round 2:					

Comment:

- I personally think this is too specific to the ‘PIE’ model.
- I think covered above
- PIE is vital. Nice to have one on contributing to the development of PIE, plus 29 on what PIE offers.

29. ***Psychologically Informed Environments leadership and service design: thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				40%	60%
How you responded in Round 2:					

Comment:

- Yes, I prefer this one to any of the others in this section (Q26-29)
- Repetitive
- This point encompasses why PIE is important on so many levels.

30. ***Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector to work in a way which is PIE and TIC (Trauma-informed care) informed.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			11%	22%	67%
How you responded in Round 2:					

Comment:

- Again a bit too ‘PIE’ focused for general homeless guidance.
- Q29 puts it more succinctly
- True. A statement really not a guideline.

Indirect guidelines where consensus was not reach and <u>will not be</u> included

18. ***Creating opportunities to be present or available if you cannot be physically present. Showing a willingness means you can understand challenges in different services if you are not able to be in a service all the time.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:	11%		22%	33%	33%
How you responded in Round 2:					

Comment:

- I think this needs to be expanded – does this mean speaking to staff by phone?
- We’re not superhuman.
- Not sure what this means?

Appendix M. Round Four with panel member vignettes, comments, and details of Round Three results and amendments.

Grey textboxes indicate guidelines where vignettes were identified from the Round One interviews. Text in white boxes indicate vignettes which were suggested by panel members during Round Four. The presence of a * next to a guideline indicates where specific feedback was received from a panel member. The original panel member feedbaxck – included verbatim - can be found below the guideline. Some information has been redacted to ensure anonymity. Boxes left blank indicate instances where no vignettes were provided. In these instances, a member of the research team provided these. Please refer to Appendix N for these.

Direct working guidelines

Approach

***2.** Be flexible in your approach, holding the person at the centre of your work, encouraging all opportunities to engage. For example, flexibly implementing protocols, moving your working hours to facilitate appointments, and considering how and where you engage people. Use outreach and in-reach approaches, taking psychological interventions to the point of need, going out to where homeless people find themselves so you are visible to the homeless community and their support networks (e.g. hostels, day centres, streets). This may mean meeting outside of the clinic or office base, meeting where service users feel comfortable e.g. meeting in public spaces providing confidentiality can be maintained.*

Vignette 1

Oliver's service is open access with no exclusion criteria to encourage engagement, going to the service user, meeting where they feel comfortable. In Oliver's experience, this often means meeting outside of the clinic environment including visiting hostels, day centres and local GP practices. Being flexible in their working hours also helps to facilitate early morning outreach providing the opportunity to engage with rough sleepers. If a person experiencing homelessness would like to talk to Oliver during this outreach, he will do this in situ, whilst respecting confidentiality and environment they are in, using this as an initial contact to build on.

Vignette 2

Neil casts the referrals net 'far and wide' including local Accident and Emergency Departments who see certain faces on a regular basis and other organisations such as housing, mental and physical health services, the police, and social services. Initial engagement means going out to meet the person where they are at rather than expecting them to come to you. If Neil does not get a response from them initially, he will keep working to get into contact with them and are often creative in the way that he does this e.g. contacting their social worker to find out where they last saw them and to provide an update on the individuals circumstances or visiting a local day centre the person is known to visit. Though flexible in taking their services to the point of need, Neil also ensures that they have implemented good, clear risk protocols for all staff operating outside of standard protocols (e.g. meeting on a canal tow path bench rather than at a clinic) which helps them and other staff members to feel safe in their role.

8. ***Prioritise relationship building as it can take time to build trust and engagement. Do not expect the work to follow a pre-determined or 'manualised therapy' route. Life events will get in the way (i.e. moving accommodation, becoming street homeless, physical health concerns), so it is important to journey alongside someone.***

Vignette 1

Working with this population has led Elaine to recognise the importance of adapting the way you engage with an individual to build the therapeutic relationship. One of Elaine's most successful therapy appointments was using 'rap therapy'. The service user found it too difficult to talk to Elaine, but they would rap about their life and how they were feeling. Using a less traditional method and being open to being creative, using the service users preferred way of communicating helped build the relationship. Being able to have humour and 'rap back' helped reduce the power imbalance as Elaine was not going in from a point of 'expertise' and communicate in a way the service user found helpful.

Vignette 2

Michael was living on the streets when he was referred to Andrew. During their work, Michael moved from the streets to a friend's house, to emergency accommodation and then was admitted to hospital before being discharged and supported into an appropriate hostel setting. Andrew worked with Michael throughout this time and remained involved in his care, meeting with him on a regular basis including on the ward, completing cognitive screenings and additional assessments. Journeying alongside Michael and continuing to be involved in his care irrespective of Michael's circumstances helped Michael to build trust with Andrew and the wider professionals and services, resulting in him being placed in appropriate supported accommodation.

9. ***Attend to the therapeutic relationship, being mindful of the interaction between trust and attachment. Use supervision to discuss and reflect on how best to manage the relational and power dynamics between yourself and the service user. DNA's and re-referrals may be part of the engagement process - reflecting on these with service users can help build understanding and trust with staff and services.***

Please feel free to provide an example you think encompasses this guideline:

Naomi had been referred to psychology twice before. She had left each time after a couple of sessions when she thought the psychologists were telling her to let go of the past by forgiving the people who had abused her. She did not attend the first session, but responded to a telephone call and had a lengthy conversation which the psychologist Thandie. Having discussed in supervision concern that Naomi would disengage early again, the need for Naomi to be confident that she could lead her therapy was highlighted. Thandie summarised the conversation in a letter both to check they had a shared understanding and to give Naomi something tangible to hold onto. Naomi felt understood and after a few telephone consultations attend sessions reliably in person.

- Initially frequent DNA's and late cancellations.
- When they did meet, lots of pushing of boundaries, attacking personal comments, questioning of credentials, and requests to change therapist.
- Discussed in supervision and considered behaviours from an attachment/MBT perspective and agreement to work through mistrust.
- Gradually built a more trusting therapeutic relationship; still ongoing interpersonal fears/paranoia, but more able to speak about this in sessions and reduction in DNA's.
- Therapist able to get permission to challenge and intervene when perceived unhelpful ways of coping and relating to therapist and others.
- Disclosures of past abuse and bullying; enabling formulation of perceived attacks of others and defensive/avoidant behaviours.

Omar was referred for a cognitive assessment in order to help hostel staff understand the impact of historical brain injuries. He became extremely distressed during the initial assessment session, and through gentle conversation he was able to share that it was approaching the anniversary of his girlfriend's death. The focus of the session now needed to shift to managing this distress and associated risk of harm to self. Future sessions would require a mix of therapy and assessment in order to complete the neuropsychological assessment in a compassionate manner. Omar's life became more chaotic over the ensuing months, as had been witnessed previously. He spent time in and out of prison and moving between hostels. The assessment took three months to complete, and then required further support to help Omar manage the overlaps in the therapeutic and assessment relationship, and build support systems from existing networks.

Matthew was a middle-aged man who presented with episodic psychotic symptoms, including paranoid ideation that made engagement very difficult. He had had limited contact with mental health services for nearly two decades and coped with his symptoms through the use of alcohol. It was therefore initially not easy for him to tolerate 1:1 clinical psychology sessions and instead the psychologist began gaining his trust and building a therapeutic rapport by slowly approaching him in the hostel art group and by sitting with him in the garden. Following four months of gradual engagement, Matthew was curious enough about other residents meet with the psychologist on their own to ask for his own meeting. At first he was able to tolerate 10 minutes of contact and had a tendancy to miss every other session. However, after a few weeks he began to build his confidence and trust in the space and the psychologist, built his tolarence for attending for a full session and would attend each week, waiting for the psychologist outside their office at the time of the session.

I found that reaching women in a high support mixed-gender hostel seemed particularly difficult. Perhaps due to histories of complex and long-running (often ongoing) traumas, difficulties building trust, perceived differences in social class and status, shame and an expectation of being judged and let down by professionals. I drew on research and input from the women themselves to devise a female centred approach. This included offering female-only groups, women from the hostel acting as co-facilitators and being creative and flexible with engagement approaches (chats over cups of tea, walking therapy). I found supervision essential for understanding engagement patterns and relational dynamics, where often a period of engagement would be followed by multiple DNAs and it was tricky to find a balance between encouraging continued therapeutic contact vs the woman having enough control over the relationship. I found the book ‘Streetalk’ by Pippa Hockton really helpful for understanding the relational patterns that can occur in therapy with very traumatised women.

10. ***Consider the likely trauma histories of service users you are working with, appreciating engagement can be a long process, as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc.***

Vignette 1

Tim arranged to meet Craig multiple times over several months to complete a neuropsychological assessment, however, Craig was not there when Tim visited at the agreed times. After several months of arranging to meet, Craig did attend the appointment, explaining he now felt ready to engage with the service. Tim explained that, by making sure he turned up at the time and place that had been agreed even if though Craig had consistently not attended showed that Tim was consistent, reliable, and did not deprioritise him over other tasks. Tim recognised that it is likely persons experiencing homelessness, including Craig, have been let down multiple times in the past in relationships, and during contact with other services, professionals, and providers. Working through this, by being reliable is likely to help build trust and increase the likelihood that a person experiencing homelessness will engage with services.

Vignette 2

Owen had worked with Heather for over a year after she moved into a hostel for women escaping domestic violence. Heather had experienced multiple traumas in her family home as a child and into her adult life with her long-term partner. Whilst working with Owen, Heather had to be rehoused several times as her ex-partner managed to locate her, and also assaulted her on one occasion. Owen had to be mindful that he was not just managing historic trauma, but live trauma. Therefore, it was important that Owen was flexible and provided a safe space for Heather to engage over a long period of time, at her pace.

16. ***Many people who are homeless may have lost touch with hope, so it is important to actively maintain it. Communicating hope to the service user and others in their system can be a radical force for change. Use supervision to nurture hope and support you to avoid problem saturated stories about service users. Avoid individualising the problems of the person who is homeless by accounting for the sociopolitical context and social/relational history of the person. Individualising and pathologising discourses can counteract hope and agency.***

Vignette 1

Oliver uses narrative formulation to help decentre away from one way of thinking. In both direct therapy and indirect working with staff, he considers what has been influential in a person's a life, incorporating the wider social context. Oliver believes this is particularly pertinent with people experiencing homelessness. Telling a story and helping the individual to develop other stories can help the person identify and understand what their values, hopes, dreams and wishes are in relation to their own moral code. This can help to foster engagement and increase motivation for them make the changes that they want to.

Vignette 2

Annabelle maintains active hope by providing service users with an element of choice and control in whether they attend appointments or not, and openly discussing with them what she is thinking of offering. Providing service users with choice, control and collaboration can be a valuable asset as many will not have experienced this before. If a service user chooses not to take up the space offered, Annabelle reiterates that the space will be available to them in the hope that they will take it up when they are ready to use it.

35. ***Have a realistic sense of optimism*, having a sense of it being worth trying even with a deep level of complexity.***

Please feel free to provide an example you think encompasses this guideline:

Ryan had experienced many traumas from his early years into adulthood. He had been a victim of violence and a perpetrator and had been imprisoned for dealing drugs. He was going through lengthy court actions to regain contact with his children who barely remembered him. In therapy Psychologist Olatunde helped Ryan explore the kind of Father he wanted to be even if he did not have direct contact with his children and signposted Ryan to both legal services and services that could support him to be the best Dad he could be directly or indirectly. By the end of the work Ryan had been allowed to write a letter to his children and was hopeful about future contact.

- MDT outreach to an entrenched rough sleeping man, avoidant of any contact.
- Opiate dependency, not engaging with addictions services, associated chaotic lifestyle. Suspected underlying psychosis and possible LD.
- Persistent offers of support (e.g. practical help and physical health checks).
- Flexible offers of psychology over a lengthy period (with significant DNA's/avoidance).
- Hospital admission with psychologist visiting and chance to build relationship.
- Further assessment and transfer to rehab and then supported accommodation.
- Ongoing substance use but less risky use and engagement with mainstream services.

Wendy was referred for a mental capacity assessment, to gauge her ability to decide on hospital discharge destination. Wendy was in temporary housing environment where domestic abuse was suspected. She relied heavily on alcohol and often fell, resulting in injury, She had a terminal diagnosis, with a life expectancy of three to six months. It took time to develop trust with Wendy, particularly as the clinical psychologist conducting the assessment was male, and Wendy had a history of multiple sexual assaults and violence from men. With time, trust grew and the assessment was completed. The capacity question was shifted to ask whether she had the capacity to decide on end of life care needs. She lacked the capacity for this and was safely moved to a palliative care setting. She died six weeks after the move had taken place, but did so in a safe and caring environment.

* This does overlap with above point 16 for me. Hope and optimism. Could it be combined with that. I feel if I added an example it might overlap with above.

34. ***Encourage curiosity in both staff and service users and their wider support network (e.g. family members and staff). Approaching clients with curiosity can help validate their experiences and support them to reflect on factors impacting their lives and explore how they are responding to these. This in turn can encourage them to become curious about psychological approaches and how they may help. Encouraging curiosity can help staff, including Clinical Psychologists, avoid assumptions and falling into dominant narratives relating to homelessness and consider what happened to the person and why they are working with them at this time.***

Vignette 1

Once Hannah catches herself as a professional thinking that she knows something in a concrete way, she takes this as an indication that she has stopped being curious and has closed down other narratives. To manage this, Hannah engages in supervision, peer support, continues to read and learn, and is part of a wider community within the field of homelessness.

Please feel free to provide an example you think encompasses this guideline:

When reflecting with services users, carers or staff Halle uses a framework she calls ‘thinking in spheres’. This means visualising the multiple contexts people are in within concentric circles that spin, change, ebb and flow over time. So, reflecting on individuals, groups, teams, services, organisations, communities, education, work, leisure, money, local and national politics, spirituality and religion. Halle encourages the person or people she is working with to imagine being in varying positions and view the world from multiple perspectives, sometimes using the ‘miracle question’.

36. ***Have strong self-awareness and reflective practice, for example through journaling and/or supervision.***

Vignette 1

Acknowledging difficulties and frustrations in this work is crucial to help manage any issues that arise. Neil highlights the need to have good relationships within the team to feel able to discuss any frustration or issues you may be facing, and, where applicable, raise these with the wider system and agencies involved. For example, he described instances where he may be frustrated working with someone because he does not perceive them to be very receptive or very grateful, or because they may agree to do one thing and then do the opposite. Openly discussing and reflecting on these issues with colleagues, and where applicable, other agencies, can help you explore how best to move forwards. Neil emphasises that this is particularly important for less experienced members of the team and when your team may be only one discipline.

Vignette 2

Considering and reflecting on the boundaries you are working within, particularly as there are no guidelines for what is and is not ok, is critical. At times, Andrew knows that at times he may be moving the boundaries too much. He acknowledges that maintaining appropriate boundaries can be hard, as you can be drawn into powerful attachments with the client. To manage this, Andrew draws on reflective practice and having ‘critical friends’ to hold them to account. He highlights that Trainee Clinical Psychologists are vital within the team, as they can provide a different perspective and are more likely to raise issues, providing they are given the support to feel safe enough to do so.

Multi-agency working

26. ***Think carefully about what your role should be with this person. Consider the network of professionals, whose role is what, boundaries, who is best placed, who has the best relationship with the service user and how you can help.***

Vignette 1

Ivan had recently moved to the UK, had no consistent work history, had been charged with a public order offence and had recently been assaulted, resulting in a brain injury. He was referred to Neil for a neuropsychological assessment to determine the impact of his brain injury. On meeting Ivan, it became clear that one of the primary difficulties was that Ivan could not speak English; a major barrier to Ivan accessing services as much of the basic information, education and advice was not available to him. Neil contacted an interpreter with experiencing of working in mental health services. The interpreter supported Neil to complete a thorough assessment of Ivan's head injury and provided Ivan with some initial signposting information in his language. Neil also consulted with Social Care to assign a Social Worker who could speak Polish to support him in pursuing housing, and Ivan has since successfully been placed in a local hostel. The neuropsychological assessment results helped Ivan obtain appropriate legal representation as he was recognised as someone who had social issues and the potential psychological implications of this. Neil recognised what his role could be in supporting Ivan by providing a neuropsychological assessment and considered who else could be best placed to optimise support for Ivan.

Vignette 2

Using psychological formulation, Matilda hypothesised with staff that Kay may find the environment of a hostel too anxiety provoking as she had been living on the streets for several years. Rather than offering psychological therapy or another service to support Kay, Matilda and the wider staff team felt it would be most beneficial for Kay's outreach worker to build a relationship with her where she was living at that time. As Kay and her outreach worker built up a relationship, her outreach worker would offer to bring Kay to the hostel for a cup of tea and speak to staff informally. Kay began to accept this offer, would visit the hostel for a cup of tea, and then return to where she was staying. Slowly Kay started to visit the hotel without her outreach worker present, as she began to build trust in the hostel staff and surrounding environment. Throughout this work, Matilda and other Clinical Psychologists in the service supported staff, including the outreach worker, to remain consistent. Being consistent in their approach allowed Kay to feel safe enough over time to begin to stay in the hostel and has since moved to another hostel full time. Carefully considering who would be best placed to build a relationship with Kay to help her feel safe in engaging with the hostel environment was key to helping her to work towards engaging with the service. As a result of this slow engagement, Kay moved into the hostel and has since moved on to other accommodation. *

*** This sentence is repetitive of one two lines up.**

28. Clear communication, within the boundaries of consent, is key with everybody. Be clear with everyone - the service user and others (e.g. those involved in the person's wider network including family, friends, GP etc.) about the direct work you are completing.

Vignette 1

Tim was asked to complete a capacity assessment to explore Jane's decision for her discharge destination from hospital. After attending a case conference, Tim spent several appointments with Jane to explain to her what his role was and what he was going to offer, and to understand and appreciate her history and consider what her needs may be regarding a possible assessment. From taking the time to speak in depth with Jane about her past and choices, it became clear to Tim that Jane did not need an assessment regarding her discharge decision, but instead needed one regarding her treatment and end of life care. Tim feels being impartial in this situation was crucial, considering what he had been asked to do whilst critically considering what Jane was telling him throughout their conversations to determine the outcome. Communicating this to third parties in their role meant Tim had to be clear with what he had been asked to do and provide evidence to support his decision, communicating the findings assertively to others whom may not agree with the decision at the time. Considering this, the focus of the work changed, as did the outcome regarding Jane's care.

Vignette 2

Oliver explained the importance of exploring with the person what they might need whilst making sure that he does not promise anything other than what he can emotionally and/or physically deliver. They use formulation and engagement to discover what he can offer the service user.

29. *Promote good multi-agency working across professionals especially when working with complexity and risk. Coming together regularly, including with the client, is vital.*

Vignette 1

Angela was behaving in ways that hostel staff were experiencing as challenging. Having left a domestically violent relationship, Angela struggled with authority and would drink alcohol to help her cope. Angela also used to get in to fights with other residents frequently and was close to being evicted due to the increasing risk to others. Erin, the clinical psychologist in the hostel, arranged a meeting with Angela and the hostel manager to think about the situation. Erin explained that they started this meeting by using a strengths-based approach, highlighting things that staff appreciated about Angela, and that they wanted her to stay in the hostel but it was getting to a point where staff and residents did not feel safe. Therefore, they offered Angela the opportunity to think about what she and staff could do to help her to feel less distressed, reduced her risk to others and enable her to stay in the hostel. Coming alongside Angela and jointly discussing risk with her helped her engage. This resulted in Angela and the staff team creating a shared agreement about how she would try to manage her distress in future, and what staff could to do help her. Following this, Angela's risk reduced, she began to engage with her alcohol worker and was able to remain in the hostel.

Vignette 2

Terry was referred to Andrew's team from the local A&E department, as he was a frequent attender, and they began to suspect underlying mental health issues. He was jointly assessed by Andrew and the Consultant Psychiatrist who were able to identify during the initial assessment the extent of his contact with other services, and recognised that he was at relatively high risk, as he was vulnerable to exploitation from others. The team, including social workers, continued to work closely with Terry to support him to obtain emergency accommodation, and Terry has formed a good relationship with his key worker. As a result of this contact with Terry and his placement, which provided him with stability and reduced his risk, he was able to form good relationships with Andrew and completed a cognitive assessment, which indicated impairments. The assessment supported exploration into looking at appointeeship for Terry's finances to avoid him being exploited, reducing his risk. Crucially, throughout this working with other professionals and agencies from the initial assessment stage, Andrew valued the input and different perspectives of other professionals to determine the best route forwards for Terry.

30. ***Where possible, be co-located and embedded within the multidisciplinary team. If this is unavailable, think of how you can access the network of services working with these groups that do offer multiple disciplines. If a care co-ordinator or someone in a similar role is not involved, consider working in ways that ensure all of a person's needs are met.***

Vignette 1

Noting a high prevalence of Autism within the homeless population, a local homelessness team, supported by Liam, actively sought out and made arrangements with a local Autism service to provide consultation for staff working with people experiencing homelessness who may be autistic. Having access to this support meant that they could further their understanding about service users they suspected may have autism and consult with the specialist about how best to engage with those service users.

Vignette 2

In Andrew's role in outreach, he takes on roles Clinical Psychologists in mainstream services may not, depending on the service user's needs and needs of the service and partnership organisations. He works flexibly within their multidisciplinary team comprised of Social Workers, Occupational Therapists, Consultant Psychiatrist, Community Mental Health Nurse and Psychology, often writing supporting letters or helping staff members to deliver items to people if other staff are not available. Working in an integrated team helps Andrew to work closely with other professionals in resolving issues around social care, such as an individual struggling to access benefits.

Individual therapy

27. ***Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse). Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g. motivational interventions) that can help people work towards their goals e.g. make changes to substance use and engaging with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g. NICE guidance for dual diagnosis and substance misuse) that can support this work.***

Vignette 1

Roger began meeting with Matilda for support with anxiety. When he initially attended appointments, he would often turn up intoxicated. Unlike other services, Matilda did not turn Roger away – instead Matilda would speak with Roger, agree a shorter session length and discuss whether he could attend the next appointment slightly less intoxicated or alternatively, whether they could schedule the appointment slightly earlier in the day when he may have consumed less alcohol. Taking the practical step of changing the time Matilda and Roger met helped to reduce his alcohol intake, meaning he was more able to explore some of his anxieties during the appointment. This helped him to recognise that he was drinking before appointments to help to reduce his anxiety as he was scared of what may come up in appointments. Over time, Roger's alcohol intake reduced, and he was slowly able to come into contact with his own feelings and early life experiences without feeling the need to overcompensate as frequently.

*Vignette 2**

When Erin first met with Megan, Megan was drunk all the time. Initially, Erin did not put many boundaries in place, as she felt that Megan would not engage with Psychology if she did. Instead, she offered a space for her to think about how she was coping. After meeting a few times, Erin spoke with Megan about how she was coping with their distress. Erin began to reinforce times Megan drank less, highlighting the improvement in the sessions. Highlighting this to Megan meant Megan began to recognise the value of the appointments and continued to decrease her alcohol intake. Erin emphasised the importance of considering the approach taken on an individual basis, as some coping mechanisms can be dangerous, e.g. using drugs with the potential risk of overdose. To manage this, Erin adapted therapy with Megan to focus more on stabilising her mood, thinking about what could help her to become more stable in both a practical and emotional way.

* I think this vignette is very similar to the one above. Perhaps a different example of the flexibility in approach would be helpful.

20. ***Working with the pre-contemplation stage is critical - you have to work with where the person is at regarding their sense of self, motivation, and values. It is important that Maslow's hierarchy of needs does not influence whether you offer psychological interventions. Service users may also need time to understand how this support can be helpful for them, as they may have had limited experience of these approaches. ****

Vignette 1

Neil has found demonstrating to service users how your contribution can be helpful is often important in encouraging engagement. He explains that, if a service user does not have a roof over their head, the fact they may have some difficulties with memory may be of interest to you as a professional but exploring this may not be a priority for them. However, if you translate some of their difficulties into something that is meaningful to them – for example, if they may struggle to remember where they put the application form for something or where they put the number for a housing organisation, this can help them to see why you might be helpful to them. Making your contribution into something meaningful which someone can understand the impact of can help to bridge the goal-discrepancy you may find yourself in.

Vignette 2

Owen visits somebody straight after they have been released from prison homeless, using an assertive outreach model. Doing so helps them to become a familiar face. He considers this to be part of the 'pre-treatment' and 'pre-engagement' phase.

* I'm not sure about privileging this model. Could you say something like "it is important to find ways to offer psychological support, even when there are other pressing self-care and support needs"?

19. ***Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies. It is important to recognise that you may retraumatise them during interventions so you need to pace the sessions carefully, allowing the service user to control what is discussed.***

Vignette 1

Elaine has experienced the engagement process taking months or years before a service user feels safe to engage. Adrian had been street homeless for 25 years before moving into the hostel Elaine worked in. Throughout his time living on the streets, he had refused to engage formally with Psychology. However, he was happy for Elaine to make him a cup of tea every week and have a brief informal conversation with him. Slowly, over a period of months, moving at Adrian's pace, they moved from the canteen area with their cup of tea to the courtyard, and then into a room to have their cup of tea. Though Elaine's conversations with Adrian never lasted longer than 20 minutes, by the end of their work together they had shared around 95 cups of tea and have completed work around Adrian's voice hearing and delusional beliefs. This example highlights the importance of moving at the service user's pace, using creative non-traditional means, in a way they feel comfortable to allow them to come into contact with Psychology at a pace they feel comfortable with.

Vignette 2

Providing a space for Judith to feel safe in beginning to think psychologically was a key consideration for Matilda. The hostel was running a group which staff felt it might be helpful for Judith to attend. However, Judith found this quite anxiety provoking, as she had been used to providing care for others and may struggle to be in a care-receiving role as the member of a group. Therefore, Matilda asked if Judith would co-facilitate the group with them so that she could maintain a more comfortable care-giving role, whilst also being present in the room to start to learn about these tools herself. By attending this group, Judith recognised that some aspects of what the group were learning may be useful for her to put into practice. Offering Judith this role in co-production meant she could keep the power and control what she wanted to discuss, feel valued and engage at her own pace, helping to avoid retraumatising Judith.

18. ***Consider screening for cognitive and neurological problems. Assessments should consider asking clients about learning problems, previous head injury and other trauma. Including cognitive difficulties such as brain injury and intellectual disability in formulations can support understanding, as these can contribute to the breakdown of placements, and impact on social and day to day functioning. Consider how therapy may need to be adapted in relation to difficulties identified.***

Vignette 1

Steve was living in a hostel and had been aggressive towards staff members. He also had a number of physical health difficulties and had a history of non-engagement with services. Hannah reviewed Steve's history and case notes and saw that he had completed a memory screening assessment at a local hospital. The outcome of the assessment summarised that he was cognitively intact – however, Hannah reviewed the assessment scores and identified that he was quite impaired, with scores indicating that he may have dementia. Exploring this resulted in a greater understanding of Steve's behaviour and previous difficulties engaging with services. Though it took two years to obtain the support required for Steve, Hannah and staff at the hotel were able to understand what may be contributing to some of his behavioural difficulties, meaning they were able to adapt their practice to Steve e.g. by recognising that he may not remember information that they tell him. Future cases benefitted from this learning with Steve as they were able to contact the local authority for support as they had for Steve, which in one case resulted in an individual receiving support relating to their brain injury within two weeks.

