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Wagstaff, Christopher; Davis, Anna; Jackson-McConnell, Elizabeth; MacDonald, Matilda; Medlyn, Ashley; Pillon, Sandra Cristina

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Experiences of homeless people who use psychoactive substances: an interpretative phenomenological study

Chris Wagstaff, Anna Davis, Elizabeth Jackson-McConnell, Matilda MacDonald, Ashley Medlyn and Sandra Pillon

Abstract

Purpose – *Homelessness and psychoactive substance (PS) use are both determinants of physical and mental ill health, with the homeless population using, and dying of PSs more frequently than the general population. However, there is a gap in research on the real-world implications psychoactive substance use (PSU) has on the homeless population. This study aims to explore the experiences of PSU from the perspective of homeless users.*

Design/methodology/approach – *Purposive sampling was adopted to recruit participants and semi-structured interviews collected data from participants, with interpretive phenomenological analysis (IPA) generating common themes from the data gathered.*

Findings – *Four participants were interviewed. The themes generated were family and close relationships; cyclical patterns; mistrust in people and services; and low self-worth.*

Research limitations/implications – *This study is limited by potential bias from researchers who built relationships with participants through the data collection process. Despite efforts to remove this bias, through reflexivity throughout data collection and analysis, some bias may be still present. The researchers saw the participants as vulnerable people who were striving to overcome adversity. Such conception of the participants is reflective of how the participants portrayed themselves. The small sample is suitable for IPA purposes. Of course, it could have been possible that if different participants had been recruited or more participants had been recruited, then there could have been different themes and findings. IPA prides itself on its idiographic focus.*

Practical implications – *More research is needed on a wider scale to assess the extent and cause of these issues. Increased education and dissemination of research such as this is required to break down stigma within the public and guide policy change in professional services.*

Originality/value – *This paper interpretatively presents themes generated by semi-structured interviews with four homeless PSUs. As such, these individuals are vulnerable and have faced adversity throughout life from both society and the services they use. Their vulnerability leads to a cycle of substance use and a feeling of low self-worth, which is perpetuated by the perceived views of those around them.*

Keywords *Homelessness, Psychoactive substance use, Interpretive phenomenological analysis*

Paper type *Research paper*

(Information about the authors can be found at the end of this article.)

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Introduction

Homelessness and psychoactive substance (PS) use are recognised as determinants of both physical and mental ill health (Homeless Link, 2014; Schulte and Hser, 2014). Despite the number of people who are homeless in the UK, the prevalence of substance use within the homeless population and the impact both can have on health and well-being, there is a massive gap in research on how these issues directly affect the population concerned.

The current study sheds light upon the complex and sensitive relationship between homelessness and substance use as well as the perceived social support the relevant

individuals receive. The current study focuses on the individual opinions and experiences of those who confront these issues daily.

The last global estimate from the United Nations (UN) estimated that 100 million people were living in homelessness worldwide in 2005, with approximately 15 million forcefully evicted every year (United Nations, 2005). Although outdated, these figures are thought to have increased over the past 10 years (UN, 2020) and show the global nature of homelessness. To produce these figures, there is a necessity to define homelessness, something that proves more complex than at first glance.

Homelessness is a worldwide problem and is an important social determinant of health. The World Health Organisation defines healthy housing as a "shelter that supports a state of complete physical, mental and social well-being" and outlines how a lack of healthy housing has a detrimental impact on health (World Health Organisation [WHO], 2021). Although in the UK, homelessness is defined as "a household that has no home in the UK or anywhere else in the world available and reasonable to occupy" (Public Health England, 2019). Therefore, by global and national definitions, being homeless does not necessarily mean to be sleeping on the streets. Homelessness includes those living in temporary accommodation, inadequate housing and insecure housing as well as those living without shelter of any kind and therefore sleeping rough (Public Health England, 2019). Most official UK data on homelessness mainly includes individuals sleeping rough or living in temporary accommodation and, therefore, this will be the definition used for this paper.

