“*My values keep me well… would they help other people?”:* A thematic analysis exploring the values and valued behaviours of people facing severe and multiple disadvantage

Sophie Jane Buckley,

BSc (Hons), MSc.

Thesis submitted in part fulfilment of requirements for the degree of

Doctorate in Clinical Psychology to the University of Nottingham

DECEMBER 2022

Portfolio Abstract

Whilst there is an emphasis placed upon offering better and more cohesive support to individuals experiencing Severe and Multiple Disadvantage (SMD, i.e., have experience of at least 3 of the following: homelessness, substance use, mental illness, offending, and domestic violence), there is still a lack of literature exploring what the "best" support looks like to those receiving it.

Service provision and support for individuals experiencing SMD tends to focus on encouraging behavioural changes, such as increasing employment or sobriety, with little consideration given to what the individual values. Services may not fully understand the barriers to enacting behavioural changes, often associating them with lack of motivation or substance addiction.

Values can be understood as personally important guiding principles or beliefs that motivate an individual's behaviour across their context or situation. Identifying and focusing on values leads to greater enactment of positive behavioural changes in a variety of populations, as such, encouraging behavioural change that is unrelated to an individual's values is likely to be less successful. This study aimed to identify and explore the values of people facing SMD, the barriers and facilitators to enacting these values, and the perceived helpfulness of service provision in encouraging valued behaviour or change.

A qualitative methodology was utilised, taking a critical realist stance. A purposive sample of twelve participants were recruited through a local charity-funded organisation and temporary accommodation services. Each participant took part in a semi-structured interview, which was recorded and transcribed verbatim. A thematic analysis was completed using a mixed inductive-deductive design.

Analysis resulted in four themes with *(subthemes)*: values are idiosyncratic and interconnected *(inconsistency in value stability*); the benefits of value identification and enactment; the risks and challenges of value identification and enactment *(challenges faced by the individual; challenges embedded in the system; needing to protect oneself)*; and the relationship between values and support *(what helps, also hinders; the potential of value-focused support).*

The results show that regardless of their context of exclusion and disadvantage, people facing SMD still have a wide range of complex, interconnected values they enact in their daily lives. Unlike in other populations, valued living is much riskier and more challenging for people facing SMD. In spite of this, people still find ways to live in line with their values. Support can both help and hinder an individuals' progress. Recruitment and response biases are discussed as limitations. Other areas of disadvantage not captured by the definition were missed. Values work could arguably be integrated into any level of support for those facing SMD to support valued living and change. However, further research on the use and efficacy of values-focused interventions in SMD is needed and suggestions are outlined.

Acknowledgements

To every person who took the time to take part in my interview. It was such a pleasure chatting to each and every one of you. Thank you for your interest, openness, and insight.

To my supervisors, for reading copious amounts of emails and supporting me through every step of this project. Thank you. Rob, your help with recruitment was invaluable, as were your ideas. Anna, your support, and mentorship over the past few years have been instrumental in my journey, helping me to find my professional identity without losing my personal one. You have always been such a wonderful role model and I hope we get to work together again in the future.

To my cohort, for being the only ones who could ever understand this rollercoaster of an experience. You have brought joy, laughter, and comradery into an otherwise stressful time. The world may have ended as we began this journey, but we not only survived, but flourished. A special shout out to my (s)quad and the qualitative queens – I never knew I would find lifelong friends throughout this experience.

To all of my friends, for keeping me sane. For every check-in text and picture of your pets, you guys are my chosen family. Thomas, for our never-ending debates and a friendship I value beyond words. Megan, for being there every single day – I made it, and you will too.

Mum and Nana, for your everlasting love and support. None of this would have possible without you.

Finally, Tom, for the patience, support, and chocolate milk that kept me going.

Statement of Contribution

I, Sophie Buckley, declare this research is the product of my own original work conducted since I began the Trent Doctorate in Clinical Psychology training programme in 2019. All supervisors provided regular guidance and supervision with all parts of the research. The original idea was conceptualised and subsequently developed by myself with support from my supervisors: Dr Anna Tickle, Rob Eagle, and Dr Dave Dawson. I developed and submitted the ethics application and subsequent amendment. All ethical applications were supported by Dr Danielle De Boos, acting as Principal Investigator. I completed all recruitment and data collection, with support from Rob Eagle and Dr Anna Tickle. Finally, I completed data analysis and writing up the report, supported with feedback and supervision from supervisors.