Please feel free to provide an example you think encompasses this guideline:

Stanislav was street homeless and had been banned from the local housing office for being aggressive. On assessment Jada found that Stanislav had had many head injuries, several episodes of losing consciousness and hospital admissions in child and adulthood. A neuropsychological assessment found that whilst his memory and attention were good, his ability to control his thoughts and feelings and understand consequences for his actions in the moment were extremely impaired. With consent this was shared with the Local Authority Housing Team, the Housing Manager attended a conference to find out more about acquired brain injury and Stanislav's priority need for housing was raised. He was then accepted into supported accommodation. Jada worked with Stanislav on predicting, minimising and coping with triggers for his aggression.

James, a brain injury case worker helped to mediate between Julie, a brain injured woman and her partner, meeting on neutral ground at following a breakdown of their increasingly volatile relationship. This had left Julie unable to afford to stay in her privately rented home and placed her at risk of homelessness unless she remained with her ex-partner. She also had a young child with a chronic medical condition. James was instrumental in providing education about brain injury and emotional support to both parties and facilitating access to legal advice. Extensive liaison was undertaken with the Council, Social Services and other family support agencies, ensuring the impact of the brain injury was taken into consideration at all stages.

- Hospital admission of entrenched rough sleeper enabled cognitive screening.
- Scored lower than anticipated, which warranted further cognitive assessment and MRI scan.
- This enabled better understanding of his support needs and strengths (providing opportunity to apply for suitable supported accommodation/support package; indirect work with support staff about how best to communicate and effectively support).
- Also, enabled more comprehensive formulation of his behaviours (e.g. disinhibition, impulsivity, and aggression), which had been attributed to substance use, mental health or ‘bad behaviour’. Opportunity to recognise direct impact of past injury, as well as frustration with comprehension and functioning, and dealing with loses and their life situation.

Throughout his adult life Jim had lived in various residential settings, he was found to struggle with self-care and independent living tasks. The hostel team where he current was living, found that he struggled to express himself and communication was a real issue. Jim would easily become frustrated or retreated and hide in his room. He was also vulnerable to exploitation from others. The hostel team had attempted to refer Jim to learning disability services for additional support, consideration over appropriate accommodation and for specialist mental health input, but these had continually been declined. The in-house Psychologist in his latest placement was slowly able to build trust and support Jim in completing some initial screening and assessment to explore his intellectual functioning, social functioning and current needs. He was felt to have learning disability or development disorder prior more in-depth formal neuropsychological assessment being completed as he had a history of attending a special needs school, had no formal qualifications, has observable intellectual and social impairment, expression and communication difficulties and difficulties with basic activities of daily living (e.g. unprompted self-care, ability to cook, clean or use a washing machine, struggles to pick up tasks when supported to completed them, unable to complete complex or multi-staged tasks). He had very basic reading skills, poor written skills but was able to tell the time. As a result of this initial screening Jim was accepted by the Mental

Health learning Disability team for some further assessment and specialist input around his complex trauma. This then subsequently led to an Adult Social Care assessment and referral to more suitable sheltered housing for people with intellectual disability outside the rough sleeper pathway.

Steve had been living in hostel accommodation for years but would often be evicted for impulsive behaviour that threatened others and spend time on the street. He appeared to have very little control over his responses when triggered and had certain problems with memory too that the accommodation staff had noticed. I did an assessment with Steve (over a number of sessions) to find out more about his history and carry out some neuropsychological tests. It emerged that Steve had had a serious head injury a number of years ago. I was able to bring together information from the GP, hospital (post injury) and from the assessment to refer Steve for a specialist neuropsychological assessment. I also wrote a report outlining the specific cognitive difficulties that Steve faced and how these affected his functioning, capacity to engage with services and capacity to live in shared accommodation. This was used to advocate for Steve to have more appropriate accommodation alongside support, which was much more sustainable for him in the long-term.

22. *It is important that goal setting is done collaboratively.*

Vignette 1

Oliver explained that when working with Sam, though they initially developed goals together, as they built trust and began to explore more of Sam's past, they built more of an understanding of what had led Sam to this point. Supporting Sam to re-address the balance of power and his value system in relation to his current difficulties resulted in Oliver and Sam reviewing and amending the goals of their work in line with Sam's new aims of wanting to re-connect with his family.

Please feel free to provide an example you think encompasses this guideline:

- Psychologist started working with someone during a hospital admission, after a period of rough sleeping (following significant losses, substance use and presentation of psychosis)
- As this man began to make a positive recovery, he started discussing returning to work in a responsible and stressful position. Also wanted to move into independent accommodation. And to take on a therapeutic role to others.
- Whilst the psychologist recognised that this man was intelligent and achieved a lot in his past, he (and wider team) were concerned that he was rushing into roles and that some expectations may be unrealistic or risk relapse in mental health.
- Psychologist continued to meet weekly in supported accommodation and tried to be flexible to needs, they experienced frustrations and new issues in therapeutic relationship.
- Began to be more client led in working towards goals and he went on to move into independent accommodation, return to an influential working role, and remains an advocate for mental health and supporting others,

Jenny had a long history of complex trauma, had experienced domestic violence, had two children taken into care from birth, a long history of unstable housing and rough sleeping. Jenny was used to using a combination of drugs and alcohol to manage these experiences. Jenny had struggled to regularly make key work meetings, substance misuse appointments, stabilise on a methadone script or sit with the visiting psychologist more than fleetingly or in crisis. In a moment of crisis around the approaching anniversary of one of her children being taken into care Jenny asked to go to detox and rehab. The team were concerned about her repeated failed attempts before, at this experience and not having developed alternative coping strategies or being ready potentially further entrenching her difficulties, were cautious in both working with Jenny to support her goals and desires, while working to be realistic and thing how she could work towards detox and rehab in a more consistent and planned way. Jenny understood about this and began attending pre-detox groups, meeting more regularly with her substance use worker and the psychologist to think about what would support her in her readiness for not using substances. This collaborative goal led to more stable approach to substance use treatment this time round for Jenny and helped her achieve her goals.

14. *Formulation is key and sometimes the most basic are the best. Sharing it collaboratively is essential, helping the individual to feel valued, making them more than just a 'label'.*

Vignette 1

Hannah carefully considers whether to share the formulation directly with service users. Though Hannah acknowledges completing a good assessment and formulation to produce goals is critical, sharing this can be overwhelming. Therefore, she applies caution when putting things in writing and/or drawing things out, as she has found it can impact service users in unexpected ways. Consequently, she uses clinical judgement and/or where possible, is led by conversations with the service users about whether to formally share their formulation.

Please feel free to provide an example you think encompasses this guideline:

Tom was a man in his late-40s who had moved between various hostel placements and rough sleeping for nearly two decades. He had a history of complex trauma from childhood as a result of physical abuse from frightening caregivers. He was alcohol dependent, had a long history of self-harm, suicide attempts and had served a custodial sentence for violence and destruction of property. Due to his aggressive behaviour Tom had struggled to sustain a hostel placement for more than a few weeks and was also a frequent attender at Accident and Emergency (A&E). When Tom moved into the Psychologically Informed Environment hostel, the hostel team and in-house clinical psychologist developed a formulation in reflective practice and through conversations with Tom that recognised how anxious and threatened he felt in everyday situations. His fear and anxiety had a pattern of resulting in either aggressive behaviour or chest pains and the belief he was having a heart attack and needed an ambulance. Once the staff realised that Tom’s aggression was the result of anxiety and fear, rather than violent intent, it became easier to understand and support him. They felt less scared of interactions with Tom and started to be more explicit about telling him they cared about him and wanted him to stay at the hostel.

To help him with his panic the whole team were trained in and practised breathing exercises with Tom, averting the need to call an ambulance. After Tom stabilised in accommodation it was possible to continue with individual therapy sessions and see a development in his ability to recognise, label and manage his emotions.

I found that a lot of the people within this population had been given a label of ‘EUPD’ but with little understanding of what this meant. I would use formulation to develop a shared understanding of what this label actually means in terms of the client’s experience – contextualising the symptoms and how these can also be understood in relation to other models (trauma, attachment, social inequalities, gender etc.). Making meaning of the person’s experience and decontextualizing shame was often key.

15. ***Trauma is highly prevalent in this population (both historic and current/repeated patterns of trauma). Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.***

Vignette 1

Creating a setting where someone feels safe to talk to you is important in facilitating engagement and trust and, for Elaine, that is rarely in a traditional therapy room. Elaine explained that in direct work she uses a lot of 'walking therapy'. She has found this to be particularly effective if someone has experienced significant and possibly repetitive traumas, meaning they find it too distressing to engage in direct face to face therapy. Going for a walk with someone side by side changes the power dynamic, making the appointment less threatening, encouraging a conversation.

Vignette 2

Peeling back the layers can take a long time to explore the impact of trauma on a service user's presentation. Bill had been sofa surfing for several was referred to Elaine for support with psychosis and anger management. Elaine said staff working with Bill felt his psychosis was his primary difficulty. However, Elaine began to consider the Power Threat Meaning Framework, resulting in her reflecting on Bill's presentation being a possible trauma response. This prompted Elaine to ask Bill about his early life. As Elaine had taken the time to build up a safe and trusting relationship, Bill disclosed that that he had been sexually abused by his father's employer when he was a child. This changed Elaine's approach and intervention away from exploring anger management and psychosis, to using Eye Movement Desensitization and Reprocessing for his trauma, resulting in his psychotic symptoms disappearing. Elaine re-formulated that Bill had experienced a Complex Post-Traumatic Stress response. She attributes this reformulation to thinking beyond the initial reason for referral, alongside keeping up with new developments in the field. Importantly, she also waited until the appropriate time in the relationship, after enough safety and trust had been established to explore this with Bill.

23. ***Make use of integrated models of psychology, paying attention to attachment and theories of motivation.***

Vignette 1

Working integratively, drawing together multiple models and formulating each person based on what they need is central to Elaine approach. Elaine has found Cognitive Analytical Therapy can be helpful for reflective practice with the service user at the start, Cognitive Behavioural Therapy can be useful to support understanding and interventions, and attachment theory is often key. For example, one young person was initially offered Cognitive Behaviour Therapy for anger management, however exploration with the service user resulted in identifying that much of their anger originated from issues relating to attachment. Elaine changed her approach to focus more on attachment, which led to uncovering a significant level of trauma, leading to using Eye Movement Desensitization and Reprocessing therapy. They then completed the work using Acceptance and Commitment Therapy, working towards the service users goals by identifying their values.

Please feel free to provide an example you think encompasses this guideline:

David has found the value in formulating Psychodynamically, recognising and respecting psychological defences, what might be split off and utilising the meaning within the transference and countertransference to make sense of someone's experience. David has found that this can be integrated into a variety of treatment approaches such as mentalization or attachment-informed models, motivational interviewing, CBT and CFT, where things such as trauma responses, interpersonal patterns of relating, self-destructive behaviours, 'stuckness' or de-motivated can be explored.

25. ***Consider what model fits the person, how to adapt it based on their current circumstances (e.g. briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work).***

Vignette 1

Using clinical judgement and thinking to review and evaluate what she is doing is crucial in Hannah's work in homelessness services, including considering the number and pace of sessions. Hannah recognises that the number of sessions a Clinical Psychologist can offer can be an area of difficulty, as services are commissioned based on the number of sessions. However, considering individual differences within this population is critical – when working in a GP practice, Hannah said one service user received 16 sessions with good outcomes, whilst another had three years-worth of contact. Hannah feels it is important to have a strong rationale from the beginning of the work for decision making, to be able to justify the work. Support from the wider team from the start can also help.

Vignette 2

Tim explains that in other services, you may take two sessions to complete neuropsychological assessments. However, when adopting a similar approach with this population, it could take multiple appointments to get to a position where an individual feels able to trust you and engage with the assessment process. This may also be impacted on by the location of the individual e.g. if they are in a busy hostel environment, then they may not be able to concentrate for as long or there may be fewer rooms available to complete the assessment.

Vignette 3

Adapting models and materials to fit the service user's needs is an everyday consideration for Elaine. Alongside working flexibly with the number of appointments, she explains that many service users do not have a high level of literacy or English as a first language, meaning you may not be able to use lots of the materials and resources you normally would. Each needs to be adapted to fit the person and to make them accessible. She highlights the importance of also being mindful of translations and the cultural context of psychological models, as many models are predicated on Western ideas of mental illness. For example, the individual may have no concept of thoughts and mental illness and instead may think that they are possessed by spirits.

24. ***Approaches to direct work should seek to apply the frameworks of Trauma-informed and Psychologically Informed Environments (PIEs) where possible, encompassing all elements that come with this (e.g. building relationships, helping people connect and feel empowered, value-based, recognise the impact of trauma on an individual and avoiding re-traumatisation).***

Vignette 1

Oliver approaches his initial assessments using a trauma-informed approach. His aim is for the person to come out of the assessment and want to see him again if they want to and if it is appropriate for them to. Instead of screening for information like other services, Oliver sees the assessments as creating a dialogue to explore what the person may find helpful.

Vignette 2

Tim formulates right from the start of the work the possible traumas an individual may have experienced during their life and possible impact of psychological work on retraumatising them. For example, if he meets a woman who he knows has been engaging in street working and may have been abused by men, then Tim considers the potential impact of his gender on the individual. Tim highlights the need for Clinical Psychologists to consider and hold in mind a range of issues prior to meeting a service user and be mindful of how these may impact the service user, as trauma may still be active. Doing so can help you to build trust with the individual and form a strong attachment with them, which may enable you to explore any trauma(s) they may have experienced and mitigate the risk of re-traumatising them.

13. ***Endings are just as important as beginnings. Actively paying attention to and working jointly with staff and service users e.g. by devising care plans at the beginning of the work for the end of the work, can help work through feelings of rejection and service withdrawal users may experience.***

Vignette 1

Within Matilda's service, a Clinical Psychologist will attend a pre-admission meeting prior to a person moving into the hostel. The service user, their key worker and the manager attend these appointments. Matilda finds the meeting helpful as she can complete a mini assessment of the person's needs and explore whether they may want to engage in Psychology. During this meeting, they consider the move in as well as the move on process, discussing where an appropriate referral onwards may be once their stay at the hostel ends.

Please feel free to provide an example you think encompasses this guideline:

Rosa is aware that services are a stepping stone in the life of a service user or carer and that the ability to sustain a healthy life comes from being connected to multiple preferred communities and activities. Therefore Rosa works with service users, carers and staff to consider the past, present and future and helps service users and carers link with people and places that are not time limited and transitions out of work in a time graded way.

The duration of work with homeless clients can vary depending on the setting, but generally flexibility around this and the ability to offer slower longer pieces of work is of real value. Nonetheless, Lucy recognises that it is vital to attend to the ending from the start of the work and has seen how this can get avoided due to feelings of guilt, abandonment, there always being more work to be done or feeling you are the main stable attachment figure for someone. She has found that it can be the clients with the greatest dependency needs or with repeated losses and abandonments, that clinician's and staff teams may feel it is hardest to end the work with and this can be avoided or unconsciously acted out (e.g. somehow forgetting to give extended notice and count down towards breaks, leave, endings; finding reasons to continue the work; repeated crises which mean it never feels the right time to end, but which could also inadvertently reinforce crises for people). This all needs careful formulation, reflection around boundaries, self-monitoring and supervision. Sometimes breaking work down into bitesize chunks, prioritising with the client, considering the next steps and any onwards referrals you may be working towards from the start, regular reviews and re-contraction as needed.

Feedback for direct working guidelines:

Really nice. I think they are spot-on for this work, very helpful and the vignette examples will be very helpful to give people a sense of the work. I look forward to sharing this with my team.

These look great and the vignettes really help to bring meaning to them. I can see the, being really helpful to psychologists working in this area.

Indirect working guidelines

Relationships and support for staff

4. The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them.

Vignette 1

Providing emotional and psychological safety is crucial to how Oliver views his role in hostels. Oliver does this by finding a space where staff feel they are able to express their opinions, attitudes, frustration, anger, and sadness, in a way which is helpful for them, the wider team and residents. In Oliver's experience this can be through a range of support mechanisms including training, team, and individual reflective practice or through interventions at a management level. Oliver finds that creating this safety often leads to increased creativity within staff teams.

Vignette 2

When Hannah began working in a local hostel, she recognised there was a significant amount of suspicion from staff members. Time was limited in the hostel, as Hannah was only able to work one day per week across three separate hostels. To manage this, Hannah was flexible in what she offered the staff, making suggestions to the team regarding teaching and training based on what had come up in her conversations with them. Working with the staff group, listening to their needs and being flexible helped Hannah tailor the support she offered to the team.

10. ***Build relationships and partnerships with staff who are key to much of what we do. Emphasise good practice, consider evolution not revolution.***

Vignette 1

Following a critical incident, staff were offered a debrief session with Elaine, which developed into ongoing reflective practice group for staff members to discuss learning taken from the incident and the team bringing other cases to discuss. Allowing this group to evolve into something the staff found helpful increased its acceptability as is indicated by the fact it has never been cancelled.

Vignette 2

When Matilda was recruited by local commissioners, one aspect of her work was to implement a Psychologically Informed Environment in a local hostel. Matilda approached this enthusiastically, but, after starting, recognised that the staff may feel implicitly and explicitly criticised, feeling that they had been told by commissioners that they 'needed a psychologist to improve practice'. This experienced highlighted to Matilda the importance of sensitivity when consider how any change in a service starts. Clinical Psychologists should pay close attention to the change management process right from the start. Actively working with the staff team, service and organisation from the beginning can help them own the work, as they will be less likely to experience the work as something that is forced upon them. If this is not completed, there can be resistance within the staff team, service and/or organisation, with people feeling disempowered or encroached upon, feeling criticised or undermined.

15. ***Think about your language and how you explain things in a way to staff that is accessible, interesting, and more than just common sense. Doing so will help to prevent staff feeling disempowered.***

Vignette 1

Erin has found applying psychological frameworks staff are familiar with, such as attachment theory, can help staff to understand why their service users are responding in a certain way e.g. if they have an insecure attachment, they may be quite avoidant or dependent on staff. Using this framework has been helpful and easy for staff to understand, as many have nursing or social work backgrounds and therefore have some knowledge and understanding of attachment theory. Using a familiar model means staff do not feel that they are learning something new, which helps them to feel more competent in their role.

Please feel free to provide an example you think encompasses this guideline:

Bessie routinely asks staff first what their understanding of a situation is to honour and learn from their knowledge, skill and experience. Where appropriate Bessie relates what she has heard from staff to psychological theory and models and / or adds to what has been said to share her understandings with staff. Staff then consider what actions they may take on the basis of the shared understandings.

Staff have found a Mentalization-based approach really empowering and helpful in understanding of their own and clients behaviour and supporting them in their everyday work, key working and team functioning. Although, the term 'Mentalization' seemed a little unfriendly at first, the services quickly found great value and made use of the approach - recognising when their own and client's mentalizing may be getting shut-down and how to bring down arousal levels by stimulating their ability to mentalize. There has been huge demand for this training across services and it has been taken up and applied by domestic, admin and management staff as well as front line support workers.

5. ***Be mindful of the stress and pressures that staff (e.g. outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be. Meet staff where they are at considering what they would find helpful, as staff may not have the supervision and training that we would like them to have.***

Vignette 1

Oliver acknowledges that many individuals are ‘running on empty’ from both a staff and organisational perspective. Within the voluntary sector, they may be chasing contracts to stay afloat and keep the service going. Consequently, Clinical Psychologists may seek to sell what they think is best practice, but this could be perceived as an expert ‘lecturing’ staff on what they should do, which is likely to damage relationships. Acknowledging that many services are just trying to survive is important, alongside managing your own and the staff members’ expectations and anxieties about what you can provide and what a service user needs.

Vignette 2

Erin is mindful in her role that staff working with people experiencing homelessness want to do well and are often eager to learn and develop psychological knowledge to support their work. However, Erin carefully considers the support she can offer as she is conscious that she may appear to be adding to staff members’ workload through additional meetings.

6. *Clinical Psychologists should provide a space for validating workers' emotional reactions/toll of the work and understanding behaviour.*

Vignette 1

Erin is flexible in the way she creates space for staff, as she acknowledges that staff deal with a lot of emotion and trauma on a daily basis, but often have little support for this. Being present in their environment and offering informal chats can help provide a space for workers to think about the work and understand why someone is doing something. Erin also uses this space to signpost to other agencies if needed or help the staff member think about what they are struggling with and provide them with some tools to help manage these difficulties.

Vignette 2

Tim provides therapeutic support for managers and staff from local hostel organisations if they have been identified or identify themselves as struggling. Staff feedback has been positive, and it is being accessed increasingly by the staff teams, with staff absences reducing across the services.

2. ***To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential. Clinical Psychologists should provide training, reflective practice, consultation, consistent team approaches and debriefs.***

Vignette 1

Tim runs reflective groups for all hostel workers and managers from a local housing organisation. He provides monthly group reflective sessions which are organised using a specific structure – they start with a grounding exercise such as mindfulness, move on to a mini training session on a range of topics from brain injury, to the purpose of reflective groups or culture and safety in the work environment. Each reflective group finishes with a practical exercise for staff to complete.

Vignette 2

Shortly after Elaine joined a new service, there was a death in the service. This had a big impact on the staff, particularly the staff member who found the service user. To help staff to manage the possible impact of this event, Elaine offered an initial debriefing session to all staff, and this later evolved into ongoing reflective practice for the staff members. She also completed some individual work with the staff member to provide them with additional support as they were beginning to experience flashbacks. Finally, to support staff in future situations, Elaine also amended the risk assessment and process, and delivered training to all staff on this to support their future practice. Staff feedback indicated that they had found this helpful, and the individual staff member who received additional support had minimal time off work for the incident, indicating they felt supported at work. *

* I think this is a possible boundary issue and we should be careful around boundaries and our role as psychologists in the service. I don't feel we are there as the staff's therapists and if we pick up signs they need additional support they can be signposted to additional support (e.g. GP, counselling, OH, support lines etc that may be provided by their organisation, to see their managers) and this feed back to their managers/organisation to follow-up with additional support as they have a responsibilities as employers and in my experience want and need to be in the loop.

26. ***Develop psychological formulations and understanding of what is happening within teams or organisations and share with organisations in order for organisations to understand how they are influencing the service users and the different levels within the service. This offers space for the organisation to think about what they do.***

Vignette 1

Within one team, though the hostel manager in one project was onboard with utilising a Psychologically Informed Environment approach and accessing support from Oliver, the staff team are more cautious. Formulating this within an organisational context has helped to build an understanding that the staff team have been around for a significant period of time and it was perceived that they had experienced the system as abusive. By understanding why this is happening, Oliver can understand which interventions would work best with the staff team.

Please feel free to provide an example you think encompasses this guideline:*

When starting work with a new staff group or organisation Magda routinely offers seminars on psychologically informed environments and trauma informed care as a starting point for later work on formulation. Whether frontline or 'behind the scenes' each staff member is asked to think about what they do in their role and tasks that encourage shared psychological formulations and contribute to the health of the service user, care, staff and organisation.

* Troublesome individual and troublesome organisation. Parallel process of a traumatised organisation.

Supporting staff to support service users, including building therapeutic skills

17. *Where possible and appropriate, work should be led by service user involvement and feedback. Be creative and flexible in your approach to this, implementing a range of methods to work co-productively e.g. through focus groups, surveys, informal verbal feedback.*

Vignette 1

Tim recruited service users to complete a small evaluation of the effectiveness of their staff reflective practice groups and individual staff support appointments. Service users were paid to complete the evaluation. They constructed the questionnaires and completed one to one interviews, collecting both qualitative and quantitative feedback. Staff valued having service users involved in the evaluation of the service being provided.

Vignette 2

Hannah is leading on a quality improvement project considering how to improve the physical and mental health of those in hostels and how to work with everyone in them, including residents and staff. The project is encouraging co-production by actively involving the residents in a 'experts by experience' group. During one meeting, an expert by experience highlighted that the work being proposed was not a one-person job, and that they may need a team of people to implement this. As a result, Hannah has sought out extra money to recruit individuals to be part of the project, and this has been supported by the commissioners.

20. ***Clinical Psychologists should be involved in ensuring that team screenings and initial needs assessments consider relevant psychosocial factors.***

Please feel free to provide an example you think encompasses this guideline:*

Andrew was engaged as a clinical psychologist to advise on an assessment protocol including formal measures for assessing complex medical and psychosocial needs. This involved facilitating a discussion amongst the wider team and structuring their experiences within a contextual psychological model then considering pros and cons of using standardised measures, exploring the literature for relevant examples. The result was the development of a semi-structured interview, supplemented by three key outcome measures published in previous homelessness research to which were added checklists and rating scales of factors the team felt were relevant but which were not captured by conventional scales.

A small CIC provide six hours of input per week to a hostel. In order to help with care planning and professional integration, they accompany the hostel managers to all their initial screening intake assessments. This enables neuropsychological, social, and environmental needs to be further considered.

* I think the example of psychologist attending a preadmission meeting above (Item 13 V1) is a good example for this.

9. ***Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes which are evaluated. Ensure that consultation is useful to care planning, not only theoretical.***

Please feel free to provide an example you think encompasses this guideline:

With permission, Roisin has adapted Hollingsworth & Johnstone's (2014) Team formulation questionnaire to routinely evaluate the reflective practice she offers. Based on the evaluation reflective practice is refined.

Lucy found that is was valuable to think about how the wide range of needs the clients had could benefit from psychologically-informed input, rather than just the mental health or psychological needs. This included for example - contributing to thinking about what might support someone taking up a bed space for a first time and how to sustain that placement; the experience of someone with a history of sexual abuse being physical touched or being asked to de-robe in a physical health appointment; or recognising that a hostel manager had a responsibility to the wellbeing of all the residents of a property and the need to balance this.

7. ***Clinical Psychologists should assess the service context in which they work, recognising and acknowledging the skills, beliefs, and ways of working already in the system and prioritise these. Work from a position of building capacity by offering what is meaningful and practical for the staff and service, developing existing strengths in staff teams. This may be by sharing knowledge and discussing ideas through reflective groups, providing additional training, formulation, case discussions and consultations. Mentoring for frontline staff should also be considered.***

Vignette 1

Due to minimal Clinical Psychology provision, Elaine has adopted a strengths based, upskilling approach, seeking to empower staff in their role to use psychological knowledge where appropriate, building capacity within the staff team. She does this predominantly through consultancy and open discussion with hostel staff to help them to consider why a service user may be presenting in a certain way. For example, one service user was identified as have difficulties with anger. Elaine helped to normalise this as an understandable reaction to their situation and helped staff to think of times they have been angry and how they have managed this. Encouraging staff to consider how they respond to these feelings themselves helps this become more accessible to staff in moments when psychology is not available and reduces the number of referrals to Psychology from staff. By supporting and upskilling staff, they can often complete much of the work providing appropriate support mechanisms are in place.

Vignette 2

By providing training, formulation sessions and access to a Clinical Psychologist, over time a local hostel team is now able to formulate using psychological knowledge and understanding without needing a Clinical Psychologist present for the duration. Being able to formulate as a team has helped staff in the hostel Matilda supports to understand and contain the distress of several clients within the service without needing to consult a Clinical Psychologist, helping to build understand and capacity within the team.

13. ***Learning and building up therapeutic and practical skills with appropriate supervision, giving people a sense of control and fostering Psychologically- and Trauma-Informed environments.***

Vignette 1

Using case-based sessions has helped Matilda to develop guidelines for ways of working consistently with individual service users. This has helped to develop a consistent team approach across all staff, including those on night shifts. Matilda noted this has worked particularly well with service users who have been self-harming significantly in public areas when staff have been unsure how to respond, resulting in inconsistency of approach, with some staff members reinforcing behaviour without meaning to e.g. providing extra care giving at certain moments may escalate behaviour. Therefore, they think as a team about the individual and consider what they may want to pay attention to, when they should give praise and when they should not.