Gaining accurate data for the number of homeless individuals in the UK is difficult due to the chaotic nature of the homeless population but it can be assumed that any figure produced is lower than the actual number. With this in mind, the UK homeless charity Shelter (2021) estimated that 274,405 individuals were homeless in the UK on a given night in the same year. This equates to approximately one in six of the general population, a staggering statistic that highlights the prevalence of homelessness within society.

People living in homelessness often experience higher rates of physical and mental ill health with housing recognised as an important social determinant of mental and physical health (WHO, 2018, 2014). The mean age of death in England and Wales is 32 years lower in the homeless population than in the general population (Office for National Statistics [ONS], 2021), with higher rates of communicable diseases as well as chronic conditions (Thomason, 2013; Lewer *et al.*, 2019). Furthermore, a review by Crisis (2009) found that all research, globally and in the UK, depicts a higher rate of mental disorders in the homeless population than in the general population. Staggering statistics such as these prove the vulnerable state of the health of the homeless population in comparison to that of the general population and raise questions about why such a disparity exists.

There are a variety of social factors and personal characteristics that contribute to health inequalities in the homeless population. The present study focuses on PS use and the impact it has on homeless individuals. In the UK, the ONS (2020) reports that 9.6% of the general population uses substances, and although there is limited evidence on the patterns of use within the homeless population, Crisis (2017) estimates that statistics may be as high as 27% in the homeless. Almost two in five deaths of homeless people were related to drug poisoning in 2020 (ONS, 2021).

However, there is a significant gap in qualitative research on the homeless population and specifically on those who use PSs. Existing research (Brunini *et al.*, 2018; de Espíndola *et al.*, 2020; Stahler *et al.*, 2005; Halpern *et al.*, 2017; Jones *et al.*, 2020; Peiter *et al.*, 2019; McVicar *et al.*, 2015) originates from countries other than the UK and lacks evidence from the point of view of the individuals themselves. Mallett *et al.* (2005) does provide a qualitative account of young psychoactive substance users' (PSUs) pathways into homelessness, although it does not include experiences of homeless PSUs after the fact, failing to shed light on the continued experiences of this group. In Brazil, research into how

interpersonal relationships changed over time in homeless PSUs attributed these changes to successive relationship breakdowns since childhood (de Espíndola *et al.*, 2020), and a Canadian study found links between psychoactive substance use (PSU) and an increased prevalence of psychotic symptoms in the homeless population of Vancouver (Jones *et al.*, 2020).

To improve the health outcomes for these individuals, services need to be formulated in a way that works for them (NHS, 2014). Without any knowledge of the experiences of homeless individuals, no such changes can be made. Consequently, this research project aims to bridge part of this research gap, highlighting the homeless PS user experience, expanding knowledge in the area and offering recommendations for service providers.

Aim

This study aimed to develop a broader understanding of the experiences of homeless individuals who use PSs. Within that, the objectives were to explore the reasons for use; any mental or physical consequences of PS; any concerns that the participants had regarding their PS use; and the participant's perceived social support.

Method

This project aimed to explore the experiences of homeless PSUs and define what meaning these experiences hold for the individuals. It was important to the team to be able to understand participants' stories from their perspectives to gain an "insider" view of homelessness and PSU. To explore this fully, knowledge of the historical, social and cultural context in which the participants experienced life, was essential. The concept of a person being embedded within the world, in varied and unique ways, played a role in developing interpretive phenomenological analysis (IPA) (Shinebourne, 2011). IPA explores psychology as an experimental and experiential discipline (Smith, 1996). IPA was chosen as it lends itself to complex and emotional topics that require a lot of attention and sensitivity (Smith and Osborne, 2015). The idiographic focus of IPA offers insight into how an individual makes sense of a given phenomenon within a given context (Cohen *et al.*, 2007) and the researcher's task is to make sense of the individual's understanding (Smith *et al.*, 2021). Not only does this method explore the experiences of participants but it also explores how the participants find meaning in their experiences. The in-depth nature of this methodology requires researchers to spend longer periods with participants than would be seen with alternative methods.