Contents

SYSTEMATIC LITERATURE REVIEW 12
Abstract 14
Introduction 15
Methods 18
Results 21
Discussion 41
References 45
JOURNAL PAPER 51
Abstract 53
Introduction 54
Method 58
Results 60
Discussion 71
References 75
EXTENDED PAPER 81
1. Extended Introduction 82
1.1. Severe and Multiple Disadvantage 82
1.2. Further Context 83
1.3. Trauma 85
1.4. Mental Health 87
1.5. Improving Support 88
1.6. Values 89
1.7. Values and Behaviour 90
1.8. Acceptance and Commitment Therapy 91
1.9. Extended Rationale and Aims 94
2. Extended Method 96
2.1. Rationale for Methodology 96
2.2. Ethical Considerations 99
2.3. Participants 102
2.4. Recruitment Procedure 103
2.5. Data Collection 105
2.6. Data Analysis 106

2.7. Expert Involvement 110
2.8. Quality Monitoring 110
3. Extended Results 112
4. Extended Discussion 129
4.1. Extended Limitations 134
4.2. Extended Clinical Implications 136
4.3. Extended Future Research 139
5. Extended Reflection 141
5.1. Researcher's stance 141
5.2. Impact of the COVID-19 Pandemic 142
5.3. Ethical Application 144
5.4. Data Collection 145
5.5. Data Analysis 148
5.6. Concluding Thoughts 151
Extended References 152
Appendices 168
Appendix A: Ethical Approval 168
Appendix B: Ethical Approval: Amendment 169
Appendix C: Participant Information Sheet 170
Appendix D: Recruitment Poster 175
Appendix E: Consent Form 176
Appendix F: Interview Schedule 177
Appendix G: Personal Values Checklist 180
Appendix H: Anonymous Extracts of Inductive Coding 182
Appendix I: Anonymous Extracts of Deductive Coding 183
Appendix J: Extracts of Theme Development 184
Appendix K: CASP Qualitative Checklist - completed by primary researcher 188
Appendix L: CASP Qualitative Checklist - completed by independent party 193
Appendix M: Primary Researcher's Completed Values Checklist 198
POSTER 200
SMALL SCALE RESEARCH PROJECT 202
Abstract 204
Introduction 205
Method 208

Results 211
Discussion 220
References 224

List of Tables and Figures

Systematic Literature Review

Table 1 Search Terms

Figure 1 PRISMA Diagram Showing Search Results

Table 2 Summary of Paper Characteristics

Table 3 Quality Assessment of Papers

Table 4 Papers Contributing to Themes and Subthemes

Table 5 Study Characteristics

Table 6 Quality Appraisal

Journal Paper

Table 7 Semi-Structured Interview Stages and Procedure

Table 8 Participant Demographics and Context

Figure 2 Thematic Map

Table 9 The Five Most-Rated Values by Category of Importance

Extended Paper

Figure 3 Adverse Childhood Experiences across the Lifespan

Figure 4 The Six Processes of Psychological Flexibility

Table 10 Six-Stages of Thematic Analysis

Figure 5 A Timeline of the Recruitment Procedure

Table 11 Example of Preliminary Data Analysis Notes

Table 12 Deductive Coding Framework

Figure 6 Values Checklist Ratings

Table 13 Scrapped Deductive Code

Small Scall Research Project

Table 14 PIE Elements and Corresponding PIZAZZ Categories

Figure 7 Overview of Changes in PIZAZZ Ratings

Figure 8 Community Service PIZAZZ Ratings

Figure 9 Hostel A PIZAZZ Ratings

Figure 10 Hostel B PIZAZZ Ratings

Figure 11 Hostel C PIZAZZ Ratings

List of Appendices

Appendix A Ethical Approval

Appendix B Ethical Approval: Amendment

Appendix C Participant Information Sheet

Appendix D Recruitment Poster

Appendix E Consent Form

Appendix F Interview Schedule

Appendix G Personal Values Checklist

Appendix H Anonymous Extracts of Inductive Coding

Appendix I Anonymous Extracts of Deductive Coding

Appendix J Anonymous Extracts of Theme Development

Appendix K CASP Qualitative Checklist: Researcher

Appendix L CASP Qualitative Checklist: Independent Party

Appendix M Primary Researcher's Completed Values Checklist

SYSTEMATIC LITERATURE REVIEW

What Adaptations Are Being Made to Psychotherapy for Low-income Clients? A Systematic Scoping Literature Review

Author(s)

Sophie Buckley[1], Dr Anna Tickle[2], Dr David L Dawson[3]

[1] University of Nottingham

[2] University of Nottingham

[3] University of Lincoln

Statement of Contribution

I, Sophie Buckley, declare that this systematic literature review is the product of my own work completed as part of the Trent Doctorate in Clinical Psychology. Dr Anna Tickle and Dr David L Dawson provided supervision and guidance throughout.