Please feel free to provide an example you think encompasses this guideline:

Developing a coherent psychological framework for the services with a training programme developing the tools and therapeutic approaches that all staff can be trained and feel confident in. This has been done using Mentalization-Based approaches in some PIE organisations; others have used CBT and DBT or narrative and strength-based approaches to great effect.

11. ***Model and reinforce the skills that you want to develop within systems and staff groups.***

Vignette 1

In Hannah’s supervision with staff, she uses a model of Appreciative Inquiry, asking staff to think about something they have done really well. Hannah noted that though staff may find this hard, when she provides them with the rationale that change can sometimes be really small, they are often able to find something to discuss. Hannah will then link this to instances with residents where staff members are often really trying to get service users to identify something positive that has happened recently, and highlights that practicing it themselves may make it easier to do this with residents. Modelling this during support sessions helps staff to identify these more easily, which then helps them to apply this learning with service users.

Vignette 2

Matilda seeks to impress upon all staff the importance of maintaining self-care and a good work-life balance. She models this to staff by taking regular breaks, going on holidays, and going home on time, believing it is important to ‘practice what you preach’. Matilda also encourages regular supervision for Clinical Psychologists working in the hostels, alongside other staff members, and has supported the implementation of regular reflective practice groups and regular team meetings.

35. ***Remember to tell stories for both direct and indirect work as these can motivate people to work together. People often remember these and will help to draw in multiple agencies.***

Vignette 1

Claire was living in a hostel and had been referred to Annabelle for support with behaviour that staff were experiencing as challenging. After several appointments with Claire and with her consent, Annabelle met with staff separately and shared some of what had been discussed. Doing this helped to provide staff with an understanding and story behind Claire about what had contributed to her current situation and presentation. Following this, Annabelle reported a visible shift in staff members' responses to Claire, as they began to feel more compassionate and connected with Claire. As a result, they began to adapt and change their interactions with Claire in subtle ways.

Vignette 2

Staff at the local hostel had had contact with Guy, who had been placed into emergency accommodation due to a snow alert. During this visit, he assaulted a member of staff and as a result had been excluded onto the streets. The team were concerned about him coming back into the hostel; they were worried that, as he had been unable to contain himself for this short period, it was likely that this may happen again. To explore Guy's background, Matilda asked his key worker to contact someone who had known him a lot longer who may be able to provide some insight into Guy. They were able to provide additional information about Guy's background, establishing that Guy had experienced significant levels of violence when he was younger. This led the team to reframe Guy from being 'aggressive', to hypothesising that Guy's background may mean that he felt continually threatened. Considering Guy's story helped staff and the wider services recognise that Guy may be scared, which reduced their anxieties around engaging with Guy. Reducing their anxieties helped staff to change their approach to Guy, implementing a caring and compassionate approach rather than being firm with the boundaries, which helped Guy begin to engage with staff and services.

16. ***In relevant contexts, when there is consent from service users, develop your interventions collaboratively with all staff including those working on shifts at night and domestic workers to promote consistency of approach.***

Vignette 1

Vanya was living in hostel accommodation and had been expressing behaviour staff were finding challenging, which was creating feelings of frustration in the staff team. Annabelle worked with Vanya to explore a safe space where she could express herself outside of the hostel and explore their thoughts and feelings in a safe space with Annabelle in the hostel. It was agreed with Vanya that these discussions could then be transferred into the wider staff support system around them. Using a narrative formulation, staff were then able to understand the reasons behind some of Vanya's behaviours and consider how staff may be perpetuating some of Vanya's behaviour, enabling them to reduce some of the triggers in Vanya's environment. Working collaboratively with Vanya and the staff team, with Vanya's consent, encouraged consistency of approach which helped to reduce Vanya's distress, preventing Vanya from being evicted.

Please feel free to provide an example you think encompasses this guideline:

Ben had lived in many hostels in the past, but the placements had often ended with his eviction after reports of violence or targeting staff. He fought against rules and boundaries that were experienced as meaningless, controlling or rejecting. Ben was particularly sensitive to hostel staff being busy and not immediately available to support him such as when in team meetings, with other residents, on the phone or taking leave. This would be a trigger for outbursts and continually banging on locked doors or meeting rooms. In group reflective practice the team shared experiences of what was working well with Ben and based on their psychological formulation, the team developed staff team approach detailing how to work most effectively. This incorporated an understanding of Ben's outbursts stemming from fears of rejection and abandonment, underpinned by expereince of childhood neglect and growing-up in care. Staff were able to understand Ben's desperation at times when he felt more excluded or neglected and made additional provision to provide reassurance and structure when it was known staff would be unavailable (e.g. lots of warning of keyworker annual leave and who would be his named keyworker cover; offering dedicated time to meet before and after team meetings; praising attempts to wait; being transparent when things could not be completed immediately and agreeing a time when this need could realistically be met). This was very effective and the team quickly became able to reassure and de-escalate Ben, helping him to settled into the hostel, sustain his accommodation and begin to trust in the staff to a greater and greater extent alongside a growing ability to regulate his emotions and manage frustration.

19. ***Contract work as transparently as you can. Ensure all including senior managers are involved, have authorised, and support the work.***

Vignette 1

Sharon was struggling to move into the local hostel accommodation, as staff hypothesised that she may find the environment threatening. Matilda and staff recognised that the move would need to go at Sharon's pace, meaning a hostel space would need to be held for her. Matilda shared the rationale behind this decision with local commissioners to help them to recognise and support the need for the bed to be held for Sharon, meaning it would be vacant for a period of time. Doing so meant the bed remained open until Sharon felt able to stay in the hostel.

Please feel free to provide an example you think encompasses this guideline:

3. ***Demonstrate that services are Trauma-Informed e.g. through staff training, awareness of processes and procedures being Trauma-Informed, providing a space for reflective practice and offering trauma therapy to service users if needed*. *Attending to the emotional impact of the work on colleagues is an important starting point. The work is potentially traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences. Where necessary, Clinical Psychologists can provide sign posting to staff to support services to manage this impact.***

Vignette 1

When delivering training on Trauma-Informed Care, Hannah did not realise that she was inadvertently re-triggering a staff member who had lived experience similar to that of the service users they work with. Hannah had created enough safety within the relationship that the staff member felt able to come and speak to them about the impact of this training on them. Considering this, Hannah holds in mind that staff may potentially have backgrounds involving trauma.

Vignette 2

Owen is mindful of the trauma that all staff engaging with service users may have experienced, and the need to ensure all staff, including receptionists at the local GP practice, are well supported in their roles. A significant amount of Owen's work has been delivering Trauma-Informed Training for staff to help them to understand the impact of trauma on their own and the service users' lives and explore ways to manage this. He also provides a space for reflective practice once per month for all staff to discuss some of the challenges they have faced, though much of the discussion is based on team resilience and exploring how best to avoid engaging in unhelpful dynamics with service users, such as being hostile and rejecting.

32. ***Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.***

Vignette 1

Karl had been living at a local hostel and had been engaging with staff and a Clinical Psychologist, Matilda, to reduce some of his agitation. As this distress decreased, the team noticed that his anxiety was increasing, and he increasingly began to present at A&E as he thought he was having a heart attack. Initially, the team contacted the local GP who completed a physical health check for Karl to show him that he did not have any sign of a heart difficulty and that it may be related to anxiety. Following this, the hostel staff implemented interventions such as breathing and relaxation techniques. They would offer to call him an ambulance when he said he was having a heart attack but would also offer to do some relaxation instead. Over time they noticed Karl was stabilising, but the hostel was still receiving alerts from A&E that Karl was attending. This resulted in the recognition that, whilst the hostel staff had been working towards reducing Karl's anxiety by reinforcing changes such as not calling an ambulance, hospital staff at A&E were reinforcing his attendance by offering him a cup of tea and having a chat with him, whilst completing their routine checks. Considering the wider system and communities in Karl's care and the impact that these were having helped Matilda to recognise that the team approach needed to be shared with other agencies in Karl's care, including the local ambulance and hospital staff. After sharing this, both agreed to complete only the functional checks from now onwards and would positively reinforce Karl returning back to the hostel. This resulted in Karl's contact with emergency services reducing, helped Karl to stabilise further within the accommodation and was able to slowly engage further in his work with Matilda. Not working in a silo and sharing the team formulation with wider services, particularly within such a mobile client group is critical, and helped to change the way the system was reacting and responding to Karl.

33. ***Think about how your indirect work can become part of the system. It is not always about seeking to create an entirely new initiative which has minimal chance of survival. Doing and planning with people and organisations rather than doing to.***

Vignette 1

Matilda works into several different hostels and has found each staff teams reflective practice needs vary. To support uptake within each team, Matilda delivers training on the value of reflective practice and provides the team with examples of what reflective practice may look like. She then co-produces this with the staff so that it fits with the team's needs and wider system. This helps staff to feel empowered and take ownership of the reflective practice group, feeling that they have 'done with' rather than been 'done to'. Consequently, reflective practice groups vary in their focus across different hostels, with some more focused on staff support, wellbeing, and the impact on the work, whilst others focus more on formulating clients and how best to work with them. Matilda acknowledges that a balance of both aspects may be best, but it is important to be mindful of what the team's needs and wants are at the time.

Please feel free to provide an example you think encompasses this guideline:

36. ***Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible. People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the service-user.***

Vignette 1

Working collaboratively with other agencies is critical to Matilda's work in this area, though she notes that the client group can prefer for services and people within these services to function in silos. Despite often having multiple needs, service users may struggle to want professionals to share information and work collaboratively with others. It can be challenging to empower the individual to have trust and feel safe that their information is protected, whilst encouraging them to share openly and think about issues of consent and collaboration. Being transparent with all aspects of the system, including the client, and respecting differences in needs can help to navigate these challenges.

Please feel free to provide an example you think encompasses this guideline:

James was a man in his early 30s with a history of deliberate self-harm and regular suicide attempts. He agreed to engage with Lucy in weekly psychology sessions where they initially focused on risk management, emotion regulation and his alcohol use which increased risk and impulsivity. At their request a workshop was also conducted with the hostel and outreach team on '*understanding and managing deliberate self-harm*'. After a serious suicide attempt the psychologist ensured James was referred and accepted under the care of a CMHT and called a multi-agency case conference (Incl: James, hostel management, keyworker, the PIE Clinical Psychologist, CMHT, probation, and substance misuse services) to develop an integrated care plan managed by the hostel key worker and PIE psychologist. This was a turning point for James and the start of more effective coordinated MDT care.

37. ***Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector. Service level structures such as Psychologically Informed Environments (PIEs) and Trauma-informed Care (TIC) can be really useful to help guide the work, for example by supporting thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work. It cannot just be about individual therapy; we need to be promoting system change. Clinical Psychologists should explore structures such as PIEs and TIC and consider whether the structure or elements of them would be beneficial in guiding work the context they are working in.***

Vignette 1

After winning a contract for a new service, Elaine began thinking about how the service could be psychologically informed right from the start of the project. Consideration was given to what would be needed in terms of staff, training, reflective support, how the building physically looked and a separate research and evaluation component. This also included considerations for the frequency of staff supervision alongside the policies and procedures across the service. Amending the evictions and sanctions policy is a key component of this work, as service users used to receive three letters under their door prior to their eviction. Thus, Elaine is working collaboratively with the service and housing leads to consider different way to make this process more psychologically informed.

Vignette 2

Matilda has supported the implementation of PIEs in several services and this is her key strategy in creating a sense of coherence within and across the projects. The PIE framework has been implemented in several ways, some of which are described below:

- Developing a specific psychological model training framework for all staff who work in the hostels irrespective of role to attend. Providing training in these areas can help staff to use these in both their personal and professional life, which can help them to regulate their own emotions supporting their work with clients alongside their own wellbeing.

- Implementing reflective practice as part of the ongoing supportive practice, including having a staff development and wellbeing function.

- By thinking about how the environment can be empowering and safe, creating spaces of safety and connection.

- By creating operational groups comprised of senior management to consider different aspects of the PIE project (e.g. the physical environment) and how this could be modified.

- Supporting the evaluation of projects through considering how best to collect data, how to analyse and evaluate what the services are going on an ongoing basis.

31. ***Setting up specialist services for homeless people is not sufficient. Inclusivity needs to be promoted within the wider system (e.g. local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.***

Please feel free to provide an example you think encompasses this guideline:*

Bethan works with a Housing Provider to develop and implement their PIE strategy. Bethan and the PIE Strategy Team celebrate the work by publishing a regular newsletter that all service users and staff have the ability to contribute to and they receive this and it is published on the organisation's website.

As highlighted in the case of James above coodrinatoed multi-agency MDT care was vital and in order for this to happen work was completed on the network and referral pathways. The psychologist in contact with the services, worked hard to develop relationships with the network of local services including establishing of a joint referral pathways meeting structure, attending Single Point of Access meetings, offering training to CMHT or Primary Care services on the needs of homeless people, lobbying locally and influencing stakholders on barriers around issues such as dual diagnosis. This was a turning point for James and the start of more effective coordinated care when through perseverance and the establishment of joint meeting structure, James' mainstream CMHT referral was finally accepted, after alcohol had proven a barrier for so long.

* Would you like something about REDACTED for here?

34. ***Working to bring different services together and to proactively support the needs of people with multiple complex needs, bridging the gaps between services that service users can fall between, helping to address service exclusion.***

Vignette 1

Being part of a multi-agency task group seeking to help people who are experiencing long term street homelessness into accommodation has provided Oliver with the opportunity to share a psychological understanding of why a service may be struggling. Bringing agencies together can help prevent service users fall between the gaps and prevent exclusion from services and promote understanding of the individual’s circumstances and needs from a psychological perspective.

Vignette 2

Collaboration and encouraging partnership working with multiple agencies is a major part of Matilda’s role. Gaps have been identified between homeless and services and health services, as service users are often excluded from these statutory services due to service design. Therefore, Matilda has been working to support services engage in a piece of work by embedding psychology at the point of need within hostels, supporting access to these services, reducing service exclusion.

25. ***Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.***

Please feel free to provide an example you think encompasses this guideline:

Jamila is part of a group of psychologists who started #HomelessPsychology Twitter chat for anyone interested in using psychological interventions within the field of homelessness. Jamila is supporting the start up of an additional forum for virtual meetings.

When beginning work in this field Jason noted the absence of psychologist groups he could turn to for advice but found by contacting homelessness charities directly that a number had connections to various psychological practitioners. Upon further research he joined the Faculty for Homelessness and Inclusion Health which led in turn to a focus group, conference presentation and email professionals group. By being willing to discuss and offer advice on research this provided a means of enhancing his own service provision and contributing to initiatives nationwide.

Sarah has worked hard to develop a network of local and national psychologist doing similar work, finds time to attend specialist training and networking events and joins in with regular opportunities to connect such as twitter chats (#HomelessPsychology). Her team have also set-up networking meetigns with other psychologist in the region to share the work and find ways to work together on national agendas. Sarah finds this supportive in work that can at times feel isolating and challenging.

Contributing to the evidence base

21. ***Clinical Psychologists should allocate time to research and evaluation. As well as seeking out opportunities to promote and complete research, they should be a source of guidance and expertise for staff, working collaboratively on research and evaluation projects whenever possible, highlighting its value to senior management.***

Please feel free to provide an example you think encompasses this guideline:

Richard worked collaboratively with a local charity in order to offer pro bono advice and training to their staff, and explore how they could better evaluate, promote and improve upon their current service. This led to suggestions for joint working and ultimately to setting up a small scale evaluation project which would be presented to staff and Trustees and used locally to promote their work

Small scale research and service evaluation is as important as larger pieces of research and wider dissemination of the work through articles and conference presentations. The evidence-base is still relatively young and there is great value in sharing evidence-based practice. Continue to measure what you're doing and share that to influence commissioning, service sustainability and expansion.

24. Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community. Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness.

Please feel free to provide an example you think encompasses this guideline:

The psychologists on the team were instrumental in writing up a service evaluation which was published through the BPS, reported at a BPS conference and posted on Researchgate as open access in order to reach a wider readership. The emphasis of the paper was on the rationale, process and learning outcomes for the team in order that it might be useful for colleagues engaged in similar work, improve service quality and help break down barriers to inclusion

Having opportunities to share learning with major national bodies such as NHSE, PHE, MHCLG has enabled us to grow the work, develop a national reputation, support others in using our evidence-base to gaining funding and developing service provision for PIEs that incorporate embedded clinical psychologists.

Feedback for indirect working guidelines:

These are more difficult to appeal across the board due to the variety of ways of working but no less important, and very much enhance the value of having guidelines for indirect as well as direct working, as this is the area clinical psychologists may have unique and potentially greater contributions to make.

Appendix A – Direct working guideline amendments from Round 3

Guideline 2 has been combined with guideline 3:

2. ***Be flexible in your approach for example working hours, implementation of protocols and how and where you engage people: having a person-centred approach, encouraging all opportunities to engage.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				37.5%	62.5%
How you responded in Round 3:					

Comments from Round 3:

- flexibility is important but the risk of being flexible in working hours is that its not always possible - - the res is essential though..
- Need to meet the person where they are at rather than expecting them to come to you.
- Be prepared to meet people outside the clinic base or office, this might entail consideration of how to maintain confidentially if meeting outdoors or in a public setting.
- I prefer this combined version. Interesting comments below about impact on staff rights etc
- I don't like the phrase 'person centred' because it could be interpreted as model specific. 'Hold the person who is homeless at the centre of your work and take a decentred position as psychologist' might be better. Other examples might be not being wedded to outcome measures and psychometrics (because they can scare people off), not giving paperwork in the first few sessions, understanding that completing paperwork can be

traumatising and impractical for someone whose housing situation is precarious, not discharging after 2nd DNA, not calling homework homework and not expecting any homework to be completed, including supportive others (eg hostel staff, outreach team members) to accompany service users to sessions initially to enhance engagement, working outside of a clinic setting, going to where the service user feels comfortable including outside if necessary.

- I’m glad we’ve changed the wording of guideline 1

3. ***Using outreach and in-reach approaches - psychological therapies are taken to the point of need by being accessible and available so that people can reach you by being located in familiar settings and locations, and going out to where homeless people find themselves so you are visible to the homeless community (e.g. hostels, day centres, streets).***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				12.5%	87.5%
How you responded in Round 3:					

Comments from Round 3:

- I would use psychological interventions that covers therapies, therapy should imply the use of an evidenced based model and that isn't what we are always doing.
- Be prepared to meet people outside the clinic base or office, this might entail consideration of how to maintain confidentially if meeting outdoors or in a public setting.
- Good to combine but quite long now and hard to hold on to it all. I wonder if it's a but repetitive. Could it be – ***Using outreach and in-reach approaches - psychological therapies are taken to the point of need by being ~~accessible and available so that people can reach you by being~~ located in familiar settings and locations, and going out to where homeless people find themselves so you are visible to the homeless community (e.g. hostels, day centres, streets).***
- 'the homeless community' **and their support networks** (ie you need to be visible not just in the street and park where people who are homeless are, but also be visible to homeless support staff from a variety of different agencies across the geographical area where you are working) it's not good enough just to drop into a hostel, meet with a person who is staying there and then disappear, liaison with the staff team supporting is also crucial.

- Agree with everything in this but some overlap with the last one and quite lengthy.

Guideline 8 has been combined with elements of guideline 25 to reduce overlap in line with participant comments:

8. ***Prioritise relationship building and be flexible. Do not expect the work to follow a pre-determined route. Things may throw you off the way and it is important to journey alongside someone***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				25%	75%
How you responded in Round 3:					

Comments from Round 3:

- Probably best to re-word. “***Prioritise relationship building and be flexible. Do not expect the work to follow a pre-determined or any ‘manualised therapy’ route. Life events will get in the way (i.e. moving accommodation, becoming street homeless, physical health concerns) so it is important to journey alongside someone***
- It can take a lot of time to build engagement, as one of our YP’s told me early on, ‘It takes time to trust especially when we have been hurt before’. And many homeless individuals have repeated experiences of being ‘let down’ by the system.
- I think these things have been covered by other guidelines above, but I do also like the positioning of the psychologist ‘alongside’ the service user.
- Really good

25. ***Adaptability, flexibility and creativity are essential, you are unlikely never to be doing manualised treatment. Consider what model fits the person and think of how to adapt it***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				10%	90%
How you responded in Round 2:					

Comments from Round 2:

- Although I would take out the word never – you may be doing manualised treatment for example when I worked in a GP Practice for the homeless for some patients I did use standardised approaches that might be used in any outpatient psychology clinic. Homeless people are not a uniform population in any sense.
- Also covered in flexibility criterion 2 but here it is emphasising what is needed for psychological therapy and that is very relevant here.

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				12.5%	87.5%
How you responded					

in Round 3:

Comments from Round 3:

- Similar to **Guidelines relating to the relationship point 8**
- First part I'd keep and remove end sentence . but this may overlap with other flexibility criteria
- The last sentence isn't well worded, I think you could just take out 'think of' and it would be improved.
- Don't think it should have the word 'never' in it

Guidelines 9 and 11 have been combined due to overlap identified:

9. ***Be mindful of the interaction between trust and attachment. A complex attachment can be formed between you and your client. Use supervision to discuss and reflect on how best to manage the relational dynamic (e.g. rejection or suspicion from the service users). DNA's and re-referrals may be part of the engagement process.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				25%	75%
How you responded in Round 3:					

Comment:

- See my point above
- All do hang together as elements of how disrupted attachment may present
- I'm not sure I like the phrase 'complex attachment' sounds pathologising and actually it's not clear whether this is good or bad or just part of the process. I don't like the phrase 'from the service users'. It also has the unfortunate potential of individualising the process of engagement and laying all the responsibility for this with the service user. This could be mitigated by

changing the language in that sentence and elaborating on the final one which does acknowledge the way our traditional process can be rejecting or excluding. These issues are related to power, and yet we haven't mentioned power at all in this guideline. I've ticked 'is important' because I agree that being mindful of trust and attachment is important and because supervision and using it reflexively is important and I totally agree with the last sentence.

11. Be attentive to your therapeutic relationship and be aware of relevant power dynamics. Reflect on this regularly in supervision, with colleagues and with service users

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				37.5%	62.5%
How you responded in Round 3:					

Comment:

- This is much better than guideline 9 above. If we combine this with no9 we may have a winner!
- Previous one better and caution needed in terms of reflecting with service users themselves, depending on what is helpful for them.

Guideline 13 was amended following participant comments in round 3:

13. ***Pay attention to endings as much as beginnings. Actively doing this with staff and service users such as by devising care plans for the end of the work from the beginning can help to work through the feelings of rejection and withdrawal service users may experience, but these can be powerfully worked through given time.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				12.5%	87.5%
How you responded in Round 3:					

Comments from Round 3:

- Very important – often need to work jointly with those who will be continuing care after your work has finished with them to ensure support continues if necessary.
- Wording still a little clunky. Could it be made more concise
- Agree but I would I would loose the last bit of the last sentence from the word ‘but’ onwards.

Guideline 16 was amended following participant comments in round 3:

16. It is important to *maintain active hope as this is essential in improving outcomes, especially when the individual and others in their system may have lost this. Grounding your formulation in the social/economic/political context and a systems-thinking stance can help contextualise this.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				50%	50%
How you responded in Round 3:					

Comments from Round 3:

- The wider system is important to consider, although often not changeable sadly so it's maybe hope with a touch of realism?
- I think intervention should be non-political; while the socio-economic context is important I don't think it's appropriate to be recommending services should come a particular political stance if that's what's meant by this.
- Better the way this is broken down and written in this way
- I've ticked 'essential' because hope is essential and so is a socio.economic/political perspective. However, these sentences aren't well worded and it's not clear how they are linked. The second sentence is tautological. What about: Many people who are homeless may have lost touch with hope, so it is important to actively maintain it. Communicating hope to the service user and others in their system can be a radical force for change. Use supervision to nurture hope and support you to avoid problem saturated stories about service users. Avoid individualising the problems of the person who is homeless by grounding your work in the sociopolitical context and social/relational history of the person. Individualising and pathologising discourses can counteract hope and agency. Although, these comments are making me question what constitutes a guideline and what does not, so I'm not sure whether the above counts as a guideline. ☺

Guideline 18 has been amended following participant comments in Round 3:

18. ***Be aware of the high prevalence of cognitive and neurological problems and how therapy may need to be adapted. Include cognitive difficulties such as brain injury and intellectual disability in formulations, as these can contribute to the breakdown of placements and impact on social and day to day functioning. Assessments exploring these should be informed by the service user's needs.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				12.5%	87.5%
How you responded in Round 3:					

Comments from Round 3:

- I still think that the high incidence of violence and injury that often starts in childhood and the high rates of substance dependence including prescribed medication means that brain injury whether acquired or born with should be screened for routinely. It's no more intrusive or time consuming than much of what we ask in a psychological assessment.
- Assessments should ask clients about learning problems and previous head injury alongside other trauma.
- Important. I think the last sentence is not needed. '***Assessments exploring these should be informed by the service user's needs.'***
- I think the last sentence should be unnecessary as the service user's needs/wishes should always be informing any assessment. Surely we can take that for granted? I would disagree that this guideline would less to young people. I have assessed many young people who are homeless who have a history of head injuries or where a neurodevelopmental difficulty or intellectual disability is suspected. With the adult population you will have increased likelihood of head injury and alcohol related brain injury. I totally agree with every part of this comment: Screening for brain injury and cognitive difficulties can be key for some people, but not everyone. There needs to be rationale for these assessments. I would suggest the point below is more appropriate. Also don't like 'They' in this (I'm sure taken from a wider

context). I'd adjust wording to say 'cognitive problems' such as brain injury, learning disability.

Guideline 20 has been amended following participant comments in Round 3:

20. ***Working with the pre-contemplation stage is critical, - you have to work with where the person is at regarding their sense of self, motivation, and values. The way you work with a service user should be approached flexibly, be that through 1-2-1 work or alternative, to do the work needed at that time.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				37.5%	62.5%
How you responded in Round 3:					

Comments from Round 3:

- Need to be aware that the person may have limited or little experience of psychological approaches and need time to understand how they may be helpful for them.
- Don't love this point and way its worded. Mixing a few things into the same thing that I think are different. Suggested alternative – ***Working with the pre-contemplation stage is critical, - you have to work with where the person is at regarding their sense of self, motivation, and values.*** ***~~The way you work with a service user should be approached flexibly, be that through 1-2-1 work or alternative, to do the work needed at that time.~~***
- I agree, although there is a grammatical error in the first sentence. And 1-2-1 should be 'one-to-one'. I think it would be worth including the comment 'essential to disregard Maslow's hierarchy of needs when planning psychological interventions' because many psychologists/services allow this to influence whether they will work with someone or not.
- Agree with this but not sure

Guidelines 25 and 26 have been amended per participant comments in guideline 25 and 26. Overlap for guideline 25 with guideline 8 was identified, and part of the guideline has been incorporated into guideline 8. The aspects of guideline 25 have been combined with guideline 26 as per participant comments in guideline 26. Guideline 26 has also been amended based on participant comments for clarity:

has now been modified to suit participant comments:

25. ***Adaptability, flexibility and creativity are essential, you are unlikely never to be doing manualised treatment. Consider what model fits the person and think of how to adapt it***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				10%	90%
How you responded in Round 2:					

Comment:

- Although I would take out the word never – you may be doing manualised treatment for example when I worked in a GP Practice for the homeless for some patients I did use standardised approaches that might be used in any outpatient psychology clinic. Homeless people are not a uniform population in any sense.
- Also covered in flexibility criterion 2 but here it is emphasising what is needed for psychological therapy and that is very relevant here.