During this project, the research team spent time in a city centre in the West Midlands (UK), engaging with the homeless population. The team learnt more about the culture of homelessness and topics that are important to the homeless population, helping to guide the interview process. During this period of engagement, the team got to know individuals in the community and invited them to participate in the research. The interviews, which were used as part of the IPA approach, were recorded as audio files on password-protected devices. For this reason, the interviews required a quiet environment so were conducted in a free café for people in need, which provided a safe and comfortable environment for the interviews.

Research participants were recruited following the period of engagement. A gatekeeper assisted with introducing participants to researchers and providing practical advice for the data collection process. Researchers were able to provide £20 shopping vouchers, as compensation for taking part in the qualitative aspect of the research. For participants only participating in the quantitative aspect, researchers were unable to provide compensation.

Ethics, sample and data collection

Ethics approval was gained through the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee (ERN_19-1733). Informed consent

was obtained from each participant before the interview, with written and verbal information about the research project provided. In the period of engagement with the homeless community before the interview, the researchers introduced themselves to the potential participants and explained the purpose of their interaction. Participants were able to withdraw from the study at any time and were provided with the contact details of the research team. The specific, lethal, method, proximity method was used in the case of one participant who presented with thoughts to end his life (National Centre for Youth Issues, 2018). Following all interviews, information was given to participants including resources on substance misuse and where to find appropriate support.

Data analysis

The recorded interview lasted between 30 and 60 min when the interview would naturally conclude. The recorded interviews were erased once they had been safely transcribed and stored. Recordings were transcribed by the research team and stored on password-protected cloud storage. The researchers who collected the data also did the analysis, they knew the participants as people, as opposed to just names and words, and there was a concerted effort to present them as people. In IPA, the researcher plays a key role in the analytic process and such a level of familiarity could have impacted the interpretative analysis. During the data collection and analysis, the reflexivity of the researchers was observed. The importance of reflexivity is researchers acknowledging that they are part of the world in which they are studying and that their actions and biases will affect observations made (Horsburgh, 2003).

Each researcher in the team analysed the transcripts individually, generating both what they understood the personal experiential themes and group experiential themes to be. From the engagement process onwards through to the development of the final themes, the researchers kept personal reflective notes that they drew on during the iterative process of analysis. The team combined all observations to form an overall picture, thus maintaining reflexivity. Codes and clusters were derived from the transcripts individually and then discussed as a team. From in-depth discussions about each participant's experience of PSU and homelessness, themes were derived. The themes included in this paper are not comprehensive but rather a representation of experiences, which the research team interpret as the most significant to the participants.

Findings and discussion

The findings and discussion sections are merged; thus, they draw on the literature in terms of the themes and add to what has already been written. In keeping with IPA traditions, only the data collected in the study is discussed within the analysis and the discussion within the themes draws on the literature only to make further sense of the findings, which is a useful way to make sense of the data.

Four participants were recruited, all four were male, all were unemployed, all identified as heterosexual and all identified with a medical diagnosis. The participants differed in age, ethnicity and the nature of their homelessness and PSU, adding depth to the findings of the project (Table 1.)

Participants

King

"There's good people out there but because I've never been around good people, I don't know how to find them"

King is a 33-year-old, mixed-race man who reports being homeless for 15 years at the time of the interview. King began PS use at approximately 13 years old, with cannabis being the

Table 1 Participant demographic information (including the period of homelessness and psychoactive substance use)

Pseudonym	*Age (years)*	*Ethnicity*	*Education (years)*	*Approximate period of homelessness*	*Approximate age beginning psychoactive substance use*
King	33	Black British	9	15 years	13
George	37	White British	12	Unsure	16
Nigel	45	White British	12	1 year	35
Philip	39	White British	17	12 weeks	13

Source: Table by authors

PS he uses most frequently alongside intermittent crack cocaine use and excessive daily alcohol consumption.

King has an easy way of talking, engaging in informal chit-chat with the researchers outside of the interview situation, with an obvious sense of humour. He reports being mistaken for being aggressive during the conversation, which perhaps is due to his loud voice and tall stature. King reports experiencing periods of extremely low and changeable mood, which he tries to hide by putting on a smile and making jokes – something which he says is an effort for him. King takes pride in his appearance; however, his low mood has reduced his motivation to look after himself causing his self-worth to deteriorate further, concerning thoughts to end his life.