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded				12.5%	87.5%

in Round 3:	
How you responded in Round 3:	
Comments from Round 3: • Similar to **Guidelines relating to the relationship point 8** • First part I'd keep and remove end sentence . but this may overlap with other flexibility criteria • The last sentence isn't well worded, I think you could just take out 'think of' and it would be improved. • Don't think it should have the word 'never' in it	

26. ***Think carefully about what your role should be with this person and what adaptations you need to make to your practice.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				40%	60%
How you responded in Round 2:					

Comments from Round 2:

- Duplication of no25 and no 25 is better
- Important to consider the network of professionals, whose role is what, boundaries, who is best placed, how you can help, how has the best relationship, how we adapt our practice to meet the needs of the client (eg briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work)

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:			12.5%	37.5%	50%
How you responded in Round 3:					

Comments from Round 3:

- agree with - *Important to consider the network of professionals, whose role is what, boundaries, who is best placed, how you can help, how has the best relationship, how we adapt our practice to meet the needs of the client (eg briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work)* – helpful elaboration
- I agree with this comment: Important to consider the network of professionals, whose role is what, boundaries, who is best placed, how you can help, how has the best relationship, how we adapt our practice to meet the needs of the client (eg briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work)

Guideline 27 was amended following participant comments in Round 3:

27. ***Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse). Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g. motivational interventions) that can help people to make changes to substance use and engage with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g. NICE guidance for dual diagnosis and substance misuse) that can support this work.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				25%	75%
How you responded in Round 3:					

Comments from Round 3:

- Need to work on the person’s current goals (not yours!) to build alliances to then address other areas such as substance use.
- This guideline also applies to people with brain injury
- Long but all important elements. Could be separated
- I’m wary of mentioning specific NICE guidelines.

Guideline 28 reach consensus following the second round of the Delphi. However, it has been amended to avoid overlap with guideline 26. The guideline prior to amendment for including in the final set of guidelines is below:

28. ***Clear communication, within the boundaries of consent, is key with everybody. Be clear with everyone - the service user and others (e.g. those involved in the person's wider network including family, friends, GP etc.) about the direct work you are completing. This includes: the boundaries, what I am doing, this is why and this is how I have come to understand this person and what we can offer.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:				50%	50%
How you responded in Round 2:					

Comment:

- Guideline: Within the boundaries of consent, communicate regularly with all involved in a person's network including family, friends, GP.
- Boundaries and communication – inherent challenges in the work that can slip due to the nature of the work. Important to keep holding this in mind.

Guideline 30 has been amended following participant comments in round 3 and to avoid overlap with guideline 29. It has also been combined with guideline 33 due to identified overlap:

30. ***Clinical Psychologists should not work in isolation from colleagues in social services, housing and healthcare. They should be part of an integrated team but the make-up will be dependent on the local circumstances. Consider working as a care co-ordinator to work effectively within this system.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				57%	43%
How you responded in Round 3:					

Comments from Round 3:

- I'm not sure if that's a guideline to working as a psychologist in homelessness it related more to how services generally should be set up.
- Overall I think this is essential and I do think we provide care co-ordination. But I am concerned that this will be misread and used as clinical psychologists working in homelessness say that they should all be care co-ordinators and then subsumed under traditional care co-ordination roles. So I would prefer the last sentence to be something like – if a care co-ordinator or someone in a similar role is not involved consider working in ways that ensure all of a person's needs are met. (so not to do it all necessarily but to not ignore some aspect of a person's needs).
- More likely to have better outcomes if work in partnership with other local agencies, although can be challenging if your approach or practice different (e.g. statutory or voluntary agency).
- Vital
- Not sure about using the language of care co-ordination as this carries particular connotations and taken for granted truths. Other than that it looks ok.

- Agree that coordination of services and support is especially important for this client group but unsure about the wording, as think some independence from some statutory services can sometimes make it easier to form the relationship. I would remove the middle sentence.

33. ***Be co-located and embedded within the multidisciplinary team. If an MDT is not available, think how you access the network of services working with these groups offering multiple disciplines.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:			12.5%	25%	62.5%
How you responded in Round 3:					

Comments from Round 3:

- close to point 30 just above and same sentiment
- I don't think you have to be an MDT in the traditional NHS sense. It's more important to work with the team around the person whatever that may look like.
- Vital but perhaps repeats or too close to 30
- This could be improved by defining MDT. In health services we think of it as one thing, in homelessness services it is often used to refer to multi-agency work. I prefer to labour the distinction. Our homelessness sector meeting at which agencies come together to support each other around complex issues relating to services users they are supporting was historically called MDT. We've now changed its name to something which reflects that it is Multi-agency rather than multi-disciplinary.

Guideline 34 has been included as it reached the required consensus level for inclusion. It has been amended following participant comments to provide clarity:

34. *Encourage curiosity.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:			11%	33%	56%
How you responded in Round 2:					

Comment:

- This is too vague – does this mean for other workers, therapist, service-user? I suppose I would normally encourage curiosity in trainees/other junior staff. But not specific to homelessness.
- Guidance rather than a guideline.

PLEASE PROVIDE COMMENT REGARDING SPECIFICITY:

Comments from Round 3:

- As a guideline I think this point is covered elsewhere
- This might already have been covered by formulation or may be added to formulation. For me this means encourage everyone involved, the service users, family, staff including myself to be curious about what has happened to the person and why you are working with them at that point in time.
- Be curious about the other person’s narrative. Give the time and space to tell it, which if traumatic may take longer. Also encourage them to be curious about psychological approaches and how they may help them.
- I didn’t rate it as essential and don’t believe it should be a guideline, you might as well put a lot of other desirable attributes in if it is.
- I did not rate as essential but agree its confusing. I would remove

- I rated this as essential because it I believe it is important always to remain curious and not make assumptions and beware of falling into dominant narratives about service users. But like many of these guidelines it is not something that is specific to working with people who are homeless. We should be enacting curiousity in any therapeutic work. I also agree that on it's own without explanation it is too vague.
- This client group have often experienced a lot of stigma and negative judgement from others (including services and professionals). It's important to come alongside the client from a position of curiosity – validating where they are at and helping them to reflect on the factors impacting on their lives and how they are responding to these.

Appendix B – Indirect working guideline amendments from Round 3

Guideline 3 has been amended following participant comments in round 3:

3. Demonstrate that services are Trauma-Informed. ***Attending to the emotional impact of the work on colleagues is an important starting point. Trauma-Informed Care provides a 'universal precaution' approach which can be used with staff as well as service users. The work is potentially traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:			12.5%	12.5%	75%
How you responded in Round 3:					

Comments from Round 3:

- I'm often torn between using language of trauma-informed and Psychologically informed. TI coming from MH services and PIE coming from a homeless mh work in the UK. Not everyone who is homeless identifies as having experienced trauma which is why I prefer psychologically informed. I'm not sure of the views of other psychologists though, most (any myself) try to say both 'psychologically-aware and trauma-informed services' but even this is imperfect.
- This has to be across the board – so can be through staff training, awareness of processes and procedures being trauma informed, as well as space for reflective practice and ability to offer trauma therapy if needed.
- I agree with the sentiment behind this but a certain amount of resilience is necessary for work in this area, there must be a clear distinction between a service recipient and professional worker – that's not to say you can't transition from one to another but at any one time you can't be both. If staff are traumatised best they have access to separate support services confidentially.
- Long. I would trim. **Demonstrate that services are Trauma-Informed.** ***Attending to the emotional impact of the work on colleagues is an important starting point.*** ***~~Trauma-Informed Care provides a 'universal~~***

~~precaution' approach which can be used with staff as well as service users.~~ The work is potentially traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences.

Guidelines 7, 12 and 14 have been combined based on participant comments and identified overlap. Guidelines 12 and 14 have been removed:

7. ***Clinical Psychologists should assess the service context in which they work, recognising and acknowledging the skills, beliefs, and ways of working already in the system and prioritise these. Offer what is meaningful and practical to the people and services you work with (which maybe reflective groups, case discussions and consultations in order to build capacity).***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:			12.5%		87.5%
How you responded in Round 3:					

Comment:

- Our approach should be an evolution not a revolution – build on existing skills and knowledge that staff have, rather than trying to present something complete new that can be read as undermining and deskilling.
- Nicely combined

12. ***Work from a position of building capacity by sharing knowledge and discussing ideas (e.g. through formulation) and developing existing strengths in staff teams.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				12.5%	87.5%
How you responded in Round 3:					

Comments from Round 3:

- Is there something to be said for – a guideline in the role is to provide training/formulation / reflective practice sessions to support building capacity by sharing knowledge and discussing ideas (e.g. through formulation) and developing existing strengths in staff teams.
- Psychologists are few and expensive – we need to be focused on system change and supporting staff teams to deliver to improve outcomes for more people.
- Helpful. Clear
- I think there is overlap here with guidline 7 above, and they could be rolled together

14. Where appropriate, *Clinical Psychologists should offer support to managers and frontline staff. Mentoring for frontline staff should also be considered.*

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:		12.5%	12.5%	50%	25%
How you responded in Round 3:					

Comment:

- similar to my comment on guideline 12 just above
- I am undecided about this because organisations have responsibility for operational and professional support and I wouldn't want this to be transferred onto clinical psychologists. Also the idea of a clinical psychologist mentoring a front line worker does not sit easily – why can't front line workers mentor each other? I suspect clinical psychologists would not mentor at all and would fall into relating to front line workers as if they were assistants, trainees or less senior psychologists. I think we can suggest coaching and mentoring, but I would be wary of providing it, should be part of an employees personal development plan.
- This has been a key part of my work during the COVID-19 lockdown as many staff have been literally risking their lives coming to work and have been very anxious and distressed at times.
- Not sure of sentence structure but point good. **Where appropriate, *Clinical Psychologists should ~~be involved as far as possible in~~ offer ~~providing~~ support ~~for~~ to managers and frontline staff. Mentoring for frontline staff should also be considered.***
- If we are including the last two guidelines, I don't think this is necessary
- I'm not sure how mentoring would be different from supervision

Guideline 16 has been amended following participant comments in Round 3:

16. ***In relevant contexts, develop your interventions collaboratively with all staff including those working on shifts at night and domestic workers to promote consistency of approach.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				12.5%	87.5%
How you responded in Round 3:					

Comment:

- As long as there is consent from service user if guideline relates to service user specific work. If guideline doesn't related to individuals then I'm wondering if it is covered else where.
- Consistency is key
- Works well in our settings

Guideline 17 has been amended following participant comments in Round 3:

17. ***Where possible and appropriate, indirect work should be led by service user involvement and feedback. Be creative and flexible in your approach to this, implementing a range of methods to work co-productively e.g. through focus groups, surveys, informal verbal feedback.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:			12.5%	12.5%	75%
How you responded in Round 3:					

Comment:

- shelters/icm ‘cause and consequence’ report is a good example of this
- Co-production is key but often takes some effort. Sometimes quality is better than quantity. I have worked with a couple of YP’s who have been really engaged rather than a large group, which has also given them opportunities for development (e.g. presenting at the BPS DCP conference earlier this year) and therefore means they are gaining rewards and skills for their contribution rather than me just ‘taking from them’.
- Not homeless specific. Generic
- Think direct work (such as what groups are run) should also be led by this and so would remove word ‘indirect’

Guideline 21 has been amended following participant comments in Round 3:

21. ***Clinical Psychologists should allocate time to research and evaluation. As well as seeking out opportunities to promote and complete research, they should be a source of guidance and expertise for staff, working collaboratively on research and evaluation projects whenever possible.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:				25%	75%
How you responded in Round 3:					

Comment:

- There is limited research in this area – so collaboration and research is essential, although sadly often seen as an 'after thought' or something you do in your own time. Research and evaluation needs more buy in for it's value (as per a PIE) from senior managers. Also value of using students for projects (e.g. I have recently supervised 2 MSc students to (1) complete a systematic review of youth offending and homelessness to make policy recommendations that our charity will take forward, and (2) a review of our data for 2019, to understand better the needs and profiles of YP's in our services to inform future commissioning. Research needs to therefore be for a purpose and not just academic to get the best buy in?.
- Can be helpful where possible

Guideline 24 was not amended following Round 3:

24. ***Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community. Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in round 3:				12.5%	87.5%
How you responded in Round 3:					

Comments from Round 3:

- v.important
- We need to not only push for sharing of research in national generic psychology forums (e.g. DCP conference) but also get better at creating spaces for psychologists working in homelessness to come together and share best practice more regularly. Is there enough of us for a special interest group in the BPS? Or ACP?
- Im really not keen on 22 being combined. I think 24 was better on its own as representing this point as others have said in their original comments/suggestions

Guideline 37, the newly proposed guideline which merged guidelines 27 – 30 in Round 2, has been amended following participant comments:

NEW GUIDELINE PROPOSED. ***Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector. Service level structures such as Psychologically Informed Environments (PIEs) and Trauma-informed Care can be really useful to help guide the work, for example by supporting thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work. It cannot just be about individual therapy; we need to be promoting system change.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 3:					100%
How you responded in Round 3:					

Comments from Round 3:

- Completely agree!
- Nice guideline. I agree. But I wonder if the points below are also highlighting the benefit of Pie and TIC in and of themselves as valuable/vital for structuring indirect as well as direct work.
- I totally agree but I don’t think this reads like a guideline, it sounds more like an introductory paragraph. I’m not sure that it gives us anything that we don’t already have. I think it’s really important that we don’t shy away from heavily referencing PIE in these guidelines because they are guidelines for psychologists. By definition we should be working in psychologically informed ways and these guidelines should be promoting that.

Appendix C – Guidelines which have been removed due to lack of consensus in Round 2 or 3

Direct guideline identified in Round 2 as not reaching consensus:

32. ***If you are doing direct work with people experiencing homelessness, be employed by the NHS.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:	30%	30%		20%	20%
How you responded in Round 2:					

Comment:

- Arguably some clients prefer to access psychology via charities because of their past negative experiences or rejections from statutory services. NHS also has a lot of specific barriers to resources, which charities can be more flexible about. Arguably the NHS can be worse for employees and homeless populations than voluntary sector.
- There can be benefits to working within NHS systems, but I can't see why people cannot offer psychological interventions from the voluntary/charitable sectors.
- Ideally yes but if not possible, you can still do really important work – strong relationship with NHS is essential thoughx
- I have found this vital in offering containment, clinical governance, working on referral pathways and helping to address some of the difficulties homeless people have had in accessing NHS services historically, particularly mental health services.
- I think being employed by NHS has strengths and also significant challenges…..

Indirect guideline identified in Round 2 as not reaching consensus:

18. ***Creating opportunities to be present or available if you cannot be physically present. Showing a willingness means you can understand challenges in different services if you are not able to be in a service all the time.***

	Not important at all	Not very important	Is neither unimportant or important	Is important	Is essential
How the panel responded in Round 2:	11%		22%	33%	33%
How you responded in Round 2:					

Comment:

- I think this needs to be expanded – does this mean speaking to staff by phone?
- We're not superhuman.
- Not sure what this means?

Appendix N. Final guidelines and vignettes.

Direct working guidelines

Approach

1. ***Be flexible in your approach, holding the person at the centre of your work, encouraging all opportunities to engage. For example, flexibly implementing protocols, moving your working hours to facilitate appointments, and considering how and where you engage people. Use outreach and in-reach approaches, taking psychological interventions to the point of need, going out to where homeless people find themselves so you are visible to the homeless community and their support networks (e.g. hostels, day centres, streets). This may mean meeting outside of the clinic or office base, meeting where service users feel comfortable e.g. meeting in public spaces providing confidentiality can be maintained.***

Vignette 1

Oliver's service is open access with no exclusion criteria to encourage engagement, going to the service user, meeting where they feel comfortable. In Oliver's experience, this often means meeting outside of the clinic environment including visiting hostels, day centres and local GP practices. Being flexible in their working hours also helps to facilitate early morning outreach providing the opportunity to engage with rough sleepers. If a person experiencing homelessness would like to talk to Oliver during this outreach, he will do this in situ, whilst respecting confidentiality and environment they are in, using this as an initial contact to build on.

Vignette 2

Neil casts the referrals net 'far and wide' including local Accident and Emergency Departments who see certain faces on a regular basis and other organisations such as housing, mental and physical health services, the police, and social services. Initial engagement means going out to meet the person where they are at rather than expecting them to come to you. If Neil does not get a response from them initially, he will keep working to get into contact with them and are often creative in the way that he does this e.g. contacting their social worker to find out where they last saw them and to provide an update on the individuals circumstances or visiting a local day centre the person is known to visit. Though flexible in taking their services to the point of need, Neil also ensures that they have implemented good, clear risk protocols for all staff operating outside of standard protocols (e.g. meeting on a canal tow path bench rather than at a clinic) which helps them and other staff members to feel safe in their role.

2. ***Prioritise relationship building as it can take time to build trust and engagement. Do not expect the work to follow a pre-determined or 'manualised therapy' route. Life events will get in the way (i.e. moving accommodation, becoming street homeless, physical health concerns), so it is important to journey alongside someone.***

Vignette 1

Working with this population has led Elaine to recognise the importance of adapting the way you engage with an individual to build the therapeutic relationship. One of Elaine's most successful therapy appointments was using 'rap therapy'. The service user found it too difficult to talk to Elaine, but they would rap about their life and how they were feeling. Using a less traditional method and being open to being creative, using the service users preferred way of communicating helped build the relationship. Being able to have humour and 'rap back' helped reduce the power imbalance as Elaine was not going in from a point of 'expertise' and communicate in a way the service user found helpful.

Vignette 2

Michael was living on the streets when he was referred to Andrew. During their work, Michael moved from the streets to a friend's house, to emergency accommodation and then was admitted to hospital before being discharged and supported into an appropriate hostel setting. Andrew worked with Michael throughout this time and remained involved in his care, meeting with him on a regular basis including on the ward, completing cognitive screenings and additional assessments. Journeying alongside Michael and continuing to be involved in his care irrespective of Michael's circumstances helped Michael to build trust with Andrew and the wider professionals and services, resulting in him being placed in appropriate supported accommodation.

3. ***Attend to the therapeutic relationship, being mindful of the interaction between trust and attachment. Use supervision to discuss and reflect on how best to manage the relational and power dynamics between yourself and the service user. DNA's and re-referrals may be part of the engagement process - reflecting on these with service users can help build understanding and trust with staff and services.***

Please feel free to provide an example you think encompasses this guideline:

Vignette 1

Naomi had been referred to psychology twice before. She had left each time after a couple of sessions when she thought the psychologists were telling her to let go of the past by forgiving the people who had abused her. She did not attend the first session, but responded to a telephone call and had a lengthy conversation which the psychologist Thandie. Having discussed in supervision concern that Naomi would disengage early again, the need for Naomi to be confident that she could lead her therapy was highlighted. Thandie summarised the conversation in a letter both to check they had a shared understanding and to give Naomi something tangible to hold onto. Naomi felt understood and after a few telephone consultations attend sessions reliably in person.

Vignette 2

Jeanne found that reaching women in a high support mixed-gender hostel seemed particularly difficult. Perhaps due to histories of complex and long-running (often ongoing) traumas, difficulties building trust, perceived differences in social class and status, shame and an expectation of being judged and let down by professionals. Jeanne drew on research and input from the women themselves to devise a female centred approach. This included offering female-only groups, women from the hostel acting as co-facilitators and being creative and flexible with engagement approaches (chats over cups of tea, walking therapy). Jeanne found supervision essential for understanding engagement patterns and relational dynamics, where often a period of engagement would be followed by multiple DNAs and it was tricky to find a balance between encouraging continued therapeutic contact vs the woman having enough control over the relationship. Jeanne found the book 'Streetalk' by Pippa Hockton really helpful for understanding the relational patterns that can occur in therapy with very traumatised women.

4. *Consider the likely trauma histories of service users you are working with, appreciating engagement can be a long process, as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc.*

Vignette 1

Tim arranged to meet Craig multiple times over several months to complete a neuropsychological assessment, however, Craig was not there when Tim visited at the agreed times. After several months of arranging to meet, Craig did attend the appointment, explaining he now felt ready to engage with the service. Tim explained that, by making sure he turned up at the time and place that had been agreed even if though Craig had consistently not attended showed that Tim was consistent, reliable, and did not deprioritise him over other tasks. Tim recognised that it is likely persons experiencing homelessness, including Craig, have been let down multiple times in the past in relationships, and during contact with other services, professionals, and providers. Working through this, by being reliable is likely to help build trust and increase the likelihood that a person experiencing homelessness will engage with services.

Vignette 2

Owen had worked with Heather for over a year after she moved into a hostel for women escaping domestic violence. Heather had experienced multiple traumas in her family home as a child and into her adult life with her long-term partner. Whilst working with Owen, Heather had to be rehoused several times as her ex-partner managed to locate her, and also assaulted her on one occasion. Owen had to be mindful that he was not just managing historic trauma, but live trauma. Therefore, it was important that Owen was flexible and provided a safe space for Heather to engage over a long period of time, at her pace.

5. ***Many people who are homeless may have lost touch with hope, so it is important to actively maintain it. Communicating hope to the service user and others in their system can be a radical force for change. Use supervision to nurture hope and support you to avoid problem saturated stories about service users. Avoid individualising the problems of the person who is homeless by accounting for the sociopolitical context and social/relational history of the person. Individualising and pathologising discourses can counteract hope and agency.***

Vignette 1

Oliver uses narrative formulation to help decentre away from one way of thinking. In both direct therapy and indirect working with staff, he considers what has been influential in a person's a life, incorporating the wider social context. Oliver believes this is particularly pertinent with people experiencing homelessness. Telling a story and helping the individual to develop other stories can help the person identify and understand what their values, hopes, dreams and wishes are in relation to their own moral code. This can help to foster engagement and increase motivation for them make the changes that they want to.

Vignette 2

Annabelle maintains active hope by providing service users with an element of choice and control in whether they attend appointments or not, and openly discussing with them what she is thinking of offering. Providing service users with choice, control and collaboration can be a valuable asset as many will not have experienced this before. If a service user chooses not to take up the space offered, Annabelle reiterates that the space will be available to them in the hope that they will take it up when they are ready to use it.

6. *Have a realistic sense of optimism, having a sense of it being worth trying even with a deep level of complexity.*

Vignette 1

Ryan had experienced many traumas from his early years into adulthood. He had been a victim of violence and a perpetrator and had been imprisoned for dealing drugs. He was going through lengthy court actions to regain contact with his children who barely remembered him. In therapy Psychologist Olatunde helped Ryan explore the kind of Father he wanted to be even if he did not have direct contact with his children and signposted Ryan to both legal services and services that could support him to be the best Dad he could be directly or indirectly. By the end of the work Ryan had been allowed to write a letter to his children and was hopeful about future contact.

Vignette 2

Peter was working in an outreach team. The multidisciplinary team (MDT) identified an entrenched rough sleeping man, Jerry, who avoided contact with others. Jerry had an opiate dependency, was not engaging with addictions services, had a chaotic lifestyle and the MDT suspected he had underlying psychosis and possibly a learning disability. Despite Jerrys avoidance, the MDT persisted with offers of support such as help finding accommodation and physical health checks alongside flexible offers of psychology input from Peter over a lengthy period of time, which was characterised by frequent DNA's. Following a hospital admission, Peter was able to visit Jerry which provided the opportunity for him to build a relationship with Jerry. Once Peter had formed a good relationship with Jerry, Jerry agreed to further assessment alongside a transfer from hospital in rehabilitation, and then on to supported accommodation. Whilst Jerry continued his substance use, he engaged in this in a less risky way, and continued to engage with mainstream services.

7. Encourage curiosity in both staff and service users and their wider support network (e.g. family members and staff). Approaching clients with curiosity can help validate their experiences and support them to reflect on factors impacting their lives and explore how they are responding to these. This in turn can encourage them to become curious about psychological approaches and how they may help. Encouraging curiosity can help staff, including Clinical Psychologists, avoid assumptions and falling into dominant narratives relating to homelessness and consider what happened to the person and why they are working with them at this time.

Vignette 1

Once Hannah catches herself as a professional thinking that she knows something in a concrete way, she takes this as an indication that she has stopped being curious and has closed down other narratives. To manage this, Hannah engages in supervision, peer support, continues to read and learn, and is part of a wider community within the field of homelessness.

Vignette 2

When reflecting with services users, carers or staff Halle uses a framework she calls 'thinking in spheres'. This means visualising the multiple contexts people are in within concentric circles that spin, change, ebb and flow over time. So, reflecting on individuals, groups, teams, services, organisations, communities, education, work, leisure, money, local and national politics, spirituality and religion. Halle encourages the person or people she is working with to imagine being in varying positions and view the world from multiple perspectives, sometimes using the 'miracle question'.

8. *Have strong self-awareness and reflective practice, for example through journaling and/or supervision.*

Vignette 1

Acknowledging difficulties and frustrations in this work is crucial to help manage any issues that arise. Neil highlights the need to have good relationships within the team to feel able to discuss any frustration or issues you may be facing, and, where applicable, raise these with the wider system and agencies involved. For example, he described instances where he may be frustrated working with someone because he does not perceive them to be very receptive or very grateful, or because they may agree to do one thing and then do the opposite. Openly discussing and reflecting on these issues with colleagues, and where applicable, other agencies, can help you explore how best to move forwards. Neil emphasises that this is particularly important for less experienced members of the team and when your team may be only one discipline.

Vignette 2

Considering and reflecting on the boundaries you are working within, particularly as there are no guidelines for what is and is not ok, is critical. At times, Andrew knows that at times he may be moving the boundaries too much. He acknowledges that maintaining appropriate boundaries can be hard, as you can be drawn into powerful attachments with the client. To manage this, Andrew draws on reflective practice and having ‘critical friends’ to hold them to account. He highlights that Trainee Clinical Psychologists are vital within the team, as they can provide a different perspective and are more likely to raise issues, providing they are given the support to feel safe enough to do so.

Multi-agency working

9. *Think carefully about what your role should be with this person. Consider the network of professionals, whose role is what, boundaries, who is best placed, who has the best relationship with the service user and how you can help.*

Vignette 1

Ivan had recently moved to the UK, had no consistent work history, had been charged with a public order offence and had recently been assaulted, resulting in a brain injury. He was referred to Neil for a neuropsychological assessment to determine the impact of his brain injury. On meeting Ivan, it became clear that one of the primary difficulties was that Ivan could not speak English; a major barrier to Ivan accessing services as much of the basic information, education and advice was not available to him. Neil contacted an interpreter with experiencing of working in mental health services. The interpreter supported Neil to complete a thorough assessment of Ivan's head injury and provided Ivan with some initial signposting information in his language. Neil also consulted with Social Care to assign a Social Worker who could speak Polish to support him in pursuing housing, and Ivan has since successfully been placed in a local hostel. The neuropsychological assessment results helped Ivan obtain appropriate legal representation as he was recognised as someone who had social issues and the potential psychological implications of this. Neil recognised what his role could be in supporting Ivan by providing a neuropsychological assessment and considered who else could be best placed to optimise support for Ivan.

Vignette 2

Using psychological formulation, Matilda hypothesised with staff that Kay may find the environment of a hostel too anxiety provoking as she had been living on the streets for several years. Rather than offering psychological therapy or another service to support Kay, Matilda and the wider staff team felt it would be most beneficial for Kay's outreach worker to build a relationship with her where she was living at that time. As Kay and her outreach worker built up a relationship, her outreach worker would offer to bring Kay to the hostel for a cup of tea and speak to staff informally. Kay began to accept this offer, would visit the hostel for a cup of tea, and then return to where she was staying. Slowly Kay started to visit the hotel without her outreach worker present, as she began to build trust in the hostel staff and surrounding environment. Throughout this work, Matilda and other Clinical Psychologists in the service supported staff, including the outreach worker, to remain consistent. Being consistent in their approach allowed Kay to feel safe enough over time to begin to stay in the hostel and she has since moved to another hostel full time. Carefully considering who would be best placed to build a relationship with Kay to help her feel safe in engaging with the hostel environment was key to helping her to work towards engaging with the service.

10. ***Clear communication, within the boundaries of consent, is key with everybody. Be clear with everyone - the service user and others (e.g. those involved in the person's wider network including family, friends, GP etc.) about the direct work you are completing.***

Vignette 1

Tim was asked to complete a capacity assessment to explore Jane's decision for her discharge destination from hospital. After attending a case conference, Tim spent several appointments with Jane to explain to her what his role was and what he was going to offer, and to understand and appreciate her history and consider what her needs may be regarding a possible assessment. From taking the time to speak in depth with Jane about her past and choices, it became clear to Tim that Jane did not need an assessment regarding her discharge decision, but instead needed one regarding her treatment and end of life care. Tim feels being impartial in this situation was crucial, considering what he had been asked to do whilst critically considering what Jane was telling him throughout their conversations to determine the outcome. Communicating this to third parties in their role meant Tim had to be clear with what he had been asked to do and provide evidence to support his decision, communicating the findings assertively to others whom may not agree with the decision at the time. Considering this, the focus of the work changed, as did the outcome regarding Jane's care.

Vignette 2

Oliver explained the importance of exploring with the person what they might need whilst making sure that he does not promise anything other than what he can emotionally and/or physically deliver. They use formulation and engagement to discover what he can offer the service user.

11. ***Promote good multi-agency working across professionals especially when working with complexity and risk. Coming together regularly, including with the client, is vital.***

Vignette 1

Angela was behaving in ways that hostel staff were experiencing as challenging. Having left a domestically violent relationship, Angela struggled with authority and would drink alcohol to help her cope. Angela also used to get in to fights with other residents frequently and was close to being evicted due to the increasing risk to others. Erin, the clinical psychologist in the hostel, arranged a meeting with Angela and the hostel manager to think about the situation. Erin explained that they started this meeting by using a strengths-based approach, highlighting things that staff appreciated about Angela, and that they wanted her to stay in the hostel but it was getting to a point where staff and residents did not feel safe. Therefore, they offered Angela the opportunity to think about what she and staff could do to help her to feel less distressed, reduced her risk to others and enable her to stay in the hostel. Coming alongside Angela and jointly discussing risk with her helped her engage. This resulted in Angela and the staff team creating a shared agreement about how she would try to manage her distress in future, and what staff could to do help her. Following this, Angela's risk reduced, she began to engage with her alcohol worker and was able to remain in the hostel.

Vignette 2

Terry was referred to Andrew's team from the local A&E department, as he was a frequent attender, and they began to suspect underlying mental health issues. He was jointly assessed by Andrew and the Consultant Psychiatrist who were able to identify during the initial assessment the extent of his contact with other services, and recognised that he was at relatively high risk, as he was vulnerable to exploitation from others. The team, including social workers, continued to work closely with Terry to support him to obtain emergency accommodation, and Terry has formed a good relationship with his key worker. As a result of this contact with Terry and his placement, which provided him with stability and reduced his risk, he was able to form good relationships with Andrew and completed a cognitive assessment, which indicated impairments. The assessment supported exploration into looking at appointeeship for Terry's finances to avoid him being exploited, reducing his risk. Crucially, throughout this working with other professionals and agencies from the initial assessment stage, Andrew valued the input and different perspectives of other professionals to determine the best route forwards for Terry.

12. ***Where possible, be co-located and embedded within the multidisciplinary team. If this is unavailable, think of how you can access the network of services working with these groups that do offer multiple disciplines. If a care co-ordinator or someone in a similar role is not involved, consider working in ways that ensure all of a person's needs are met.***

Vignette 1

Noting a high prevalence of Autism within the homeless population, a local homelessness team, supported by Liam, actively sought out and made arrangements with a local Autism service to provide consultation for staff working with people experiencing homelessness who may be autistic. Having access to this support meant that they could further their understanding about service users they suspected may have autism and consult with the specialist about how best to engage with those service users.

Vignette 2

In Andrew's role in outreach, he takes on roles Clinical Psychologists in mainstream services may not, depending on the service user's needs and needs of the service and partnership organisations. He works flexibly within their multidisciplinary team comprised of Social Workers, Occupational Therapists, Consultant Psychiatrist, Community Mental Health Nurse and Psychology, often writing supporting letters or helping staff members to deliver items to people if other staff are not available. Working in an integrated team helps Andrew to work closely with other professionals in resolving issues around social care, such as an individual struggling to access benefits.

Individual therapy

13. ***Do not exclude someone from psychological therapy because of their presenting difficulties (including dual diagnosis/substance misuse). Instead adapt your practice to be inclusive and give the best chance to people engaging (including taking on more practical roles as appropriate). Psychologists have valuable skills (e.g. motivational interventions) that can help people work towards their goals e.g. make changes to substance use and engaging with other services. Work creatively to do this and critically consider and where appropriate follow the relevant guidance (e.g. NICE guidance for dual diagnosis and substance misuse) that can support this work.***

Vignette 1

Roger began meeting with Matilda for support with anxiety. When he initially attended appointments, he would often turn up intoxicated. Unlike other services, Matilda did not turn Roger away – instead Matilda would speak with Roger, agree a shorter session length and discuss whether he could attend the next appointment slightly less intoxicated or alternatively, whether they could schedule the appointment slightly earlier in the day when he may have consumed less alcohol. Taking the practical step of changing the time Matilda and Roger met helped to reduce his alcohol intake, meaning he was more able to explore some of his anxieties during the appointment. This helped him to recognise that he was drinking before appointments to help to reduce his anxiety as he was scared of what may come up in appointments. Over time, Roger's alcohol intake reduced, and he was slowly able to come into contact with his own feelings and early life experiences without feeling the need to overcompensate as frequently.

Vignette 2

When Erin first met with Megan, Megan was drunk all the time. Initially, Erin did not put many boundaries in place, as she felt that Megan would not engage with Psychology if she did. Instead, she offered a space for her to think about how she was coping. After meeting a few times, Erin spoke with Megan about how she was coping with their distress. Erin began to reinforce times Megan drank less, highlighting the improvement in the sessions. Highlighting this to Megan meant Megan began to recognise the value of the appointments and continued to decrease her alcohol intake. Erin emphasised the importance of considering the approach taken on an individual basis, as some coping mechanisms can be dangerous, e.g. using drugs with the potential risk of overdose. To manage this, Erin adapted therapy with Megan to focus more on stabilising her mood, thinking about what could help her to become more stable in both a practical and emotional way.

14. Working with the pre-contemplation stage is critical - you have to work with where the person is at regarding their sense of self, motivation, and values. It is important that Maslow's hierarchy of needs does not influence whether you offer psychological interventions. Service users may also need time to understand how this support can be helpful for them, as they may have had limited experience of these approaches.

Vignette 1

Neil has found demonstrating to service users how your contribution can be helpful is often important in encouraging engagement. He explains that, if a service user does not have a roof over their head, the fact they may have some difficulties with memory may be of interest to you as a professional but exploring this may not be a priority for them. However, if you translate some of their difficulties into something that is meaningful to them – for example, if they may struggle to remember where they put the application form for something or where they put the number for a housing organisation, this can help them to see why you might be helpful to them. Making your contribution into something meaningful which someone can understand the impact of can help to bridge the goal-discrepancy you may find yourself in.

Vignette 2

Owen visits somebody straight after they have been released from prison homeless, using an assertive outreach model. Doing so helps them to become a familiar face. He considers this to be part of the 'pre-treatment' and 'pre-engagement' phase.

15. *Follow a graded model of care that includes flexibility and creativity and allows people to come into contact and take support at their own pace, starting with informal engagement but includes an offer of group and individual formal psychological therapies. It is important to recognise that you may retraumatise them during interventions so you need to pace the sessions carefully, allowing the service user to control what is discussed.*

Vignette 1

Elaine has experienced the engagement process taking months or years before a service user feels safe to engage. Adrian had been street homeless for 25 years before moving into the hostel Elaine worked in. Throughout his time living on the streets, he had refused to engage formally with Psychology. However, he was happy for Elaine to make him a cup of tea every week and have a brief informal conversation with him. Slowly, over a period of months, moving at Adrian's pace, they moved from the canteen area with their cup of tea to the courtyard, and then into a room to have their cup of tea. Though Elaine's conversations with Adrian never lasted longer than 20 minutes, by the end of their work together they had shared around 95 cups of tea and have completed work around Adrian's voice hearing and delusional beliefs. This example highlights the importance of moving at the service user's pace, using creative non-traditional means, in a way they feel comfortable to allow them to come into contact with Psychology at a pace they feel comfortable with.

Vignette 2

Providing a space for Judith to feel safe in beginning to think psychologically was a key consideration for Matilda. The hostel was running a group which staff felt it might be helpful for Judith to attend. However, Judith found this quite anxiety provoking, as she had been used to providing care for others and may struggle to be in a care-receiving role as the member of a group. Therefore, Matilda asked if Judith would co-facilitate the group with them so that she could maintain a more comfortable care-giving role, whilst also being present in the room to start to learn about these tools herself. By attending this group, Judith recognised that some aspects of what the group were learning may be useful for her to put into practice. Offering Judith this role in co-production meant she could keep the power and control what she wanted to discuss, feel valued and engage at her own pace, helping to avoid retraumatising Judith.

16. ***Consider screening for cognitive and neurological problems. Assessments should consider asking clients about learning problems, previous head injury and other trauma. Including cognitive difficulties such as brain injury and intellectual disability in formulations can support understanding, as these can contribute to the breakdown of placements, and impact on social and day to day functioning. Consider how therapy may need to be adapted in relation to difficulties identified.***

Vignette 1

Steve was living in a hostel and had been aggressive towards staff members. He also had a number of physical health difficulties and had a history of non-engagement with services. Hannah reviewed Steve's history and case notes and saw that he had completed a memory screening assessment at a local hospital. The outcome of the assessment summarised that he was cognitively intact – however, Hannah reviewed the assessment scores and identified that he was quite impaired, with scores indicating that he may have dementia. Exploring this resulted in a greater understanding of Steve's behaviour and previous difficulties engaging with services. Though it took two years to obtain the support required for Steve, Hannah and staff at the hotel were able to understand what may be contributing to some of his behavioural difficulties, meaning they were able to adapt their practice to Steve e.g. by recognising that he may not remember information that they tell him. Future cases benefitted from this learning with Steve as they were able to contact the local authority for support as they had for Steve, which in one case resulted in an individual receiving support relating to their brain injury within two weeks.

Vignette 2

Throughout his adult life Jim had lived in various residential settings, he was found to struggle with self-care and independent living tasks. The hostel team where he current was living, found that he struggled to express himself and communication was a real issue. Jim would easily become frustrated or retreated and hide in his room. He was also vulnerable to exploitation from others. The hostel team had attempted to refer Jim to learning disability services for additional support, consideration over appropriate accommodation and for specialist mental health input, but these had continually been declined. The in-house Psychologist in his latest placement was slowly able to build trust and support Jim in completing some initial screening and assessment to explore his intellectual functioning, social functioning and current needs. He was felt to have learning disability or development disorder prior more in-depth formal neuropsychological assessment being completed as he had a history of attending a special needs school, had no formal qualifications, has observable intellectual and social impairment, expression and communication difficulties and difficulties with basic activities of daily living (e.g. unprompted self-care, ability to cook, clean or use a washing machine, struggles to pick up tasks when supported to completed them, unable to complete complex or multi-staged tasks). He had very basic reading skills, poor written skills but was able to tell the time. As a result of this initial screening Jim was accepted by the Mental Health learning Disability team for some further assessment and specialist input around his complex trauma. This then subsequently led to an Adult Social Care assessment and referral to more suitable sheltered housing for people with intellectual disability outside the rough sleeper pathway.

17. *It is important that goal setting is done collaboratively.*

Vignette 1

Oliver explained that when working with Sam, though they initially developed goals together, as they built trust and began to explore more of Sam's past, they built more of an understanding of what had led Sam to this point. Supporting Sam to re-address the balance of power and his value system in relation to his current difficulties resulted in Oliver and Sam reviewing and amending the goals of their work in line with Sam's new aims of wanting to re-connect with his family.

Vignette 2

Nathan started working with Martin during a hospital admission following a period of rough sleeping following significant losses, substance use alongside a presentation of psychosis. As Martin began to make a positive recovery, he started discussing returning to work in a responsible and stressful position. Martin always wanted to move into independent accommodation and take on a therapeutic role to others. Whilst Nathan recognised that this man was intelligent and achieved a lot in his past, he (and wider team) were concerned that he was rushing into roles and that some expectations may be unrealistic or risk a relapse in his mental health. Nathan continued to meet with Martin weekly in supported accommodation and tried to be flexible to his needs, however they began to experience frustrations and new issues in therapeutic relationship. To resolve this, Nathan began to be more client led in working towards goals. Martin went on to move into independent accommodation, return to an influential working role, and remains an advocate for mental health and supporting others

18. ***Formulation is key and sometimes the most basic are the best. Sharing it collaboratively is essential, helping the individual to feel valued, making them more than just a 'label'.***

Vignette 1

Hannah carefully considers whether to share the formulation directly with service users. Though Hannah acknowledges completing a good assessment and formulation to produce goals is critical, sharing this can be overwhelming. Therefore, she applies caution when putting things in writing and/or drawing things out, as she has found it can impact service users in unexpected ways. Consequently, she uses clinical judgement and/or where possible, is led by conversations with the service users about whether to formally share their formulation.

Vignette 2

I found that a lot of the people within this population had been given a label of ‘Emotionally Unstable Personality Disorder’ but with little understanding of what this meant. I would use formulation to develop a shared understanding of what this label actually means in terms of the client’s experience – contextualising the symptoms and how these can also be understood in relation to other models (trauma, attachment, social inequalities, gender etc.). Making meaning of the person’s experience and decontextualizing shame was often key.

19. ***Trauma is highly prevalent in this population (both historic and current/repeated patterns of trauma). Irrelevant of diagnosis/presenting issues, it is key to assess for this (when someone feels able to discuss) and hold in mind when formulating. It is important to be mindful of this information, to help consider what may help a person feel safe in therapy and forming other relationships.***

Vignette 1

Creating a setting where someone feels safe to talk to you is important in facilitating engagement and trust and, for Elaine, that is rarely in a traditional therapy room. Elaine explained that in direct work she uses a lot of 'walking therapy'. She has found this to be particularly effective if someone has experienced significant and possibly repetitive traumas, meaning they find it too distressing to engage in direct face to face therapy. Going for a walk with someone side by side changes the power dynamic, making the appointment less threatening, encouraging a conversation.

Vignette 2

Peeling back the layers can take a long time to explore the impact of trauma on a service user's presentation. Bill had been sofa surfing for several was referred to Elaine for support with psychosis and anger management. Elaine said staff working with Bill felt his psychosis was his primary difficulty. However, Elaine began to consider the Power Threat Meaning Framework, resulting in her reflecting on Bill's presentation being a possible trauma response. This prompted Elaine to ask Bill about his early life. As Elaine had taken the time to build up a safe and trusting relationship, Bill disclosed that that he had been sexually abused by his father's employer when he was a child. This changed Elaine's approach and intervention away from exploring anger management and psychosis, to using Eye Movement Desensitization and Reprocessing for his trauma, resulting in his psychotic symptoms disappearing. Elaine re-formulated that Bill had experienced a Complex Post-Traumatic Stress response. She attributes this reformulation to thinking beyond the initial reason for referral, alongside keeping up with new developments in the field. Importantly, she also waited until the appropriate time in the relationship, after enough safety and trust had been established to explore this with Bill.

20. ***Make use of integrated models of psychology, paying attention to attachment and theories of motivation.***

Vignette 1

Working integratively, drawing together multiple models and formulating each person based on what they need is central to Elaine’s approach. Elaine has found Cognitive Analytical Therapy can be helpful for reflective practice with the service user at the start, Cognitive Behavioural Therapy can be useful to support understanding and interventions, and attachment theory is often key. For example, one young person was initially offered Cognitive Behaviour Therapy for anger management, however exploration with the service user resulted in identifying that much of their anger originated from issues relating to attachment. Elaine changed her approach to focus more on attachment, which led to uncovering a significant level of trauma, leading to using Eye Movement Desensitization and Reprocessing therapy. They then completed the work using Acceptance and Commitment Therapy, working towards the service users goals by identifying their values.

Vignette 2

David has found the value in formulating Psychodynamically, recognising and respecting psychological defences, what might be split off and utilising the meaning within the transference and countertransference to make sense of someone’s experience. David has found that this can be integrated into a variety of treatment approaches such as mentalization or attachment-informed models, motivational interviewing, Cognitive Behavioural Therapy and Compassion Focused Therapy, where things such as trauma responses, interpersonal patterns of relating, self-destructive behaviours, ‘stuckness’ or de-motivated can be explored.

21. ***Consider what model fits the person, how to adapt it based on their current circumstances (e.g. briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work).***

Vignette 1

Using clinical judgement and thinking to review and evaluate what she is doing is crucial in Hannah's work in homelessness services, including considering the number and pace of sessions. Hannah recognises that the number of sessions a Clinical Psychologist can offer can be an area of difficulty, as services are commissioned based on the number of sessions. However, considering individual differences within this population is critical – when working in a GP practice, Hannah said one service user received 16 sessions with good outcomes, whilst another had three years-worth of contact. Hannah feels it is important to have a strong rationale from the beginning of the work for decision making, to be able to justify the work. Support from the wider team from the start can also help.

Vignette 2

Adapting models and materials to fit the service user's needs is an everyday consideration for Elaine. Alongside working flexibly with the number of appointments, she explains that many service users do not have a high level of literacy or English as a first language, meaning you may not be able to use lots of the materials and resources you normally would. Each needs to be adapted to fit the person and to make them accessible. She highlights the importance of also being mindful of translations and the cultural context of psychological models, as many models are predicated on Western ideas of mental illness. For example, the individual may have no concept of thoughts and mental illness and instead may think that they are possessed by spirits.

22. *Approaches to direct work should seek to apply the frameworks of Trauma-informed and Psychologically Informed Environments (PIEs) where possible, encompassing all elements that come with this (e.g. building relationships, helping people connect and feel empowered, value-based, recognise the impact of trauma on an individual and avoiding re-traumatisation).*

Vignette 1

Oliver approaches his initial assessments using a trauma-informed approach. His aim is for the person to come out of the assessment and want to see him again if they want to and if it is appropriate for them to. Instead of screening for information like other services, Oliver sees the assessments as creating a dialogue to explore what the person may find helpful.

Vignette 2

Tim formulates right from the start of the work the possible traumas an individual may have experienced during their life and possible impact of psychological work on retraumatising them. For example, if he meets a woman who he knows has been engaging in street working and may have been abused by men, then Tim considers the potential impact of his gender on the individual. Tim highlights the need for Clinical Psychologists to consider and hold in mind a range of issues prior to meeting a service user and be mindful of how these may impact the service user, as trauma may still be active. Doing so can help you to build trust with the individual and form a strong attachment with them, which may enable you to explore any trauma(s) they may have experienced and mitigate the risk of re-traumatising them.

23. ***Endings are just as important as beginnings. Actively paying attention to and working jointly with staff and service users e.g. by devising care plans at the beginning of the work for the end of the work, can help work through feelings of rejection and service withdrawal users may experience.***

Vignette 1

Within Matilda's service, a Clinical Psychologist will attend a pre-admission meeting prior to a person moving into the hostel. The service user, their key worker and the manager attend these appointments. Matilda finds the meeting helpful as she can complete a mini assessment of the person's needs and explore whether they may want to engage in Psychology. During this meeting, they consider the move in as well as the move on process, discussing where an appropriate referral onwards may be once their stay at the hostel ends.

Vignette 2

The duration of work with homeless clients can vary depending on the setting, but generally flexibility around this and the ability to offer slower longer pieces of work is of real value. Nonetheless, Lucy recognises that it is vital to attend to the ending from the start of the work and has seen how this can get avoided due to feelings of guilt, abandonment, there always being more work to be done or feeling you are the main stable attachment figure for someone. She has found that it can be the clients with the greatest dependency needs or with repeated losses and abandonments, that clinician's and staff teams may feel it is hardest to end the work with and this can be avoided or unconsciously acted out (e.g. somehow forgetting to give extended notice and count down towards breaks, leave, endings; finding reasons to continue the work; repeated crises which mean it never feels the right time to end, but which could also inadvertently reinforce crises for people). This all needs careful formulation, reflection around boundaries, self-monitoring and supervision. Sometimes breaking work down into bitesize chunks, prioritising with the client, considering the next steps and any onwards referrals you may be working towards from the start, regular reviews and re-contraction as needed.

Indirect working guidelines

Relationships with and support for staff

1. *The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them.*

Vignette 1

Providing emotional and psychological safety is crucial to how Oliver views his role in hostels. Oliver does this by finding a space where staff feel they are able to express their opinions, attitudes, frustration, anger, and sadness, in a way which is helpful for them, the wider team and residents. In Oliver's experience this can be through a range of support mechanisms including training, team, and individual reflective practice or through interventions at a management level. Oliver finds that creating this safety often leads to increased creativity within staff teams.

Vignette 2

When Hannah began working in a local hostel, she recognised there was a significant amount of suspicion from staff members. Time was limited in the hostel, as Hannah was only able to work one day per week across three separate hostels. To manage this, Hannah was flexible in what she offered the staff, making suggestions to the team regarding teaching and training based on what had come up in her conversations with them. Working with the staff group, listening to their needs and being flexible helped Hannah tailor the support she offered to the team.

2. ***Build relationships and partnerships with staff who are key to much of what we do. Emphasise good practice, consider evolution not revolution.***

Vignette 1

Following a critical incident, staff were offered a debrief session with Elaine, which developed into ongoing reflective practice group for staff members to discuss learning taken from the incident and the team bringing other cases to discuss. Allowing this group to evolve into something the staff found helpful increased its acceptability as is indicated by the fact it has never been cancelled.

Vignette 2

When Matilda was recruited by local commissioners, one aspect of her work was to implement a Psychologically Informed Environment in a local hostel. Matilda approached this enthusiastically, but, after starting, recognised that the staff may feel implicitly and explicitly criticised, feeling that they had been told by commissioners that they ‘needed a psychologist to improve practice’. This experienced highlighted to Matilda the importance of sensitivity when consider how any change in a service starts. Clinical Psychologists should pay close attention to the change management process right from the start. Actively working with the staff team, service and organisation from the beginning can help them own the work, as they will be less likely to experience the work as something that is forced upon them. If this is not completed, there can be resistance within the staff team, service and/or organisation, with people feeling disempowered or encroached upon, feeling criticised or undermined.

3. ***Think about your language and how you explain things in a way to staff that is accessible, interesting, and more than just common sense. Doing so will help to prevent staff feeling disempowered.***

Vignette 1

Erin has found applying psychological frameworks staff are familiar with, such as attachment theory, can help staff to understand why their service users are responding in a certain way e.g. if they have an insecure attachment, they may be quite avoidant or dependent on staff. Using this framework has been helpful and easy for staff to understand, as many have nursing or social work backgrounds and therefore have some knowledge and understanding of attachment theory. Using a familiar model means staff do not feel that they are learning something new, which helps them to feel more competent in their role.

Vignette 2

Bessie routinely asks staff first what their understanding of a situation is to honour and learn from their knowledge, skill and experience. Where appropriate Bessie relates what she has heard from staff to psychological theory and models and / or adds to what has been said to share her understandings with staff. Staff then consider what actions they may take on the basis of the shared understandings.

4. ***Be mindful of the stress and pressures that staff (e.g. outreach, hostel, and day centre staff) are under and how challenging their day-to-day work can be. Meet staff where they are at considering what they would find helpful, as staff may not have the supervision and training that we would like them to have.***

Vignette 1

Oliver acknowledges that many individuals are 'running on empty' from both a staff and organisational perspective. Within the voluntary sector, they may be chasing contracts to stay afloat and keep the service going. Consequently, Clinical Psychologists may seek to sell what they think is best practice, but this could be perceived as an expert 'lecturing' staff on what they should do, which is likely to damage relationships. Acknowledging that many services are just trying to survive is important, alongside managing your own and the staff members' expectations and anxieties about what you can provide and what a service user needs.

Vignette 2

Erin is mindful in her role that staff working with people experiencing homelessness want to do well and are often eager to learn and develop psychological knowledge to support their work. However, Erin carefully considers the support she can offer as she is conscious that she may appear to be adding to staff members' workload through additional meetings.

5. ***Clinical Psychologists should provide a space for validating workers' emotional reactions/toll of the work and understanding behaviour.***

Vignette 1

Erin is flexible in the way she creates space for staff, as she acknowledges that staff deal with a lot of emotion and trauma on a daily basis, but often have little support for this. Being present in their environment and offering informal chats can help provide a space for workers to think about the work and understand why someone is doing something. Erin also uses this space to signpost to other agencies if needed or help the staff member think about what they are struggling with and provide them with some tools to help manage these difficulties.

Vignette 2

Tim provides therapeutic support for managers and staff from local hostel organisations if they have been identified or identify themselves as struggling. Staff feedback has been positive, and it is being accessed increasingly by the staff teams, with staff absences reducing across the services.

6. ***To buffer against burnout and vicarious trauma and the challenges of working in complex systems, a range of staff support systems are essential. Clinical Psychologists should provide training, reflective practice, consultation, consistent team approaches and debriefs.***

Vignette 1

Tim runs reflective groups for all hostel workers and managers from a local housing organisation. He provides monthly group reflective sessions which are organised using a specific structure – they start with a grounding exercise such as mindfulness, move on to a mini training session on a range of topics from brain injury, to the purpose of reflective groups or culture and safety in the work environment. Each reflective group finishes with a practical exercise for staff to complete.

Vignette 2

Shortly after Elaine joined a new service, there was a death in the service. This had a big impact on the staff, particularly the staff member who found the service user. To help staff to manage the possible impact of this event, Elaine offered an initial debriefing session to all staff, and this later evolved into ongoing reflective practice for the staff members. She also provided some additional support to the staff member as they were beginning to experience flashbacks. Finally, to support staff in future situations, Elaine also amended the risk assessment and process, and delivered training to all staff on this to support their future practice. Staff feedback indicated that they had found this helpful, and the individual staff member who received additional support had minimal time off work for the incident, indicating they felt supported at work.

7. Develop psychological formulations and understanding of what is happening within teams or organisations and share with organisations in order for organisations to understand how they are influencing the service users and the different levels within the service. This offers space for the organisation to think about what they do.

Vignette 1

Within one team, though the hostel manager in one project was onboard with utilising a Psychologically Informed Environment approach and accessing support from Oliver, the staff team are more cautious. Formulating this within an organisational context has helped to build an understanding that the staff team have been around for a significant period of time and it was perceived that they had experienced the system as abusive. By understanding why this is happening, Oliver can understand which interventions would work best with the staff team.