King describes a childhood surrounded by alcohol and PS use; King reports that his mother was a person with a substance use disorder who paid little attention to what he was doing and so King found it easy to access PS at a young age. He was first incarcerated at 13 after which he went through the foster-care system, remembering how he wished he could "go home to mummy". King reports serving regular prison sentences every two years since then for low-level crimes such as theft. He describes prison as a type of personal rehab for him and seems to feel safer when he is incarcerated than on the streets.

Philip

"When I'm taken, I can't wait. I really can't."

Philip was a 39-year-old, white man who had been homeless for 12 weeks at the time of the interview and chose to live on the streets despite having access to a hostel. Philip had a friendly and open manner but was initially reluctant to talk in-depth about his experiences out of fear he would be misunderstood. His eventual willingness to reveal his life experiences allowed for a comfortable and insightful conversation.

Philips's PS use began at just age 13 and opioid use appeared to have been a constant part of his life up until a few weeks before the time of the interview. Despite continuous use of opioids throughout his teenage and young adult years, Philip completed school and continued to graduate from university with a BSc in psychology and sociology, an achievement he was proud of.

Philip struggled with his mental and physical health, suffering from anxiety and depression, as well as a chronic inflammatory condition. Throughout the conversation, he alluded to feelings of low mood and linked these feelings, not only to his medical condition but to his substance use. He expressed feelings of guilt surrounding how his actions have affected the people around him as well as how they have negatively affected his own life, whilst also recognising how PSU has played a perceived positive role.

Nigel

"I always felt like he [Father] didn't give a shit"

Nigel was a 45-year-old white man who reported being homeless for one year and living on the streets at the time of the interview. Nigel's substance use began at age 35, unlike the other participants who all reported using from their young teens. Nigel appeared to have great insight into his PS use and his situation was able to reflect on his actions and past experiences.

Nigel described a childhood governed by his ex-military father who had a regimental parenting technique, whilst also telling of a mother who drank heavily and took her own life when he was 20, for which he feels the blame. He partly attributed his substance use to his childhood experiences of arguing with his father and the pressure he felt as an elder sibling tasked with looking after his brothers and sisters. He described the breakdown of his marriage and his movement into shared accommodation as a turning point for him into a downwards spiral of addiction.

Just as his family had influenced his PSU, his PSU had significantly impacted his relationships. He described cutting himself off from his children to protect them from his addiction as well as feeling deep guilt about how he treated his father whilst addicted. PSU also had a catastrophic impact on his mental health, contemplated taking his own life before experiencing an epiphany in the form of a spiritual connection through the Catholic Church – an event that led to his recovery from addiction through seeking help from services.

George

"Some people think I'm fucking stupid, yeah"

George was a 37-year-old white man who reported being homeless for multiple years. He was a regular user of crack cocaine and heroin and at the time of the interview reported living in sheltered accommodation. George behaved chaotically throughout the interview, frustrated by some questions and avoidant others. He reported having ADHD and recognised that he had a changeable mood, which may contribute to his chaotic behaviour, along with his PS use.

George began using PS when he was 16 and attributed his long-term use to an injury he sustained at a young age for which he required analgesia and still has complications with. He reported distrust in the health-care professionals who treated him and believed they are worsening his physical health with treatments. However, George also recognised that his PS use worsened the state of his physical health and took some responsibility for his situation.

George presented differently from the other participants. He was far less trusting of the researchers, questioning the purpose of the research and suspicious of what his data was being used for. Unlike the others, George's opinion of himself was grandiose and he repeatedly referred to his high intelligence, describing how he can do "powerful things too". Despite this, he described feelings of embarrassment about being unable to wash and clean himself up as a homeless PS user, specifically referring to his family – a topic that he otherwise seems to avoid. It appeared George's character is contradictory, believing he is powerful and intelligent whilst also caring about others' opinions of him and feeling embarrassed about his situation. This may represent a need to overcompensate for his insecurities.