Vignette 2

In thinking about different levels of organisations and how they influence service users and staff, pseudonym Rosie draws on the model of ‘parallel processes’ and ‘trauma organised systems’, written about by Sandra Bloom. Pseudonym has delivered training sessions to staff within services, senior managers at all levels, and local partnership agencies and commissioners about this model. This has included highlighting how service users’ feelings may impact on staff, which in turn may impact on senior managers and the wider organisation, leading to potentially unhelpful responses to staff, who may in turn offer unhelpful responses to service users, increasing distress and unhelpful behaviour throughout the system. Such team and organisational formulations allow space to validate the natural responses to challenging work, while also allowing space to consider what can be done differently to contain and more helpfully respond at all levels.

Supporting staff to support service users, including building therapeutic skills

8. *Where possible and appropriate, work should be led by service user involvement and feedback. Be creative and flexible in your approach to this, implementing a range of methods to work co-productively e.g. through focus groups, surveys, informal verbal feedback.*

Vignette 1

Tim recruited service users to complete a small evaluation of the effectiveness of their staff reflective practice groups and individual staff support appointments. Service users were paid to complete the evaluation. They constructed the questionnaires and completed one to one interviews, collecting both qualitative and quantitative feedback. Staff valued having service users involved in the evaluation of the service being provided.

Vignette 2

Hannah is leading on a quality improvement project considering how to improve the physical and mental health of those in hostels and how to work with everyone in them, including residents and staff. The project is encouraging co-production by actively involving the residents in a ‘experts by experience’ group. During one meeting, an expert by experience highlighted that the work being proposed was not a one-person job, and that they may need a team of people to implement this. As a result, Hannah has sought out extra money to recruit individuals to be part of the project, and this has been supported by the commissioners.

9. ***Clinical Psychologists should be involved in ensuring that team screenings and initial needs assessments consider relevant psychosocial factors.***

Vignette 1

Andrew was engaged as a clinical psychologist to advise on an assessment protocol including formal measures for assessing complex medical and psychosocial needs. This involved facilitating a discussion amongst the wider team and structuring their experiences within a contextual psychological model then considering pros and cons of using standardised measures, exploring the literature for relevant examples. The result was the development of a semi-structured interview, supplemented by three key outcome measures published in previous homelessness research to which were added checklists and rating scales of factors the team felt were relevant but which were not captured by conventional scales.

Vignette 2

A Clinical Psychologist, Keith, was working for a small Community Interest Company. Keith provide six hours of input per week to a hostel. In order to help with care planning and professional integration, they accompany the hostel managers to all their initial screening intake assessments. This enables neuropsychological, social, and environmental needs to be further considered.

10. ***Make sure that indirect work is meaningful to the people and services we are working with - be pragmatic and seek helpful and meaningful outcomes which are evaluated. Ensure that consultation is useful to care planning, not only theoretical.***

Vignette 1

With permission, Roisin has adapted Hollingsworth & Johnstone's (2014) Team formulation questionnaire to routinely evaluate the reflective practice she offers. Based on the evaluation, reflective practice is refined.

Vignette 2

Lucy found that is was valuable to think about how the wide range of needs the clients had could benefit from psychologically-informed input, rather than just the mental health or psychological needs. This included for example - contributing to thinking about what might support someone taking up a bed space for a first time and how to sustain that placement; the experience of someone with a history of sexual abuse being 'physical touched' or being asked to de-robe in a physical health appointment; or recognising that a hostel manager had a responsibility to the wellbeing of all the residents of a property and the need to balance this.

11. ***Clinical Psychologists should assess the service context in which they work, recognising and acknowledging the skills, beliefs, and ways of working already in the system and prioritise these. Work from a position of building capacity by offering what is meaningful and practical for the staff and service, developing existing strengths in staff teams. This may be by sharing knowledge and discussing ideas through reflective groups, providing additional training, formulation, case discussions and consultations. Mentoring for frontline staff should also be considered.***

Vignette 1

Due to minimal Clinical Psychology provision, Elaine has adopted a strengths based, upskilling approach, seeking to empower staff in their role to use psychological knowledge where appropriate, building capacity within the staff team. She does this predominantly through consultancy and open discussion with hostel staff to help them to consider why a service user may be presenting in a certain way. For example, one service user was identified as have difficulties with anger. Elaine helped to normalise this as an understandable reaction to their situation and helped staff to think of times they have been angry and how they have managed this. Encouraging staff to consider how they respond to these feelings themselves helps this become more accessible to staff in moments when psychology is not available and reduces the number of referrals to Psychology from staff. By supporting and upskilling staff, they can often complete much of the work providing appropriate support mechanisms are in place.

Vignette 2

By providing training, formulation sessions and access to a Clinical Psychologist, over time a local hostel team is now able to formulate using psychological knowledge and understanding without needing a Clinical Psychologist present for the duration. Being able to formulate as a team has helped staff in the hostel Matilda supports to understand and contain the distress of several clients within the service without needing to consult a Clinical Psychologist, helping to build understand and capacity within the team.

12. ***Learning and building up therapeutic and practical skills with appropriate supervision, giving people a sense of control and fostering Psychologically- and Trauma-Informed environments.***

Vignette 1

Using case-based sessions has helped Matilda to develop guidelines for ways of working consistently with individual service users. This has helped to develop a consistent team approach across all staff, including those on night shifts. Matilda noted this has worked particularly well with service users who have been self-harming significantly in public areas when staff have been unsure how to respond, resulting in inconsistency of approach, with some staff members reinforcing behaviour without meaning to e.g. providing extra care giving at certain moments may escalate behaviour. Therefore, they think as a team about the individual and consider what they may want to pay attention to, when they should give praise and when they should not.

Vignette 2

Developing a coherent psychological framework for the services with a training programme developing the tools and therapeutic approaches that all staff can be trained and feel confident in. This has been done using Mentalization-Based approaches in some PIE organisations; others have used Cognitive Behavioural Therapy and Dialectical Behavioural Theraly or narrative and strength-based approaches to great effect.

13. ***Model and reinforce the skills that you want to develop within systems and staff groups.***

Vignette 1

In Hannah's supervision with staff, she uses a model of Appreciative Inquiry, asking staff to think about something they have done really well. Hannah noted that though staff may find this hard, when she provides them with the rationale that change can sometimes be really small, they are often able to find something to discuss. Hannah will then link this to instances with residents where staff members are often really trying to get service users to identify something positive that has happened recently, and highlights that practicing it themselves may make it easier to do this with residents. Modelling this during support sessions helps staff to identify these more easily, which then helps them to apply this learning with service users.

Vignette 2

Matilda seeks to impress upon all staff the importance of maintaining self-care and a good work-life balance. She models this to staff by taking regular breaks, going on holidays, and going home on time, believing it is important to 'practice what you preach'. Matilda also encourages regular supervision for Clinical Psychologists working in the hostels, alongside other staff members, and has supported the implementation of regular reflective practice groups and regular team meetings.

14. ***Remember to tell stories for both direct and indirect work as these can motivate people to work together. People often remember these and will help to draw in multiple agencies.***

Vignette 1

Claire was living in a hostel and had been referred to Annabelle for support with behaviour that staff were experiencing as challenging. After several appointments with Claire and with her consent, Annabelle met with staff separately and shared some of what had been discussed. Doing this helped to provide staff with an understanding and story behind Claire about what had contributed to her current situation and presentation. Following this, Annabelle reported a visible shift in staff members' responses to Claire, as they began to feel more compassionate and connected with Claire. As a result, they began to adapt and change their interactions with Claire in subtle ways.

Vignette 2

Staff at the local hostel had had contact with Guy, who had been placed into emergency accommodation due to a snow alert. During this visit, he assaulted a member of staff and as a result had been excluded onto the streets. The team were concerned about him coming back into the hostel; they were worried that, as he had been unable to contain himself for this short period, it was likely that this may happen again. To explore Guy's background, Matilda asked his key worker to contact someone who had known him a lot longer who may be able to provide some insight into Guy. They were able to provide additional information about Guy's background, establishing that Guy had experienced significant levels of violence when he was younger. This led the team to reframe Guy from being 'aggressive', to hypothesising that Guy's background may mean that he felt continually threatened. Considering Guy's story helped staff and the wider services recognise that Guy may be scared, which reduced their anxieties around engaging with Guy. Reducing their anxieties helped staff to change their approach to Guy, implementing a caring and compassionate approach rather than being firm with the boundaries, which helped Guy begin to engage with staff and services.

15. ***In relevant contexts, when there is consent from service users, develop your interventions collaboratively with all staff including those working on shifts at night and domestic workers to promote consistency of approach.***

Vignette 1

Vanya was living in hostel accommodation and had been expressing behaviour staff were finding challenging, which was creating feelings of frustration in the staff team. Annabelle worked with Vanya to explore a safe space where she could express herself outside of the hostel and explore their thoughts and feelings in a safe space with Annabelle in the hostel. It was agreed with Vanya that these discussions could then be transferred into the wider staff support system around them. Using a narrative formulation, staff were then able to understand the reasons behind some of Vanya's behaviours and consider how staff may be perpetuating some of Vanya's behaviour, enabling them to reduce some of the triggers in Vanya's environment. Working collaboratively with Vanya and the staff team, with Vanya's consent, encouraged consistency of approach which helped to reduce Vanya's distress, preventing Vanya from being evicted.

Vignette 2

Ben had lived in many hostels in the past, but the placements had often ended with his eviction after reports of violence or targeting staff. He fought against rules and boundaries that were experienced as meaningless, controlling, or rejecting. Ben was particularly sensitive to hostel staff being busy and not immediately available to support him such as when in team meetings, with other residents, on the phone or taking leave. This would be a trigger for outbursts and continually banging on locked doors or meeting rooms. In group reflective practice the team shared experiences of what was working well with Ben and based on their psychological formulation, the team developed staff team approach detailing how to work most effectively. This incorporated an understanding of Ben's outbursts stemming from fears of rejection and abandonment, underpinned by experience of childhood neglect and growing-up in care. Staff were able to understand Ben's desperation at times when he felt more excluded or neglected and made additional provision to provide reassurance and structure when it was known staff would be unavailable (e.g. lots of warning of keyworker annual leave and who would be his named keyworker cover; offering dedicated time to meet before and after team meetings; praising attempts to wait; being transparent when things could not be completed immediately and agreeing a time when this need could realistically be met). This was very effective, and the team quickly became able to reassure and de-escalate Ben, helping him to settled into the hostel, sustain his accommodation and begin to trust in the staff to a greater and greater extent alongside a growing ability to regulate his emotions and manage frustration.

16. ***Contract work as transparently as you can. Ensure all including senior managers are involved, have authorised, and support the work.***

Vignette 1

Sharon was struggling to move into the local hostel accommodation, as staff hypothesised that she may find the environment threatening. Matilda and staff recognised that the move would need to go at Sharon’s pace, meaning a hostel space would need to be held for her. Matilda shared the rationale behind this decision with local commissioners to help them to recognise and support the need for the bed to be held for Sharon, meaning it would be vacant for a period of time. Doing so meant the bed remained open until Sharon felt able to stay in the hostel.

Vignette 2

Bridget was always keen to be involved in her support and very capable of involvement. However, she found meetings overwhelming. Felicity sought her consent to bring together members of the hostel, substance misuse service, and community navigator for a formulation meeting. Before the meeting, Bridget and Felicity went through the formulation model together and filled in all the information that Bridget wanted people to know about her and how best to support her. This was added to by staff in the formulation meeting with observations made by those supporting Bridget. This was talked through with Bridget after the meeting and she appreciated strengths-focused observations from staff and was involved in refining the support plan, which was signed off by senior managers.

17. ***Demonstrate that services are Trauma-Informed e.g. through staff training, awareness of processes and procedures being Trauma-Informed, providing a space for reflective practice and offering trauma therapy to service users if needed*. *Attending to the emotional impact of the work on colleagues is an important starting point. The work is potentially traumatising for staff, many of whom also come with trauma backgrounds who may have come into this because of their own past and present experiences. Where necessary, Clinical Psychologists can provide sign posting to staff to support services to manage this impact.***

Vignette 1

When delivering training on Trauma-Informed Care, Hannah did not realise that she was inadvertently re-triggering a staff member who had lived experience similar to that of the service users they work with. Hannah had created enough safety within the relationship that the staff member felt able to come and speak to them about the impact of this training on them. Considering this, Hannah holds in mind that staff may potentially have backgrounds involving trauma.

Vignette 2

Owen is mindful of the trauma that all staff engaging with service users may have experienced, and the need to ensure all staff, including receptionists at the local GP practice, are well supported in their roles. A significant amount of Owen’s work has been delivering Trauma-Informed Training for staff to help them to understand the impact of trauma on their own and the service users’ lives and explore ways to manage this. He also provides a space for reflective practice once per month for all staff to discuss some of the challenges they have faced, though much of the discussion is based on team resilience and exploring how best to avoid engaging in unhelpful dynamics with service users, such as being hostile and rejecting.

Approaching systems change

18. ***Think about the system the work is happening in - the individual relationships between staff and service users, the organisations they work with, the wider societal context and communities that they are working in.***

Vignette 1

Karl had been living at a local hostel and had been engaging with staff and a Clinical Psychologist, Matilda, to reduce some of his agitation. As this distress decreased, the team noticed that his anxiety was increasing, and he increasingly began to present at A&E as he thought he was having a heart attack. Initially, the team contacted the local GP who completed a physical health check for Karl to show him that he did not have any sign of a heart difficulty and that it may be related to anxiety. Following this, the hostel staff implemented interventions such as breathing and relaxation techniques. They would offer to call him an ambulance when he said he was having a heart attack but would also offer to do some relaxation instead. Over time they noticed Karl was stabilising, but the hostel was still receiving alerts from A&E that Karl was attending. This resulted in the recognition that, whilst the hostel staff had been working towards reducing Karl's anxiety by reinforcing changes such as not calling an ambulance, hospital staff at A&E were reinforcing his attendance by offering him a cup of tea and having a chat with him, whilst completing their routine checks. Considering the wider system and communities in Karl's care and the impact that these were having helped Matilda to recognise that the team approach needed to be shared with other agencies in Karl's care, including the local ambulance and hospital staff. After sharing this, both agreed to complete only the functional checks from now onwards and would positively reinforce Karl returning back to the hostel. This resulted in Karl's contact with emergency services reducing, helped Karl to stabilise further within the accommodation and was able to slowly engage further in his work with Matilda. Not working in a silo and sharing the team formulation with wider services, particularly within such a mobile client group is critical, and helped to change the way the system was reacting and responding to Karl.

Vignette 2

Therapy can lead to significant disclosures, for example relating to safeguarding concerns and / or criminal activity, but sometimes without enough information to support specific action to be taken. In such cases, Henry has worked with the client to gain consent to liaise with other members of the system to support them to feel as safe as possible to disclose, while allowing them to take control of whether they do. This has included: supporting hostel staff to understand destructive or abusive behaviour in the context of trauma and strategies to build relationships that promote a sense of safety; working with local police and safeguarding leads to encourage them to understand barriers to disclosure and offer named individuals to build a relationship; liaising with GPs and sexual violence services to support clients to visit and understand processes of disclosure and physical examination so they can make an informed choice about disclosure; and realistic discussion with all involved about potential threat to the individual within the community and the limitations of the criminal justice system, so that barriers for the client and limits of support can be understood by all involved.

19. ***Think about how your indirect work can become part of the system. It is not always about seeking to create an entirely new initiative which has minimal chance of survival. Doing and planning with people and organisations rather than doing to.***

Vignette 1

Matilda works into several different hostels and has found each staff teams reflective practice needs vary. To support uptake within each team, Matilda delivers training on the value of reflective practice and provides the team with examples of what reflective practice may look like. She then co-produces this with the staff so that it fits with the team's needs and wider system. This helps staff to feel empowered and take ownership of the reflective practice group, feeling that they have 'done with' rather than been 'done to'. Consequently, reflective practice groups vary in their focus across different hostels, with some more focused on staff support, wellbeing, and the impact on the work, whilst others focus more on formulating clients and how best to work with them. Matilda acknowledges that a balance of both aspects may be best, but it is important to be mindful of what the team's needs and wants are at the time.

Vignette 2

Kathryn works with a large provider of temporary accommodation, street outreach, and substance misuse services. Through regular connections with senior management, she has worked to embed psychologically informed approaches through organisational initiatives that are already happening, such as work with the Staff Council, revision of supervision documents to embed more reflective approaches, reviews of policies and procedures, and the promotion of staff well-being initiatives. Supporting changes that the organisation was already seeking to make through collaborative consultation has offered a way of contributing to a shift in organisational culture towards more psychologically informed approaches, rather than trying to introduce completely new approaches to systems with limited capacity for change.

20. ***Joined up, systemic working is essential. Work closely with other agencies and a wide MDT as much as possible. People will have multiple needs which psychology alone cannot resolve. Respect and value perspectives from other professionals/agencies and incorporate in care planning, as agreed by the service-user.***

Vignette 1

Working collaboratively with other agencies is critical to Matilda's work in this area, though she notes that the client group can prefer for services and people within these services to function in silos. Despite often having multiple needs, service users may struggle to want professionals to share information and work collaboratively with others. It can be challenging to empower the individual to have trust and feel safe that their information is protected, whilst encouraging them to share openly and think about issues of consent and collaboration. Being transparent with all aspects of the system, including the client, and respecting differences in needs can help to navigate these challenges.

Vignette 2

James was a man in his early 30s with a history of deliberate self-harm and regular suicide attempts. He agreed to engage with Lucy in weekly psychology sessions where they initially focused on risk management, emotion regulation and his alcohol use which increased risk and impulsivity. At their request a workshop was also conducted with the hostel and outreach team on '*understanding and managing deliberate self-harm'*. After a serious suicide attempt the psychologist ensured James was referred and accepted under the care of a CMHT and called a multi-agency case conference (Incl: James, hostel management, keyworker, the PIE Clinical Psychologist, CMHT, probation, and substance misuse services) to develop an integrated care plan managed by the hostel key worker and PIE psychologist. This was a turning point for James and the start of more effective coordinated MDT care.

21. ***Psychologists are in prime place to influence and develop services including mental health and the wider homeless service sector. Service level structures such as Psychologically Informed Environments (PIEs) and Trauma-informed Care (TIC) can be really useful to help guide the work, for example by supporting thinking about how all systems, policies, practices, and processes utilised by services can be psychologically informed in order to offer safe, compassionate, and thoughtful approaches to the work. It cannot just be about individual therapy; we need to be promoting system change. Clinical Psychologists should explore structures such as PIEs and TIC and consider whether the structure or elements of them would be beneficial in guiding work the context they are working in.***

Vignette 1

After winning a contract for a new service, Elaine began thinking about how the service could be psychologically informed right from the start of the project. Consideration was given to what would be needed in terms of staff, training, reflective support, how the building physically looked and a separate research and evaluation component. This also included considerations for the frequency of staff supervision alongside the policies and procedures across the service. Amending the evictions and sanctions policy is a key component of this work, as service users used to receive three letters under their door prior to their eviction. Thus, Elaine is working collaboratively with the service and housing leads to consider different way to make this process more psychologically informed.

Vignette 2

Matilda has supported the implementation of PIEs in several services and this is her key strategy in creating a sense of coherence within and across the projects. The PIE framework has been implemented in several ways, some of which are described below:

- Developing a specific psychological model training framework for all staff who work in the hostels irrespective of role to attend. Providing training in these areas can help staff to use these in both their personal and professional life, which can help them to regulate their own emotions supporting their work with clients alongside their own wellbeing.

- Implementing reflective practice as part of the ongoing supportive practice, including having a staff development and wellbeing function.

- By thinking about how the environment can be empowering and safe, creating spaces of safety and connection.

- By creating operational groups comprised of senior management to consider different aspects of the PIE project (e.g. the physical environment) and how this could be modified.

- Supporting the evaluation of projects through considering how best to collect data, how to analyse and evaluate what the services are going on an ongoing basis.

22. ***Setting up specialist services for homeless people is not sufficient. Inclusivity needs to be promoted within the wider system (e.g. local mental health teams). This level of service development is hard, so it is important to also be pleased with modest gains and promote these successes.***

Vignette 1

Jimmy a 54-year-old man was referred for support from a third sector neuropsychology service, due to concerns about his cognitive abilities. Liaison with a range of services and a review of his medical records enabled the development or a neuropsychological formulation which drew attention to his psychosocial context. Jimmy had attended a school for children with special educational needs and had lived in his parental home until the age of 42. Leaving the parental home led to a deterioration into self-neglect, addiction, criminal behaviour, and rough sleeping. Strong relationships between the third sector agency and statutory services led to a more compassionate and contextual understanding of his difficulties, with a neuropsychological formulation shared across homeless provisions, healthcare, social services, and probation.

Vignette 2

A specific case highlighted that coordinated multi-agency multidisciplinary care was vital. For this to happen in other cases, work was completed on the network and referral pathways. The psychologist in contact with the services, worked hard to develop relationships with the network of local services including establishing of a joint referral pathways meeting structure, attending Single Point of Access meetings, offering training to Community Mental Health Team or Primary Care services on the needs of homeless people, lobbying locally and influencing stakeholders on barriers around issues such as dual diagnosis. This was a turning point for James and the start of more effective coordinated care when through perseverance and the establishment of joint meeting structure, James' mainstream CMHT referral was finally accepted, after alcohol had proven a barrier for so long.

23. ***Working to bring different services together and to proactively support the needs of people with multiple complex needs, bridging the gaps between services that service users can fall between, helping to address service exclusion.***

Vignette 1

Being part of a multi-agency task group seeking to help people who are experiencing long term street homelessness into accommodation has provided Oliver with the opportunity to share a psychological understanding of why a service may be struggling. Bringing agencies together can help prevent service users fall between the gaps and prevent exclusion from services and promote understanding of the individual’s circumstances and needs from a psychological perspective.

Vignette 2

Collaboration and encouraging partnership working with multiple agencies is a major part of Matilda’s role. Gaps have been identified between homeless and services and health services, as service users are often excluded from these statutory services due to service design. Therefore, Matilda has been working to support services engage in a piece of work by embedding psychology at the point of need within hostels, supporting access to these services, reducing service exclusion.

24. ***Maintain contact and liaise with other Clinical Psychologists in the national field, working together to develop ideas nationally about psychological approaches to homelessness.***

Vignette 1

When beginning work in this field Jason noted the absence of psychologist groups he could turn to for advice but found by contacting homelessness charities directly that a number had connections to various psychological practitioners. Upon further research he joined the Faculty for Homelessness and Inclusion Health which led in turn to a focus group, conference presentation and email professionals group. By being willing to discuss and offer advice on research this provided a means of enhancing his own service provision and contributing to initiatives nationwide.

Vignette 2

Sarah has worked hard to develop a network of local and national psychologist doing similar work, finds time to attend specialist training and networking events and joins in with regular opportunities to connect such as twitter chats (#HomelessPsychology). Her team have also set-up networking meetings with other psychologist in the region to share the work and find ways to work together on national agendas. Sarah finds this supportive in work that can at times feel isolating and challenging.

Contributing to the evidence base

25. ***Clinical Psychologists should allocate time to research and evaluation. As well as seeking out opportunities to promote and complete research, they should be a source of guidance and expertise for staff, working collaboratively on research and evaluation projects whenever possible, highlighting its value to senior management.***

Vignette 1

Richard worked collaboratively with a local charity in order to offer pro bono advice and training to their staff, and explore how they could better evaluate, promote and improve upon their current service. This led to suggestions for joint working and ultimately to setting up a small scale evaluation project which would be presented to staff and Trustees and used locally to promote their work.

Vignette 2

Small scale research and service evaluation is as important as larger pieces of research and wider dissemination of the work through articles and conference presentations. The evidence-base is still relatively young and there is great value in sharing evidence-based practice. Continue to measure what you are doing and share that to influence commissioning, service sustainability and expansion.

26. ***Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community. Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness.***

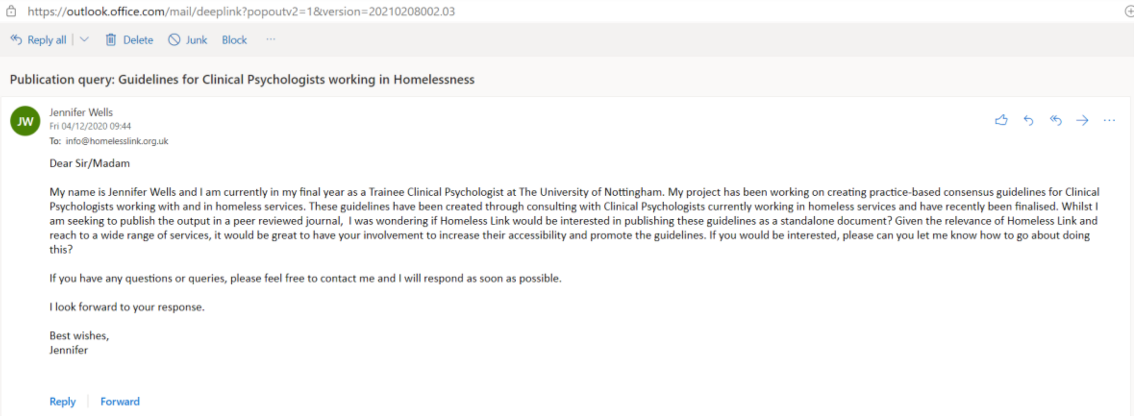
Vignette 1

The psychologists on the team were instrumental in writing up a service evaluation which was published through the BPS, reported at a BPS conference and posted on Researchgate as open access in order to reach a wider readership. The emphasis of the paper was on the rationale, process and learning outcomes for the team in order that it might be useful for colleagues engaged in similar work, improve service quality and help break down barriers to inclusion.

Vignette 2

Having opportunities to share learning with major national bodies such as NHSE, PHE, MHCLG has enabled us to grow the work, develop a national reputation, support others in using our evidence-base to gaining funding and developing service provision for PIEs that incorporate embedded clinical psychologists.

Appendix O. Dissemination Emails.



https://outlook.office.com/mail/deeplink?popoutv2=1&version=20210208002.03

Publication query: Guidelines for Clinical Psychologists working in Homelessness

Jennifer Wells
Fri 04/12/2020 09:44
To: info@homelesslink.org.uk

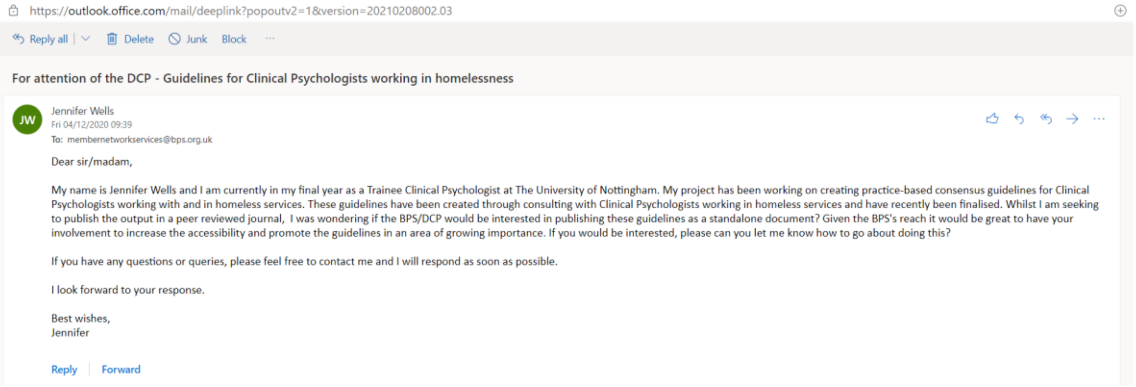
Dear Sir/Madam

My name is Jennifer Wells and I am currently in my final year as a Trainee Clinical Psychologist at The University of Nottingham. My project has been working on creating practice-based consensus guidelines for Clinical Psychologists working with and in homeless services. These guidelines have been created through consulting with Clinical Psychologists currently working in homeless services and have recently been finalised. Whilst I am seeking to publish the output in a peer reviewed journal, I was wondering if Homeless Link would be interested in publishing these guidelines as a standalone document? Given the relevance of Homeless Link and reach to a wide range of services, it would be great to have your involvement to increase their accessibility and promote the guidelines. If you would be interested, please can you let me know how to go about doing this?

If you have any questions or queries, please feel free to contact me and I will respond as soon as possible.

I look forward to your response.

Best wishes,
Jennifer



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For attention of the DCP - Guidelines for Clinical Psychologists working in homelessness

Jennifer Wells
Fri 04/12/2020 09:39
To: membernetworkservices@bps.org.uk

Dear sir/madam,

My name is Jennifer Wells and I am currently in my final year as a Trainee Clinical Psychologist at The University of Nottingham. My project has been working on creating practice-based consensus guidelines for Clinical Psychologists working with and in homeless services. These guidelines have been created through consulting with Clinical Psychologists working in homeless services and have recently been finalised. Whilst I am seeking to publish the output in a peer reviewed journal, I was wondering if the BPS/DCP would be interested in publishing these guidelines as a standalone document? Given the BPS's reach it would be great to have your involvement to increase the accessibility and promote the guidelines in an area of growing importance. If you would be interested, please can you let me know how to go about doing this?

If you have any questions or queries, please feel free to contact me and I will respond as soon as possible.

I look forward to your response.

Best wishes,
Jennifer

Poster

Consensus based good practice guidelines for Clinical Psychologists working in and with homelessness: A Delphi study

Jennifer Wells, Dr Anna Tickle, Dr Danielle De Boos

Background

Social policy is increasing seeking to address homelessness (National Housing Federation, 2020; United Kingdom Parliament, 2017). Clinical Psychologists are increasingly being employed to work in homelessness, many of whom are severe and multiple disadvantaged (Sosenko et al., 2020). Despite growing numbers and the complexity of the client group, there is little empirical evidence or guidelines for Clinical Psychologists or commissioners to refer to when consider the resources required to support their work within homelessness. As Clinical Psychologists have been working in this area, it was hypothesised that they will have generated practice-based evidence (PBE) which could be harnessed to create guidelines to support this research-practice gap.

Clinical Mindlines

This study used the concept of 'clinical mindlines' proposed by Gabbay & le May (2011), who found when faced with novel situations and gaps in their knowledge, healthcare professionals turn to colleagues over policies to guide decision making. This informal information sharing forms implicit tacit knowledge. This study sought to replicate this informal sharing of clinician experiences.

Aims

- To elicit and synthesise existing Clinical Psychologists knowledge and wisdom from their practice-based experiences of working in homelessness
- To produce a set of consensus-based good practice based guidelines for direct and indirect working using this collective-clinician wisdom and information sharing
- To provide two clinical vignettes for each guideline to replicate the informal information sharing, supporting implementation

Examples of the final endorsed consensus-based good practice guidelines

Direct guidelines

Approach

"Consider the likely trauma histories of service users you are working with, appreciating engagement can be a long process, as it is likely trust has been violated multiple times. Re-building this will take time and will require flexibility regarding DNAs etc."

Multi-agency working

"Promote good multi-agency working across professionals especially when working with complexity and risk. Coming together regularly, including with the client, is vital"

Individual therapy

"Consider what model fits the person, how to adapt it based on their current circumstances (e.g., briefer sessions over longer periods of time, more warming up and cooling down/containment time in sessions, more stabilisation work)"

Indirect guidelines

Relationships with and support for staff

"The foundation has to be based on spending time to build relationships. Consider what safety means for different staff groups and take the time to get to know them"

Supporting staff to support service users, including building therapeutic skills

"Learning and building up therapeutic and practical skills with appropriate supervision, giving people a sense of control and fostering Psychologically- and Trauma-Informed environments"

Approaching systems change

"Think about how your indirect work can become part of the system. It is not always about seeking to create an entirely new initiative which has minimal chance of survival. Doing and planning with people and organisations rather than doing to"

Contributing to the evidence base

"Consider how to take research and evaluations that you have done and share them more widely in the organisation and research community. Contributing to the evidence base of effective ways of working with this population will help influence policy and system level interventions that improve practice, reduce social and service exclusion and address inequalities, promoting more helpful narratives around homelessness"

Method

The Delphi Method (Linstone & Turoff, 1975) was used to develop practice-based consensus guidelines to support UK Clinical Psychologists direct and indirect work in homelessness. A panel of 12 UK Clinical Psychologists with experience of working within homelessness were recruited to the expert 'panel' through advertising on social media and snowball sampling.

Consensus was set apriori guided by previous research at ≥80% agreement (Jorm, 2015).

- Round One: Each panel member was interviewed individually and asked to proposed three recommendations for direct working and three for indirect working.
- Round Two: A survey was distributed with the 36 direct and 36 indirect guidelines to panel members asked to rate the guidelines on importance and provide written feedback. Eleven panel members responded.
- Round Three: Following Round two, amendments were made and a personalised survey sent to panel members containing how they had rated alongside the panel, anonymised panel feedback and details of amendments made. Participants were able to amend their original responses. Eight participants responded.
- Round Four: All amendments were distributed to participants for member checking. Clinical vignettes, taken from the Round One interviews, were provided for review. Where <2 vignettes were available, participants were asked to provide examples of the guideline in practice. Six panel members responded.

Results

Across two survey rounds, 23 direct and 26 indirect guidelines were endorsed by the expert panel. Direct guidelines fell under the following three themes:
"Approach" (8 guidelines), "Multi-agency working" (4 guidelines), "Individual Therapy" (11 guidelines)
Indirect guideline full under the following four themes:
"Relationships with and support for staff" (7 guidelines), "Support staff to support service users, including building therapeutic skills" (10 guidelines), "Approaching systems change" (7 guidelines), "Contributing to the evidence base" (2 guidelines)
Examples for each of these guidelines are displayed in the centre of this poster

Discussion

This research highlights practice-based evidence is being generated. Guidelines broadly reflects existing literature, placing importance on the relational needs of staff and service users, particularly considering the impact of trauma in and on interactions. Maximising capacity in teams and adopting a strengths-based approach is highlighted. Further research and continued conversations are recommended to support evidence-generation and sharing in the area.

Limitations, implications and future research

Attrition increased across the Rounds, falling below the desired 16-28% (Hanafin & Brooks, 2005), impacting on response weighting. Despite this, consensus remained high, with little divergence across Rounds. Given consensus was reached, these guidelines provide valuable guidance on the resources needed to support Clinical Psychologists working in homelessness. Future research should seek to explore staff and service users views of the guidelines in practice, alongside the views of mainstream services in their uptake.

References: Sosenko, F., bramley, G., & Johnsen, S. (2020). *Gender Matters: Gendered patterns of severe and multiple disadvantage in England* (Connected, Issue). Ministry of Housing Communities & Local Government. (2020). *Evaluation of the Implementation of the Homelessness Reduction Act: Final Report*. Homelessness Reduction Act 2017, (2017). Gabbay, J., & le May, A. (2011). *Practice-based evidence for healthcare: Clinical Mindlines*. Routledge. Linstone, H., & Turoff, M. (1975). *The Delphi Method: Techniques and Applications*. Addison-Wesley. Jorm, A. F. (2015, Oct). Using the Delphi expert consensus method in mental health research *Aust N Z J Psychiatry, 49*(10), 887-897. https://doi.org/10.1177/0004867415600891 Hanafin, S., & Brooks, A. -M. (2005). *The Delphi Technique: A Methodology to Support the Development of a National Set of Child Well-being Indicators*. D. T. S. Office.

Small Scale Research Project

What is the acceptability of the Consultation Support Tool in Oncology in practice?

Trainee[1,2], Dr Nima Moghaddam[1] and Dr Lynn Furber[3]

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Email: Omitted personal details to maintain anonymity for submission

Submission formatted as per the 'British Journal of Cancer'.

Abstract

Background

Communication remains a key area of complaint within the National Health Service. The Consultation Support Tool was designed for joint doctor-patient use in Oncology to improve communication. This evaluation reports preliminary exploration into its acceptability in practice.

Methods

The Consultation Support Tool was used at a single outpatient Oncology service in the United Kingdom. Ten patients and four doctors were recruited. The Spielberger State-Trait Anxiety Inventory-6 and the Consultation and Relational Empathy Measure evaluated patient anxiety and perception of person centred care pre and post initial assessment and at follow-up consultation. Unstructured interviews were completed after consultations with doctors and patients. The Theoretical Framework of Acceptability was used to complete a retrospective, deductive analysis to explore acceptability in practice.

Results

Significant amounts of data were missing for patients and doctors. Preliminary results indicate the tool was more acceptable for patients than doctors. Acceptability was established in one area regarding patient anxiety, with remaining domains requiring further exploration.

Conclusions

The tool appears broadly acceptable to patients, though clinician feedback indicated preferences for selective applications in practice. Further modification and evaluation of the tool is required. Gaps in knowledge regarding clinician anxiety are highlighted.

Background

Healthcare provision has moved from a paternalistic approach towards a patient-centred approach, encouraging clinicians to be open and supporting patients in making informed decisions about their care (1, 2)[44]. Delivering this requires effective doctor-patient communication, as reflected in the National Institute for Health and Care Excellence (NICE) Improving Outcomes Guidance in Cancer Services (3) and the NHS Cancer Plan (4). Evidence repeatedly highlights good face-to-face communication and information sharing can benefit patients: by increasing patient satisfaction, reducing emotional distress, enabling adjustment to diagnosis, and improving treatment adherence (5-9). The latter is of particular importance given a recent WHO report (5) highlighting increased adherence would have the single biggest impact on improving clinical outcomes. Thus, good communication, which promotes patient-centred care, is likely to increase treatment adherence, thereby improving outcomes. The British Psychological Society (BPS) (10) highlights communication skills as integral to the Clinical Psychologists (CP) role in healthcare services: through supporting service users; providing supervision and training to staff; and using communication and research skills to facilitate the design, development, and subsequent dissemination of research findings. This compliments NICE guidelines (3) identifying CP’s role in developing and maintaining communication skills within Oncology services. Therefore, CP’s are well-positioned to support improvements in national drives to deliver high standards of care.

Despite increased training provision through the national ‘Connected’ (11) communication training programme, communication remains a key complaint in primary and secondary care (12). Within Oncology, research exploring patient-doctor communication highlights multiple factors to consider. Doctors may: find it hard to discern what a patient wants to know

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[44] References are in Vancouver style as per the BJC guidelines (Appendix A)

about their diagnosis, avoid difficult conversations (including prognosis) to manage their own and the patients emotions (13), and over-estimate their communication abilities (14). Research into patient communication needs highlights the desire for increased information, including prognosis. A large multi-centre UK study (15) found 87% of patients wanted all information irrespective of content, and other research highlights dissatisfaction at the amount of information received can reduce engagement and increase distress (16-18). Although patients commonly prefer more information, there is considerable individual-level variability. It is important to recognise these differences to help mitigate the associated poorer outcomes when information needs are not met. Information needs vary depending on factors including sex, age, type of cancer and treatment, and can vary across time (9). Other non-specific clinician factors, including empathy and honesty, are also critical in supporting patient participation, satisfaction, and adherence (19, 20). Consequently, communication in consultations is a complex, multifactorial, dyadic, and highly idiosyncratic process with the potential for a mismatch in information needs in either under or over provision resulting in poor patient-related outcomes (8).

Though various communication aids have been developed (21-24), none are ideal, as they often consider patients and doctors in isolation (19) or require additional resources (e.g. training), increasing implementation costs (25). Developed collaboratively with patients and doctors, the Consultation Support Tool (19;CST,see Appendix B) is designed for joint patient-doctor use. Developed using conversational analysis from oncology consultations, the CST aims to promote the patient's specific information needs, helping doctors to address 'difficult' topics, and provide structure to the consultation. The CST comprises of two information booklets; one for the patient on what to expect at the consultation, and one for the doctor reminding them of key communication skills e.g. responding to emotional distress. Patients also receive a leaflet to complete before each consultation about their information needs, including decision-making and prognosis.

The doctor receives this before the consultation to review and use during the consultation.

Preliminary evaluation of the CST in a patient-doctor focus group (19) indicated patients overwhelmingly supported the CST. Doctors supported the CSTs design and content, stating it would increase insight into the patient's information needs, facilitate patient empowerment and person-centred care. However, they raised two concerns: the first being the aid lengthening consultations. The second related to prognosis being raised at an early stage, with concerns it may increase patient distress. Concerns such as these are legitimate; using an aid which increases consultation times would impact on waiting lists, which, within UK Oncology pathways, have strict wait times (26). Additionally, increasing psychological distress is likely to impact patient wellbeing, which may impact on treatment adherence and prognosis (27, 28). However, research indicates that when aids are used correctly and questions actively addressed, consultation times can be significantly reduced – and may be shorter than consults without communication aids, increasing efficiency (6, 29). BPS Psycho-Oncology guidance highlights the role of CP's in improving the patient experience by increasing efficiency in services, which the CST seeks to do by providing a structure for consultations. Finally, whilst doctors consistently highlight fears that information on prognosis can increase emotional distress, studies indicate that, if the patient desires this information, providing it can reduce rather than increase anxiety (6).

Whilst the CST has been developed using detailed analysis of patient experiences to improve communication– and holds promise in a prospective doctor-patient evaluation – it has yet to be evaluated. This paper aims to explore the acceptability of the CST in practice using the Theoretical Framework of Acceptability (30;TFA). Sekhon et al.,(30) argue healthcare interventions need to be acceptable to patients who will have to adhere to the intervention, and doctors who will need to deliver the intervention. If the intervention is unacceptable, it will lead to either low patient adherence or modification of delivery by doctors, impacting on its overall efficacy. Thus, the TFA identifies key domains which can be used to explore whether the CST is acceptable in practice and address the specific acceptability concerns raised by doctors regarding patient anxiety and consultation efficiency. This initial exploration can be used to inform future trials of the CST. The TFA is also relatively new, therefore this study serves as an exploration of the framework's usability.

Methods

Fourteen participants (ten patients and four doctors) were recruited through a single outpatient oncology department. The term 'CST' will be used in this paper to refer to both aspects of the tool (booklet and leaflet(s)) unless stated otherwise.

Design materials

An external CP was consulted throughout the research design, supporting the selection of appropriate measures. To consider the impact of the CST on patient anxiety and perceptions of person-centred care, patients completed the Spielberger State-Trait Anxiety Inventory-6 (31:STAI-6, Appendix C) and the Consultation and Relational Empathy Measure (32;CARE). The STAI-6, used widely in healthcare settings (33), seeks to measures anxiety caused by external stressors, and has good internal consistency alongside sound construct validity and reliability (34, 35). The CARE, a ten item scale, has good internal reliability and face validity, and is used in a numerous medical settings nationally to measure patient perceptions of empathy (32, 36). There is a minimum score of 10 and maximum of 50. Higher scores indicate increased levels of perceived empathy (table 1). Established cut-offs for the CARE suggest scores of ≥ 43 identify consultation episodes considered 'above average' in perceived quality/person-centeredness (37).

Table 20: CARE Measure scoring system (32)

Scoring category	Corresponding numerical rating
Poor	1
Fair	2
Good	3
Very good	4
Excellent	5
Not applicable	*Can have a maximum of two 'Not applicable' and/or missing values which are substituted with the average of remaining scores. If there are more than two instances, the questionnaire is omitted from the analysis.*

Procedure

Patients were sent the CST prior to their first appointment and asked to complete and bring the leaflet to their initial appointment and follow-up appointment. When patients arrived, the researcher (also the CST developer), would give the leaflet to the doctor to review prior to the consultation. Doctors would also be given a copy of the communication booklet for reference. Pre-consultations patients were asked to complete the STAI-6. Post-consultations, patients completed the CARE and STAI-6. Patients and doctors were invited separately to an unstructured interview with the CST developer-researcher after each consultation to discuss the CST, which was recorded and transcribed.

Data analysis

In applying the TFA and domains (table 2), we separated out the ethicality subdomain of *ethical consequences* to explicitly capture the potential for adverse effects (including iatrogenic increase in anxiety) – to ensure we addressed the prospective concerns[45].

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[45] See Appendix D for further information on this separation.

A mixed deductive-inductive template analysis was applied (38) from a critical-realist stance (39). The deductive template was formed by the TFA a priori domains, with secondary exploration and sub-coding within the TFA framework undertaken inductively. Interview data was considered for inclusion based on frequency and salience. All data was analysed and coded by two researchers independently to control for researcher bias and sent to a third for final checks. Illustrative quotes are used to support the findings though only include the participant number for significant quotes or discussion points, supporting clarity.

Quantitative outcome data was analysed using descriptive statistics. To overcome limitations with Likert scales, Rasch-analysis scoring was used for the STAI-6 analysis, weighting the scoring on participant contribution (33, 40).

Table 21: TFA domains, definition and considerations from Sekhon et al.,(30), and sub themes identified

Domain	Definition	Key considerations indicated in Sekhon et al.,(32) (if present)	Data included / subthemes identified (where applicable)
Affective Attitude	How an individual feel's taking part in an intervention (prospective and retrospective)	Attitude towards intervention Attitude measures	
Burden	The perceived amount of effort that is required to participate in the intervention	Reasons for discontinuation (e.g. time, expense, cognitive load) Reasons for dropout (e.g.	Patient completion data Impact on consultation length

		time, expense, cognitive load) (All reasons not related to a participants confidence in the intervention)	Impact on consultation preparation
Ethicality - values	The extent to which the intervention has a good fit with an individual's value system		Individual values
Ethicality - consequences	Associated side effects with the intervention		Anxiety (STAI-6) Prognostic information
Intervention Coherence	The extent to which the participant understands the intervention and how it works	An understanding of the perceived fit between the components of the intervention and intended aim of the intervention e.g. face validity of the intervention to the recipient or deliverer	Understanding the purpose of the intervention Using the CST Difficulties experienced by patients

Opportunity Costs	The extent to which benefits, profits or values must be given up to engage in the intervention		
Perceived Effectiveness	The extent to which the intervention is perceived as likely to achieve its purpose		CARE measure Patient perceptions of the CST components Person-centred care, participation and decision-making Future practice
Self-efficacy	The participants confidence that they can perform the behaviour(s) required to participate in the intervention	Reflects own confidence in the perceived ability to exert control over one’s own motivation, behaviour or social environment	

Results

The results below are structured using the TFA domains that formed the template for analysis. Appendix D provides a summary of the data and a subjective quality appraisal rating by the researchers for each domain, added to identify gaps where further research is required.

Affective attitude

Of the four doctors, three (75%) voiced support for the CST. One felt the CST had ‘huge potential’ and another that it supported their preparation for one appointment, but not for another. Exceptionally, one doctor (25%) did not think it altered their consultations and did not feel the CST was helpful.

Of the ten patients, two (20%) explicitly said they found the CST helpful. Two (20%) indicated the booklet could be helpful for others, recognising the need to ‘cover everything’. The remaining 60% provided no comment regarding helpfulness.

Burden

Patient completion data

Data were missing for multiple components. Based on the available data, only one participant (10%) completed all study measures fully including the CST at both timepoints. The remaining nine (90%) partially completed all measures, and two (20%) of these provided no data for the second timepoint.

For the quantitative data, six participants (60%) fully or partially completed the STAI-6 and CARE at both timepoints; four (40%) did not complete the STAI-6 pre and post both timepoints, and three (30%) did not complete or partially completed the CARE at each timepoint. One participant completed only the STAI-6 and CARE data at each timepoint. Eight participants (80%) completed the first unstructured interview, and four (40%) provided interview data at both timepoints.

Data on how the CST leaflet was completed by the participant prior to consultation was available for six (60%) participants. Five participants (50%) fully or partially completed the CST at both timepoints and the remaining 10% provided data only at timepoint one. A further three participants (30%) indicated during the interviews they had completed the CST at the first timepoint, but completion data was absent.

Impact on consultation preparation

Doctors views were mixed regarding consultation preparation, with two (50%) indicating the CST did not alter their consultation preparation. The remaining two (50%) indicated the CST leaflet could be helpful; one highlighted it may have been helpful in preparing had the patient completed the form correctly by selecting only one option where applicable. For two doctors who saw the same 'complex' patient for different consultations, the CST was very helpful for this 'hard consultation' due to the prognostic results. One found it helped them feel able to address all the patient concerns and 'prepare psychologically'. Interestingly, this same doctor felt the CST was less helpful preparing for another, less 'complex' patient.

Impact on consultation length

All three doctors (75%) who used the CST during at least one consultation explicitly stated the CST did not lengthen the consultation. One felt it made the consultation more 'slick' as they were able to address questions more efficiently, though the other two noted it would depend on the patient's information preferences. The remaining doctor (25%) did not comment on consultation length.

Ethicality

Individual values

Two patients (20%) explicitly stated the tool helped 'empower' them. One said the CST brought a 'sense of equality' and 'control' to the consultation.

None of the remaining eight participants (80%), explicitly mentioned empowerment.

Only one doctor (25%) alluded to empowering the patient in their choice of treatment and the CST reducing potential communication errors. The remaining three (75%) provided no comments relating to individual values.

Ethicality – consequences

Anxiety

The STAI-6 suggests there is no evidence the CST elevated patient anxiety (Figure 1). Pre and post scores were available for all ten (100%) participants at timepoint one, and six (60%) at timepoint two. Patients scores were generally in the range of 'low anxiety' (calm/relaxed). Scores from the pre to post consultation show a trend towards reduced anxiety, though the effect size was small (rs=.10-.19).

There were two outliers; one participant had the highest anxiety pre-consultation one, which dropped post-consultation from +3 to -3. Considering the qualitative data, this participant received their diagnosis unexpectedly via post which may account for their elevated anxiety. The second participant's anxiety increased significantly from within the normal range to 2.42 post-consultation. Considering the interview data, this participant was the only to receive a terminal prognosis. They attributed their increased anxiety to:

> *'our expectations going in were different to what we were told so that made us tense'* (P004, first consultation)

Their scores remained elevated at timepoint two, though this could be attributed to receiving an anxiety-provoking diagnosis.

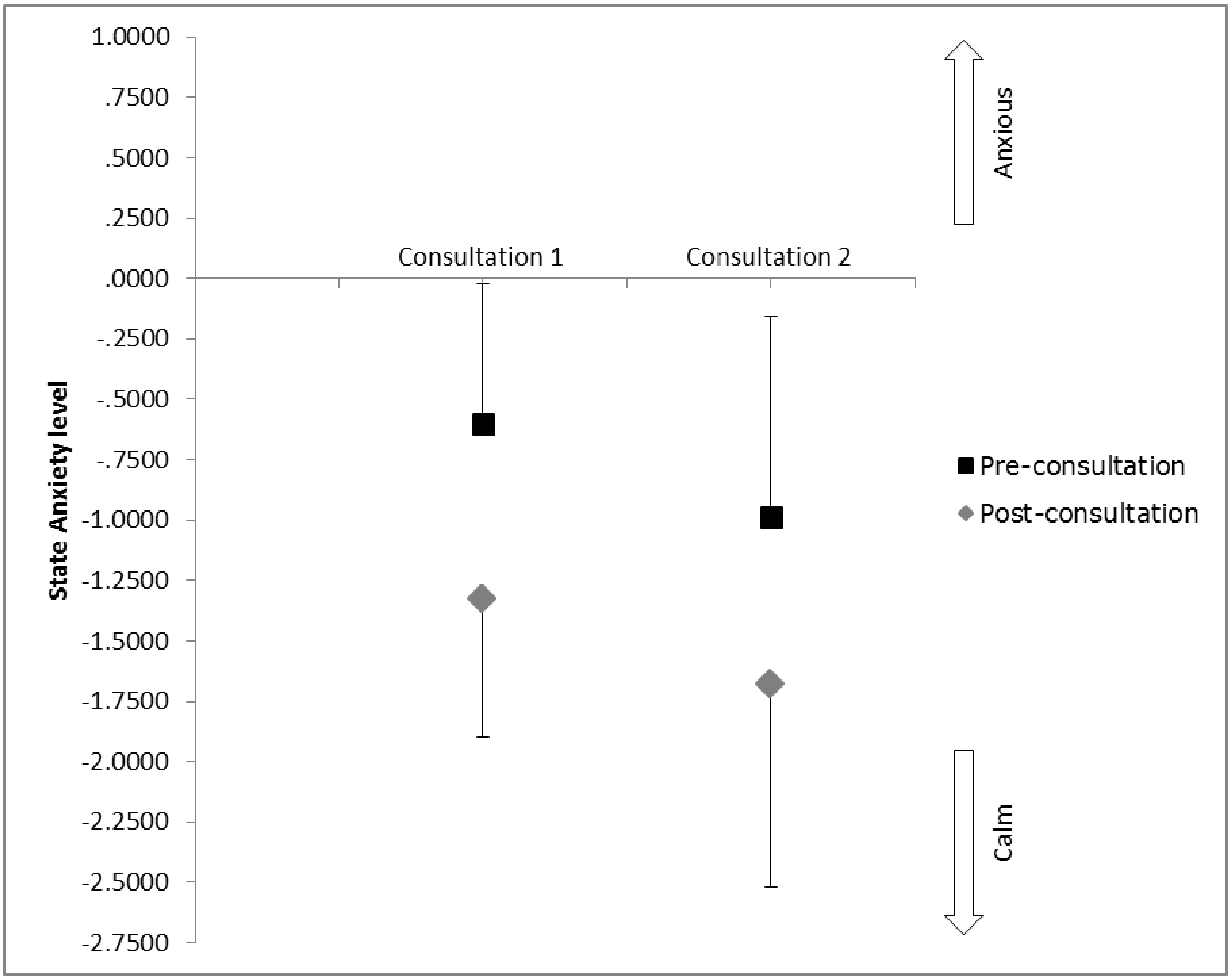

Figure 8. STAI-6 scores showing mean and standard error pre- and post-consultation one and two, using continuous Rasch-scaling (33)

Prognostic information

Five (50%) patients provided information regarding the CSTs impact on considering prognostic information. One (10%) explicitly stated it had no impact on their anxiety whilst two (20%) said they initially had to 'put the leaflet down' as the prognostic question 'really threw' them. A further 20% (two) said it helped them think about the future and their information preferences. Despite increasing anxieties, all five patients expressed a desire to be provided with this option, with none wanting it to be removed.

One participant (10%) provided insight into the impact of the CST on receiving a terminal prognosis. They acknowledged sometimes you receive information you 'don't want to hear' and liked being able to decide how much information they desired. However, they also note it is important the doctor communicates this information well, as the CST is unable to substitute sound communication skills.

Intervention coherence

Understanding the purpose of the intervention

Two (50%) doctors indicated they understood the purpose of the intervention, with one noting it could improve patient experience by 'considering their needs, avoiding a mismatch between…agendas'. The second noted the CST acts as a reminder for doctors to be aware of the patient's needs. The remaining two (50%) did not discuss the purpose of the CST.

Of the patients, five (50%) mentioned the CST could help inform the doctor about their information preferences, and help them to understand what to expect, improving the consultation experience. The remaining five (50%) did not discuss the purpose of the CST.