The purpose of this project was to explore the experiences of PSUs within the homeless population. Through analysis of the interview recordings and transcripts, four main themes were identified:

1. family influence;
2. cyclical patterns;
3. low self-worth; and
4. mistrust in people and society.

The themes are not definitive but demonstrate commonalities in the experiences of those who are homeless and use PSs. The themes and subordinate themes are summarised in Table 2.

The findings give an overview of how PSU and homelessness fit together and how these two facets of a person's life can pervade their lives and self-perpetuate. Regardless of whether we consider homelessness a choice or otherwise, there is an undeniable negative impact on the individual, characterised by the immense feelings of low self-worth observed.

Themes

Family influence

"She don't know I'm drinking cos she's drinking she's not concentrating" – King

King's first exposure to PSs was through his mother who would invite her friends to their house to drink alcohol and smoke cannabis. King acknowledged that his mother did not pay attention or notice that he was stealing alcohol and "spliff nubs"; however, he was protective of his mother and took some responsibility for why she could not notice him.

King reported being detained at the age of 13 and released two years later directly into residential homes and foster care. He became childlike in his mannerisms when speaking about the anger he felt towards the prison and social care system for taking him away from his mother.

Adverse childhood experiences, including substance use and neglect, are a strong predictor for a clinical diagnosis of substance use disorder (LeTendre and Reed, 2017; Dube *et al.*, 2006; Stein *et al.*, 2017). Trauma-informed care is shown to be effective over longer periods in the treatment of substance use disorders, particularly in women (Amaro *et al.*, 2007; Covington, 2008). However, the trauma-informed practice has now integrated into general mental health care and is promoted as an effective treatment for all genders (Brown *et al.*, 2013). The practice involves promoting continuity of care, something not found in any participant's experiences (see Mistrust in People and Society).

King's relationship with his mother was complex. He had three biological children who he no longer has contact with following adoption placement orders. He held resentment towards his mother for not fighting for custody of his children and felt she had rejected him. One explanation he used was that his mother felt guilty for the way King's life had developed. Again, he placed blame on his mother but then immediately removed it when he explained how he needed to protect her from pain.

Concerns about hurting family with PSU is consistent across all participants. George felt shame about his lifestyle choices, including PSU and homelessness, and reflected this upon his family. Nigel had a complex relationship with his family that improved during the beginning of his sobriety. The historical relationship with his siblings and father made Nigel

Table 2 Themes and sub-themes derived from participant

Theme	*Subordinate theme*
Family influence	The influence family relationships have on PSU and homelessness
	The impact PSU and homelessness have on family relationships
Cyclical patterns	Habitual behaviours
	Negative feedback loop
Low self-worth	Low self-worth driving self-harming behaviours
	Impact of outsiders on self-worthiness
Mistrust in people and society	Inadequate provision of services by professionals
	Breakdown of relationships with professionals because of negative behaviours

Source: Table by authors

hesitant to rekindle any form of relationship out of fear; he felt it was better to distance himself from his family to avoid worrying about them. Childhood experiences impacted Nigel's relationships with his siblings; his homelessness and PSU led to him borrowing money from his family and failing to repay them, which deteriorated relationships further.

His experience of alcohol use as a child informed the decisions he made as an adult regarding his children. Nigel had three children who all lived with their mother. He was in contact with the two older children who were understanding of his addiction, but the youngest struggled to understand Nigel's point of view, believing Nigel "chose drugs over" his children.

Adverse childhood experiences appeared throughout Nigel and King's stories; however, with such a small sample size, it is impossible to conclude the prevalence of this within the homeless community. The literature finds, however, that adverse childhood experiences are an indicator of homelessness and PSU and prevention strategies should focus on people with extensive childhood adversities (Tsai *et al.*, 2011). An important part of a nursing assessment with PSUs within the homeless population is to encourage and allow the person to be open about their story and move forward with treatments sensitive to their experiences (Kalmakis and Chandler, 2015).

Conversely to his peers, Philip actively involved his mother in his drug use by asking her to hold substantial amounts of heroin so that he could buy in bulk and visit her to pick up his weekly requirements. He labelled his mother as his "best friend" but acknowledged that asking her to hold substantial amounts of heroin put a strain on the relationship. Philip reported a very stable childhood with no obvious adverse childhood experiences. He has siblings who have chosen to distance themselves and their families from him. Philip self-identifies as the "black sheep of the family" but cared deeply for his mother and held on to a level of guilt for his behaviour.

From the limited evidence available, there is a small significant difference in the efficacy of support provided for a variety of problems facing the homeless population, including PSU (Coren *et al.*, 2016). Coren's systematic review focussed on young people and showed that the initial benefits of family therapy were not sustained long term when a rise in PSU was seen. Coren shows that interventions implemented in adolescence, if successful, could help in the prevention of problematic and dangerous behaviours in adults; however, our project reveals many of the participants became homeless later in life. Predominantly, PSU began at an early age; however, one participant started using at age 35, and given the small sample size, it is unlikely to be representative of the wider population. Interventions targeted at children and young people may be beneficial but cannot be the sole intervention. More research into the quality of support available to adults is needed.

The family therapy most suited to PSU is family psychoeducation involving educating the family on the problem, treatments and prognosis (Varghese *et al.*, 2020). For substance use, brief strategic family therapy is a well-established treatment, which is short term and requires strict instruction and early behavioural changes (Hogue *et al.*, 2021). The purpose is to reduce the negative consequences of the person's PSU on the family, reduce any barriers to treatment perpetuated by the family and educate the family on how to support the user in therapy and reduce the chance of relapse (Centre for Substance Abuse Treatment, 2004). Unfortunately, this treatment is restricted to those who have contact with their family and are committed to stopping their PSU.

Despite the evidence supporting these early intervention preventative strategies, and the effectiveness of these interventions, they fail to address the root of the problem. The interventions target individuals who are "at risk" of homelessness or who are already homeless; the focus should be on poverty reduction and include this as a target for homelessness prevention (Parsell and Marston, 2012). "People in poverty face systemic

discrimination in societies that remain deeply segregated by wealth" (United Nations Human Rights, 2021).

Cyclical patterns

"You're damned if you do and you're damned if you don't! It's-it's, I dunno [. . .] it's just a horrible, horrible circle. It really is" – Nigel

The UN released poverty reduction guidance with the main message being how we can "break vicious cycles" (United Nations Human Rights, 2021). The participants in our study made observations about cyclical patterns that they experience and how these affect homelessness and PSU.

King discussed a concerning pattern, prevalent throughout his adult life, involving regular detentions in prison due to low-level criminal activity. His reasoning for this is that he finds prison the most useful place for drug rehabilitation. Prison appears to provide housing during the important times of King's year. Another cyclical pattern observed in King's life is in his PSU. The PSU is self-perpetuating because of the balancing effects of mixing PSs. The borrowing culture within the homeless population was also prevalent in PSUs, which all participants reported resulted in conflict and debt.

Many of these cycles are perpetuated by the inequalities faced by PSUs within the homeless population. For example, the homeless community is often criminalised for using public spaces, thus restricting their freedom and resulting in fines that disproportionately affect them, leading to increased poverty and perpetuation of substandard living conditions (United Nations Human Rights Office of the Commissioner, 2021a). The UN report that governments should "repeal or reform any laws that criminalize life-sustaining activities" meaning people who sleep rough or use begging to afford food, personal hygiene products and clothing. The researchers conducting the interviews did not see this implemented but instead witnessed homeless PSUs who felt intimidated by police presence and were moved from places they felt safest due to the prioritisation of commercial activities.

It is a common theme in the literature that vicious cycles perpetuate both homelessness (Williams and Stickley, 2011; Dai and Zhou, 2020) and PSU (Frischknecht *et al.*, 2011; Perry and Lawrence, 2017), including factors inside and outside of their control. The vicious cycles observed in the homeless PSU population are like those seen in schools (Wong *et al.*, 2022). Wong finds deviant behaviours create a negative environment that encourages more of these behaviours and "deviant groups" to form. A school's negative environment translates to poor success rates; similarly, within the homeless community, there are standards that homeless people wish to meet. When these standards are not met, people feel low self-worth, further perpetuating negative behaviours (Jessor, 1991).