Using the CST

Three (75%) doctors indicated they had read the CST leaflet prior to meeting at least one patient and two (50%) referred to it in at least one consultation. One (25%) felt unable to use the CST as it had been completed incorrectly. The remaining doctor (25%) had not received the leaflet prior to the consultation.

Nine patients (90%) indicated they had reviewed and completed the CST prior to at least one consultation. For those where CST completion data was available, two (20%) completed the tool 'incorrectly' at timepoint one; one (10%) selected multiple rather than a single option for 'your prognosis' and both (20%) selected multiple options for 'decision-making'. None completed the CST 'incorrectly' at the second timepoint. One patient highlighted that, when considering decision-making, they felt selecting all options ‘best described what I wanted’. The second highlighted confusion around how many options they could select.

Difficulties experienced by patients

Three (30%) expressed difficulties completing the CST leaflet. One (10%) related to difficulties understanding terminology for diagnosis and prognosis, suggesting terminology may need to be clarified to avoid confusion. Two (20%) felt the CST was easier to complete for the second consultation as they had more information from the first consultation to guide their information requirements.

Opportunity costs

Two doctors (50%) considered the potential for a detrimental impact on consultations, while the remaining two (50%) provided no comment. One said the CST was helpful but was unsure whether this would apply in a busy clinic as it would depend on the patients’ information-preferences, which may lengthen consultations. The second felt the CST had altered their existing consultation structure making them feel ‘a little bit all over the place’ but did not discuss this further.

Perceived effectiveness

CARE measure

The CARE measure, exploring patient experience of person-centred care, indicated rating of consultations were above normative averages for both consultation one (M=44,SD=8.18) and consultation two (M=44.67, SD=4.27) suggesting the CST is not associated with poor or detrimental care scores (37). However, the lack of comparator means it cannot be determined whether this is different from standard care.

Patient perceptions of CST components

Of the patients who explicitly commented on the CST’s individual components, feedback on the information booklets was positive. Four

(40%) commented on their accessibility, and three (30%) explicitly stated they valued the patient quotes as it helped them understand what to expect. One (10%) felt it helped minimise them worrying about asking 'silly questions'. Considering the leaflet, none provided any negative feedback regarding its layout, with five (50%) indicating it was a helpful prompt to consider how much information they desired. Additionally, two (20%) explicitly voiced support for the information preferences selection boxes relating to prognosis and treatment decisions. Two amendments were suggested for the leaflet; the CST be made mandatory and the term 'condition' be used rather than 'cancer'.

Person-centred care, participation, and decision-making

Two doctors (50%) commented the CST supported patient participation by providing an avenue to write down questions and helped the clinician focus on the patients' agenda. However, for both this seemed to depend on the patient; feeling the CST was helpful for the same patient (P004) who was viewed as 'complex'. One (Dr6) voiced less support for the CST for a patient they perceived as less complex (P003).

Five patients (50%) discussed shared decision-making, with three (30%) providing positive comments around 'feeling involved' and feeling 'able to talk and ask questions'. The remaining two (20%), experienced difficulties with shared decision-making despite selecting this as an option on the CST, feeling this did not occur. The first recognised they may have fewer treatment options due to their religion and had included this information on the CST. The patient explained they knew the doctor had reviewed the CST prior to the consultation as they referred to their religion during the consultation. However, when discussing the options, the patient mentioned:

> *'I don't think there was a lot of sharing…it would have been nice to have shared alternatives with us'* (P004, first consultation)

This patients' first and second consultations were with two different doctors. After the second consultation, they compared the two:

> '*She said I will just go through your questions and answer them…I did feel as if she listened better…than the first one, took more notice of what I wanted'* (P004, second consultation)

This difference could be attributed to the second doctor considering all of the information needs highlighted on the CST, tailoring the consultation accordingly. Interestingly, the doctor from the first consultation felt the CST supported their ability to deliver person-centred care in a 'complex' case, indicating a mismatch between the patient and doctors' perceptions of shared decision-making.

The second patient had a similar experience, saying they 'told us' what the treatment cycle would be, despite selecting shared decision-making. They go on to say:

> *'I think they could have looked at that and said we see you wanted to share the responsibility between us but we feel that after discussing it this would be the best thing for you'* (P003, first consultation)

This indicates the patient recognises the doctor is best-placed to decide the treatment option but would appreciate understanding the rationale. This is highlighted by another patient who had a positive experience of shared decision-making, saying the doctor 'explained what was going to happen', helping them feel involved.

As with the first example, the second also felt the second consultation was better because:

> *'….she looked at my two questions and she wanted to know stuff about what I was doing and how I had reacted, so she was yes, more personal'* (P003, second consultation)

And compares the two consultations:

> *'...today was more, I felt she used it and answered the questions rather than before'* (P003, second consultation)

Interestingly, though both patients had different doctors for the first consultation, they had the same doctor (Dr6) for the second consultation where both patients felt the doctor had used the CST, feeling involved in decision-making. Interestingly, P003 is the patient Dr6 felt the CST was less useful for as they were less 'complex', though this is not reflected in P003's experiences.

The remaining doctors and patients did not discuss shared decision-making and participation.

Future practice

Two (50%) doctors highlighted the CST could improve continuity of care should the patient not have the same consultant for each appointment, as it could provide consistency around the patient's agenda. The remaining two (50%) provided no comment on the CST's ongoing use.

None of the patients explicitly disagreed with the CST being used in future practice, though three (30%) thought it could have been introduced at different points; one at the start of the process, one for new consultations only, and one from the second consultation onwards.

Self-efficacy

None of the patients discussed their confidence in the intervention. Of the doctors, one (25%) explicitly stated it did not raise their anxieties and alluded to it reducing any anxieties. However, one doctor (25%) said the CST raised their anxieties as they had to 'work through' the patients' questions, though noted this could be due to them not having 'dealt with things like that before'. The remaining two (50%) did not explore the impact of the CST in relation to self-efficacy.

Discussion

Considering the key points within the available data, the CST appears largely acceptable in practice for patients. The majority used the CST in at least one consultation, several explicitly voiced support at being provided with options relating to their care, and none felt the CST was unnecessary. Amendments were suggested in relation to terminology and introduction into the pathway.

Despite questions regarding prognosis initially causing distress, all patients who commented wished for this to remain within the CST. Combined with the STAI-6 data, this suggests that, contrary to concerns (19), considering prognosis using the CST prior to and during consultations does not increase anxiety above the normative range. This provides additional evidence that, if the information is desired, discussing prognosis does not increase patient anxiety (6, 41, 42). Research suggests doctor's avoid prognostic discussions to manage patient anxiety (43), though less research has considered doctors anxiety discussing prognosis. These concerns may be reflective of their own anxiety rather than the patients'. A systematic review indicated doctors are less likely to provide information on prognosis than all other aspects of care, as these were 'difficult' conversations (44), are more likely to talk about being unable to 'remove' the cancer unless explicitly prompted for prognostic information (44, 45), and other research indicates clinician reticence discussing prognosis (46). Whilst 'Breaking bad news' is included in the 'Connected' training (2008), CP's could build on this by supporting doctors to have these conversations, through supervision, training, and feedback-informed practice. This may reduce communication errors, thus reducing the level of psychological distress for patients, improving outcomes (5-9).

Patients supported shared decision-making. Satisfaction reduced when information preferences regarding shared decision-making were perceived to have been dismissed. These instances focused on a perceived lack of information-sharing regarding the rationale behind decisions, highlighting a failure in information-preference matching. Though under or over provision of information is linked to detrimental care outcomes (8), this was not replicated in the CARE scores. This may be because in both instances, the information preference was resolved during the second consultation, highlighting the potential for the CST to rebuild trust between doctors and patients when adhered to. Research indicates distrust in professionals can increase if patient choice is ignored, and is linked to reduced adherence to treatment recommendations (47). Therefore, if the CST is not perceived to have been followed completely, this could result in detrimental care outcomes. Additionally, in one instance, the information-mismatch appeared to be due to a lack of congruence between the doctor's perception of their communication skills and use of the CST (14) and the patient's perception. This suggests the CST is unable to mitigate mismatches in information delivered, reiterating the importance of building sound communication skills through continued training, supervision, and deliberate feedback-informed practice.

Similar to previous research (6), the CST did not lengthen consultations. Despite doctors voicing considerable support for the CST, only fifty percent used the CST during at least one consultation, suggesting it was less acceptable to doctors than patients. Adherence to and usefulness of the CST was mediated by two aspects: 'correct' completion and case complexity. For the former, difficulties reported by patients completing the CST indicate aspects may need to be amended to increase usability, which may impact clinician acceptability. For the latter, a mediating factor may be differences in doctor-patient perception. Though one doctor felt the CST supported them more for a complex case, both patients who received a CST-supported consultation felt the same doctor tailored the consultation to fit their information needs. Therefore, though doctors may not perceive the CST as useful, it may improve the patients experience of person-centred care. Evidence continues to indicate differences in doctor-patient perceptions in areas critical to good face-to-face communication such as empathy (48), doctor-perceptions of level of patient distress following diagnosis (49), and overestimation of patient satisfaction and efficacy of their own communication skills (50). Therefore, the CST may help bridge this gap between patient-doctor perceptions, providing the doctor adheres to the CST.

This research has adopted a position which considers communication aids as a positive addition to consultations. It is possible the CST increases the likelihood of mismatches in communication being identified, as, unlike other aids, patients explicitly identify their information needs, which may increase their expectations these will be met, though further research into this hypothesis is required. Furthermore, the lack of a comparator means this research is unable to determine how CST-supported consultations compare with usual care in Oncology services.

Significant amounts of data were missing limiting this study’s utility. Reasons for poor completion rates were unclear, though it could be attributed to the study design being burdensome. Interview data was largely unstructured and completed by the developer/researcher whose dual role is a clear limitation, increasing biases within the data set with leading questions identified throughout. Unstructured interviews within health research requires the researcher to hold in mind the research question(s), whilst allowing open exploration of the participants’ perceptions, increasing data validity. Thus, natural variations in richness and applicability of data to the research question are likely to occur (51). For many domains of the TFA, the data was absent making conclusions regarding acceptability problematic. This can be seen in Appendix D where, though subjective, only one domain - ethicality – consequences – was given a ‘green’ rating, whilst the rest were red or amber indicating further evidence is required. Therefore, a clear recommendation is the completion of a large-scale study comparing CST-supported consultations to non-CST supported consultations, with clear patient completion and doctor adherence records and independent researcher.

Similar to previous research, several of the TFA domains overlap (52), suggesting a lack of discriminant validity and need for refinement of domains (53). Arguably, much of the data could apply to many domains; for example, if an intervention is considered incoherent, this is likely to increase its burden and resulting opportunity costs. This is evident within the data presented, with data fitting into and being presented in multiple domains. Using the TFA may be problematic when assessing unstructured qualitative data as using a framework may pertain to a more positivist position, suggesting a mismatch between the selected framework and the researchers' epistemological stance. Therefore, future research should explore the uniqueness of TFA domains and suitability of use for a range of data.

In conclusion, preliminary data suggests the CST is largely acceptable for patients who valued shared decision-making. Doctor acceptability was mediated by case complexity and correct completion of the CST, resulting in variability of CST use in practice. These acceptability concerns and moderating factors need to be addressed for future evaluations of the CST, due to the dyadic nature of the communication aids requiring acceptability of use by patients and doctors. It is clear the CST should be seen as supporting (not replacing) sound communication skills. CP's play a key role in improving these communication skills by supporting staff through supervision and ongoing training, alongside continued research. Recommendations for future research include further exploration of clinician anxiety in influencing prognostic discussions and exploration of the TFA frameworks validity and usability.

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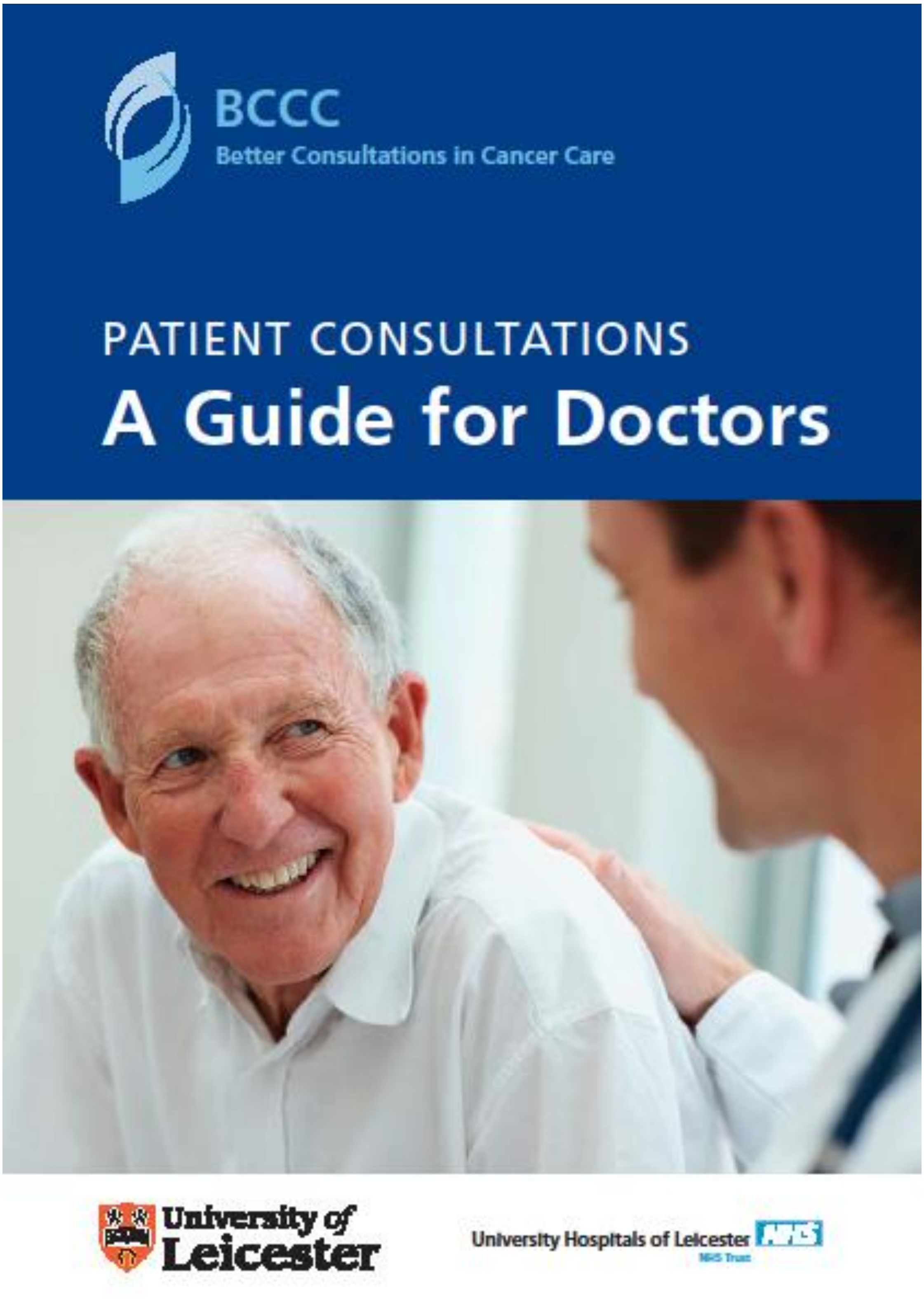
Appendix A

CST components



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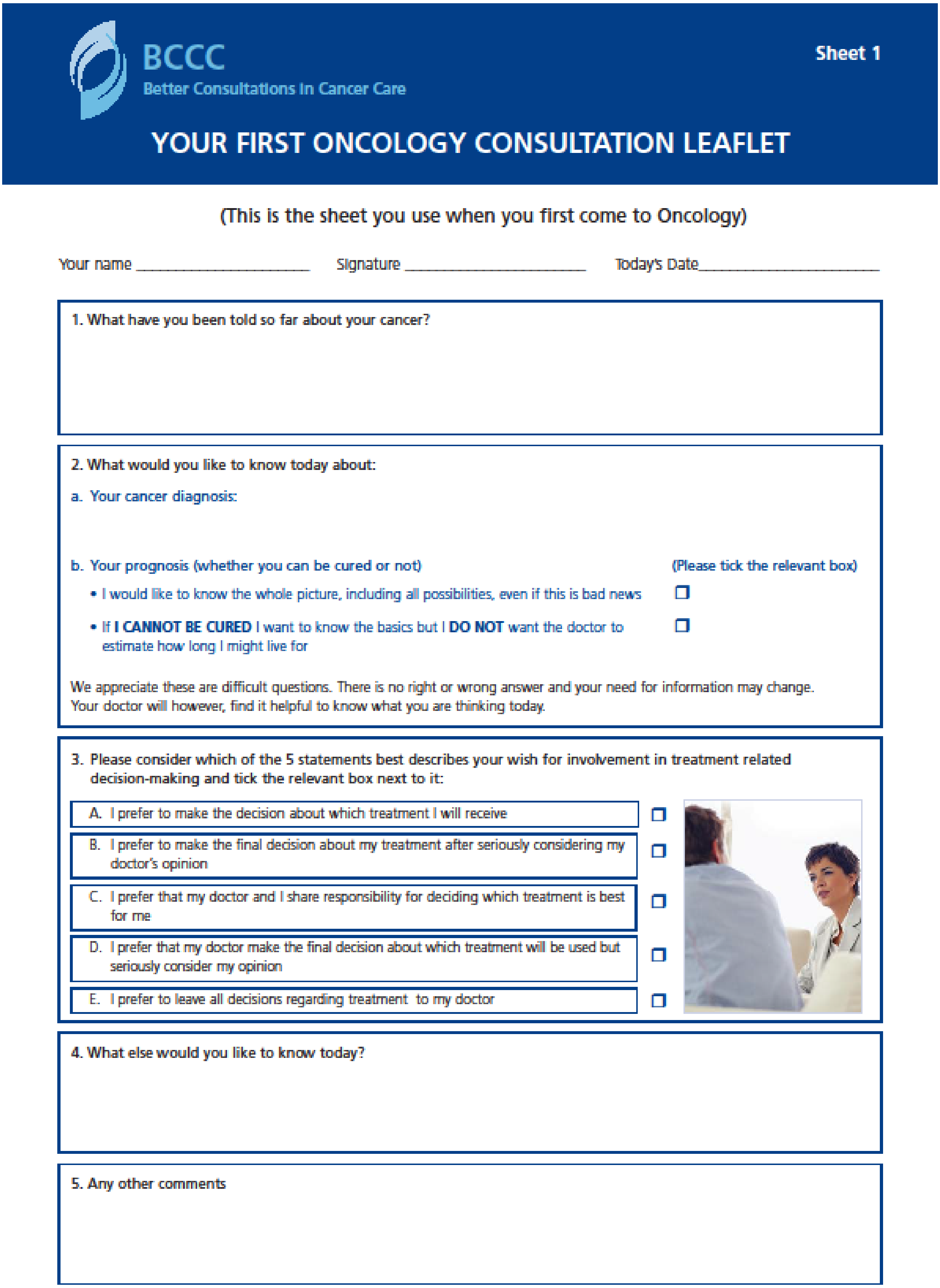

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Sheet 1

YOUR FIRST ONCOLOGY CONSULTATION LEAFLET

(This is the sheet you use when you first come to Oncology)

Your name ______________________ Signature ______________________ Today's Date______________________

1. What have you been told so far about your cancer?

2. What would you like to know today about:

a. Your cancer diagnosis:

b. Your prognosis (whether you can be cured or not) (Please tick the relevant box)

- I would like to know the whole picture, including all possibilities, even if this is bad news ☐
- If **I CANNOT BE CURED** I want to know the basics but I **DO NOT** want the doctor to estimate how long I might live for ☐

We appreciate these are difficult questions. There is no right or wrong answer and your need for information may change. Your doctor will however, find it helpful to know what you are thinking today.

3. Please consider which of the 5 statements best describes your wish for involvement in treatment related decision-making and tick the relevant box next to it:

A. I prefer to make the decision about which treatment I will receive ☐
B. I prefer to make the final decision about my treatment after seriously considering my doctor's opinion ☐
C. I prefer that my doctor and I share responsibility for deciding which treatment is best for me ☐
D. I prefer that my doctor make the final decision about which treatment will be used but seriously consider my opinion ☐
E. I prefer to leave all decisions regarding treatment to my doctor ☐

4. What else would you like to know today?

5. Any other comments

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Sheet 2

YOUR FOLLOW UP CONSULTATION LEAFLET

(This is the sheet you use for follow up consultations)

Your name ______________________ Signature ______________________ Today's Date______________________

1. What have you been told so far about your cancer?

2. Has your need for information changed in any way since your last consultation? And if so what would you like to know today?

3. Please consider which of the 5 statements best describes your wish for involvement in treatment related decision-making and tick the relevant box next to it:

A. I prefer to make the decision about which treatment I will receive ☐

B. I prefer to make the final decision about my treatment after seriously considering my doctor's opinion ☐

C. I prefer that my doctor and I share responsibility for deciding which treatment is best for me ☐

D. I prefer that my doctor make the final decision about which treatment will be used but seriously consider my opinion ☐

E. I prefer to leave all decisions regarding treatment to my doctor ☐

We appreciate these are difficult questions. There is no right or wrong answer and your need for information may change. Your doctor will however, find it helpful to know what you are thinking today.

4. If you have recently had some tests (CT/MRI/ Bone Scan/X-rays) you may want to think about the following options and tick all boxes that apply to your needs:

- I would like the doctor to show me my scan results ☐
- I would like to know the whole picture, including information about the size of my cancer **AND** what effect this has on my prognosis ☐
- I would like to receive information about the size of my cancer **BUT I DO NOT** want to know what effect this has on my prognosis. I want to concentrate on what you can do to help me ☐
- I would prefer it if you just told me if my cancer had grown or not and didn't go into any more details ☐
- If you give me some bad news I would like the option of going into a quiet room at the end of the consultation for a few minutes to compose myself ☐

5. Any other comments

Appendix B

STAI-6 scoring

Scoring for each question on the STAI-6 can be seen in table 2:

Table 22: STAI-6 Scoring

Scoring category	Corresponding numerical rating
Not at all	1
Somewhat	2
Moderately	3
Very much	4

Marteau and Bekker (54) advised to calculate the STAI-6 using the following method, as used in this study:

- For positive items, reverse the scoring e.g. a score of 1 would be a 4
- Add all scores six and multiply this score by 20/6
- Use the STAI manual to interpret the score

Within the manual, a standard score falls within the 34 – 36 range. Scores above a cut off of 39 – 40 indicate clinically significant state anxiety(55).

Appendix C

In version 2 of the TFA, ethical considerations is considered as 'value-congruence'; however the researchers felt that this omitted the ethical 'consequences' of an intervention, as the side effects of an intervention, particularly one which could increase anxiety, is a key ethical consideration. Therefore, this was included as a separate domain.

Table 23: Summary of the CST data in the CST with ratings for each domain indicating areas requiring further exploration

Domain & definition	**Data included / subthemes identified (where applicable)**	**Summary of findings**	**Rating for each domain indicating areas requiring further exploration**[1]
Affective Attitude How an individual feel's taking part in an intervention (prospective and retrospective)		Four (75%) of doctors explicitly voiced support for the CST, whilst one (25%) did not think it was helpful. Two patients (20%) indicated the CST was helpful with a further two (20%) highlighting the booklet may be helpful for others. Six (60%) provided no comment.	Amber
Burden The perceived amount of effort that is required to participate in the intervention	Patient completion data Impact on consultation preparation Impact on consultation length	*Patient completion data* Significant amounts of data missing for all measures at both timepoints including the CST, STAI and CARE. Patient completion of interviews at the second timepoint was significantly lower than the first timepoint, but reasons for this is unclear. *Impact on consultation preparation* Feedback support doctor consultation preparation was mixed. Fifty percent (two) indicated it did not change their consultation, whilst the remaining two (50%) both indicated that the CST was helpful preparing for a more challenging consultation. *Impact on consultation length* None of the doctors who commented on the impact of the CST on consultation length (3 doctors, 75%). Two of the doctors (50%) felt it may depend on how much the patient writes, and one (25%) felt it made the consultation more efficient.	Red for patient data Amber for clinician data
Ethicality - values The extent to which the intervention has a good fit with an individual's value system	Individual values	Despite two (20%) of participants stating the CST helped to 'empower them, eight (80%) provided no comment regarding their individual values. One doctor (25%) provided evidence that they felt the CST helped to empower the patient and reduce communication errors.	Amber

Ethicality – consequences Associated side effects with the intervention	Anxiety (STAI-6) Prognostic information	STAI-6 indicates that the CST did not elevate patient anxiety above normative range. Qualitative feedback indicates that, despite patients finding information and discussions regarding prognosis to be distressing, all of those who commented on prognostic information wanted this to remain in the CST as an option for patients.	Green
Intervention Coherence The extent to which the participant understands the intervention and how it works	Understanding the purpose of the intervention Using the CST Difficulties experienced by patients	*Understanding the purpose of the intervention* Fifty percent (two) doctors indicated they understand the CST could avoid communication errors and could act as a reminder to consider the patient's needs. Of the patients, 50% provided no comment on the purpose of the CST. The remaining 50% mentioned the CST could help the doctors understand their information preferences and improve the consultation experience. *Using the CST* Three doctors (75%) indicated they had reviewed the CST before meeting with at least one patient. Two (50%) used the CST in at least one consultation, one (25%) felt unable to use it as it had been completed incorrectly. The final doctor (25%) had not received the CST before the consultation. *Difficulties experienced by the patient* Three (30%) of patients experienced difficulties completing the CST leaflet. Suggestions were made regarding terminology.	Amber
Opportunity Costs The extent to which benefits, profits or values must be given up to engage in the intervention		Two (50%) of doctors considered possible costs of the intervention, with one querying how it would fit in to a busy clinic, and the second indicated increases in their anxiety as it impacted on the consultations structure.	Amber
Perceived Effectiveness The extent to which the intervention is perceived as likely to achieve its purpose	CARE measure Patient perceptions of the CST components Person-centred care, participation and decision making Future practice	*CARE Measure* The CARE measure indicates the CST is not associated with detrimental care scores at consultation one (M=44, SD=8.18) or consultation two (M=44.67, SD=4.27). *Patient perceptions of the CST components* Patient feedback of the booklets was positive with four (40%) explicitly commenting on how helpful the booklets were. No negative feedback was received relating to the CST leaflet, with 50% explicitly indicating it was helpful as an information preference prompt. A further two (20%) explicitly voiced support for the information preferences regarding prognosis and treatment decisions.	

	Person-centred care, participation and decision making Complexity appeared to mediate two doctors (50%) perceptions of how useful the CST was. For both, it helped them focus on the patient's agenda. Shared decision making was discussed by five (50%) of patients, with three (30%) providing positive comments. The remaining two (20%) expressed difficulties with this, with both feeling the information preferences had been ignored. Interestingly, both felt the second consultation included shared decision making which was with the same doctor.	Amber
	Future practice Two (50%) of the doctors felt the CST could provide continuity of care for the patient. The remaining 50% provided no comment. None of the patients disagreed with the CST being used in future practice, though there was some disagreement about when this should be introduced.	
Self-efficacy The participants confidence that they can perform the behaviour(s) required to participate in the intervention	None of the patients discussed their confidence in the intervention. Two doctors (50%) discussed anxiety, with one saying it reduced their anxiety, whilst the second felt it increased it. The remaining two provided no comment on the CST and self-efficacy.	Red for patient data Amber for clinician data

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[1]Green – Evidence identified, Amber – Partial evidence found further consideration required, Red – Lack of evidence, further consideration and exploration required