Low self-worth

"[. . .] my death can't come soon enough I'm telling you. It really can't." – Philip

All participants reported feelings of low self-worth, which were either because of PSU and homelessness or part of the cause. Three of the four participants explicitly mentioned thoughts of dying or wanting to be dead. The reasons for low self-worth are varied; Philip feels defeated by his plaque psoriasis, King feels deflated by the way people treat him and Nigel feels disgusted by himself due to his self-critical nature.

Feelings of low self-worth align with previous research suggesting that this population, like the general population, care deeply about others' opinions. Providing an accessible and acceptable service should be at the forefront of promoting improved health and well-being for PSUs in the homeless population (McCoy *et al.*, 2001). Low self-worth mostly stems from the opinions of the public, which are expressed as they walk past the homeless on the street (Williams and Stickley, 2011). The combination of this evidence along with the

findings of our study demonstrates the vicious cycle this community faces; low self-worth precedes PSU that leads to judgement from others, intensifying these feelings and leading to more PSU.

Attempting to tackle the stigma towards homeless PSUs is challenging but can be achieved through telling positive stories of PSUs and, at a structural level, education and training programmes for health-care students and professionals (Livingston *et al.*, 2012). The implementation of these programmes is difficult and not always successful (Crapanzano *et al.*, 2014). In the latter study, students and professionals claimed that this stigma would not influence their practice and an educational programme for first-year nursing students found a reduction in stigma and an increase in quality of care for those with substance use disorders (Lanzillotta-Rangeley *et al.*, 2020). This programme used a PowerPoint presentation, interaction with students throughout and a personal recovery story. More research into the effectiveness of these educational programmes is needed, but through the reduction of stigma in professional services, it is hoped that the self-worth of homeless PSUs will increase alongside trust in services.

Mistrust of people and society

"It feels like the world's failed me, I do. Stupid people that don't know much and think they know everything" – George

There was a powerful sense of mistrust among all participants, which stemmed mostly from past experiences, and the biggest concerns were the attitudes towards and from professionals. The support and treatment offered to them were inadequate and detrimental to their well-being. When asked about the support offered, a common answer was "You don't get no help." Each participant had a unique story of being failed by services and charities. King's use of prison for drug rehabilitation is a testament to the inadequate support provided.

Some health-care students' attitudes towards homeless people tend towards neutral; however, there are cases where nursing students would refuse care to homeless patients (Zrinyi and Balogh, 2004). Similarly, but perhaps more worrying, is a study that reveals medical students grow to have a more negative view of homeless patients as their training progresses (Masson and Lester, 2004). It is therefore unsurprising that our homeless participants did not trust professionals. A 2014 Cochrane review found no evidence to support any interventions to improve trust in doctors but recommended further research into the impact of patient-centred care and shared decision-making on improving trust (Rolfe *et al.*, 2014). To provide true patient-centred care, providers must acknowledge the diverse needs of PSUs as well as the complex needs of the homeless population.

Hostels provided by social workers and probation officers do not meet these needs. Placements are often unsuitable and make rehabilitation challenging. More concerning is the revelation that private hostels can be corrupt. One participant reported that hostel owners are promoting PSU and financially exploiting residents. The staff in the hostels often hold the residents' benefits and finances. They take money from the residents as "rent" but use this to buy illicit substances for them. King reported that the hostel owners would say "You don't have to pay your service charge if you buy your drugs off me" creating challenging living conditions due to a dramatic power imbalance between the staff and residents.

The staff in the hostels King described were distant and manipulative of residents, which is detrimental to their drug rehabilitation goals and their physical and mental well-being. Supportive hostel staff and good social networks provide further resources for residents' recovery (Neale and Stevenson, 2015). The staff in the three hostels included in Neale and Stevenson's research formed positive relationships with residents that were beneficial towards recovery. This is strikingly different to King's report. Further investigation is needed

to exclude selection bias as corrupt hostels are unlikely to volunteer for research. In addition, our sample size is small, so further investigation into the conditions King describes is essential, not only for academic purposes but for the safety of homeless PSUs.

The current Homelessness Code of Guidance, updated in 2022, states "The quality of accommodation provided within hostels varies considerably, and authorities should be particularly careful when securing or helping to secure accommodation with non-commissioned providers of hostel places that are not monitored or quality assessed" (Department for Levelling Up and Housing and Communities, 2018). This means that in the UK, homeless people can be placed in hostel accommodation that is not monitored or quality assessed, meaning the practice that King describes is entirely possible. Further research into the impact poorly managed hostels have on the well-being of residents should be conducted and this new evidence implemented.

The responsibility for the deterioration in the well-being of homeless PSUs cannot belong solely to professional and charitable services, as the former has an individual responsibility to work towards a more sustainable life. This is recognised by the participants; however, it does not excuse current service inadequacy. The complex interrelated problems with homelessness and PSU require a broad range of support and flexibility in the services provided (Neale, 2012).

Maybe I haven't helped myself, but nobody has helped me [. . .] (King)

Implications for practice

One of the implications for practice is that services, both statutory and charity, should strive to be as flexible as possible and try to incorporate services that help this vulnerable population deal with the multiple levels of trauma to which they have been exposed.

In addition, there needs to better understanding of the management of private hostels, ensuring that the environments are safe. Following further research into the impact of hostel management, suggestions for changes to existing policy and guidance regarding hostel placement should be developed. It is unethical to place any person in a hostel unsuitable for safe living.

Further research is needed into the efficacy of treatments such as family therapy and trauma-informed care within this population. Dissemination of results and education to health-care students and professionals is vital in the journey to rebuild trust. In addition, the assessment of past trauma should be integral to the nursing assessment. Finally, an investigation into the current state of hostel accommodation for the homeless must be conducted and advice for governments and policymakers developed and implemented.

Limitations

This study is limited by potential bias from researchers who built relationships with participants through the data collection process. Despite efforts to remove this bias, through reflexivity throughout data collection and analysis, some bias may be still present. The researchers saw the participants as vulnerable people who were striving to overcome adversity. Such conception of the participants is reflective of how the participants portrayed themselves.

The small sample is suitable for IPA purposes. Of course, it could have been possible that if different participants had been recruited or more participants had been recruited, then there could have been different themes and findings. IPA prides itself on its idiographic focus.

Conclusion

There is a wide body of literature relating to homelessness and PSU individually and the impact that both have on mental and physical well-being. There is a gap in the literature regarding the experiences of PSUs within the homeless population and how the combination can add complexities to a person's well-being. Both are important social determinants of health and are not mutually exclusive. This study used IPA to explore these experiences and how the participants interpret these experiences. Participants felt a lot of responsibility towards family but also identified ways in which their family relationships had led to homelessness and PSU. Most participants felt stuck in a vicious cycle and this led to extremely low self-worth. The mistrust in people and society identified was due to the experience of inadequacy within services and lack of continuity of care.

Dissemination of these findings is essential to help reduce bias held by professionals and promote therapeutic relationships between homeless PSUs and the professionals involved in their care. This includes highlighting the reality of homelessness to health-care students, including experiences shared by the homeless population and PSUs as well as the health risks associated with this lifestyle.

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Author affiliations

Chris Wagstaff is based at the Department of Nursing and Midwifery, University of Birmingham, Birmingham, UK.

Anna Davis is based at Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK.

Elizabeth Jackson-McConnell is based at University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK.

Matilda MacDonald is based at Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK.

Ashley Medlyn is based at the Department of Nursing and Midwifery, University of Birmingham College of Medical and Dental Sciences, Birmingham, UK.

Sandra Pillon is based at the Department of Nursing, University of São Paulo, São Paulo, Brazil.

Corresponding author

Chris Wagstaff can be contacted at: c.wagstaff@bham.ac.uk