Abstract

Purpose: To scope the current literature to explore what adaptations are being made to individual psychotherapy for low-income adults/adults living in poverty. Furthermore, to explore what, if any, empirical evidence supports such adaptations.

Methods: A systematic scoping review was completed. Six databases were systematically searched. Eleven papers were identified as meeting the selection criteria and included in the review. The relevant data from each paper was extracted, the quality of the papers was appraised, and the results were then collated and reported.

Results: A variety of adaptations were found in the available literature including: clinicians actively increasing their understanding of, reflections upon, and acknowledgement of poverty, classism, and the related stressors as well as flexibly adapting psychotherapy for example by negotiating traditional boundaries in sessions, advocating for clients, focus on practical engagement through consideration of barriers and education, taking a multi-disciplinary approach to better suit the needs of the population. However, the available literature is limited, and the empirical evidence for such adaptations even more so.

Conclusions: Individuals living in poverty are experiencing significant health inequalities; they are more likely to experience mental illness, less likely to access or complete psychological therapy, or achieve positive outcomes in comparison with their more economically advantaged counterparts. There is a concerning lack of literature that explores how clinicians can best adapt their practice to better serve this population; the literature that does exist lacks robust, reliable evidence. There is a clear need for further research in this area.

Introduction

There are a variety of ways to define poverty and low-income, from ‘absolute poverty’, which refers to the minimum set of resources a person needs to survive, to ‘relative poverty’, a measurement of the resources and living conditions in relation to others (Schwartzman, 2000). This is further complicated by the use of low-income or poor socioeconomic status (SES) as alternative terms often used synonymously, meaning individuals who do not have or earn much money (Cambridge International Dictionary of English, 1995). The present review will use the terms poverty and low-income interchangeably, mirroring the language used in the relevant research.

Inequalities in SES are associated with a variety of social and health problems, with research showing that lower status individuals are more likely to experience poorer health, but also have fewer resources to buffer against the negative impact of poor health (e.g. Smith & Kington, 1997; Wilkinson & Pickett, 2007). Adults living in poverty are faced with a variety of chronic stressors in their everyday life, including unemployment, unstable housing or homelessness, lack of transportation, and insufficient resources to pay for food or bills (Mickelson & Kubzansky, 2003). Furthermore, individuals living in poverty face social exclusion, not only due to being poor or working-class, but also as a result of characteristics such as ethnicity, race, gender, or immigration status, increasing the risk of discrimination and distress (Kabeer, 2000).

Research consistently demonstrates that common mental health problems are more prevalent amongst individuals living in poverty, experiencing hunger, facing debt, with lower levels of education, and poorer quality housing when adjusting for other explanatory variables (e.g. Araya, Lewis, Rojas, & Fritsch, 2003; Patel, Araya, de Lima, Ludermir, & Todd, 1999). Studies of health inequalities suggest a consistent positive correlation between low-income and mood, anxiety disorders, and psychotic disorders (Jenkins et al., 2008) as classified by the International Classification of Diseases-10 (ICD-10; World Health Organization, 1992). Alongside this, poor and working-class individuals are more likely to report chronic physical health problems when compared to middle class people (Kessler, Chiu, Demler, & Walters, 2005; Krieger et al., 1999; Menec, Shooshtari, Nowicki, & Fournier, 2010).

There is a cyclical relationship between poverty and poor mental health. Research shows that the likelihood of experiencing poverty is higher if an individual experiences a severe mental illness (Breslau, Lane, Sampson, & Kessler, 2007); on the other hand, living with poverty-related stressors increases an individual's risk for mental illness (Patel & Kleinman, 2003). This is for a variety of reasons including: a lack of financial resources to maintain basic standards of living; having fewer opportunities for education and employment; higher exposure to adverse living environments; and less access to good quality health care (WHO, 2007).

Mental health services tend to be located outside of poorer communities (Levy & O'Hara, 2010) and only offer appointments during working hours, meaning that lower income individuals are more likely to need to make childcare and travel arrangements to access services, which can act as additional barriers to gaining much needed treatment. Despite this, there is also evidence that people living in deprived areas are not only less likely to access psychological treatment (Saxon et al., 2007), but are less likely to improve when they do so (Delgadillo, Asaria, Ali, & Gilbody, 2016) and have higher levels of attrition (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). A recent systematic review and meta-analysis (Finegan, Firth, Wojnarowski, & Delgadillo, 2018) found a small but significant relationship between socioeconomic deprivation and poorer treatment outcomes in psychotherapy for common mental health disorders, specifically in employment differences. One limitation of the literature highlighted by this review was the inconsistency in the definition of SES; such inconsistencies made it difficult to consider the specific aspects of SES and the relationship with treatment outcomes.

Many psychological theories were developed by white, western, heterosexual, middle- and upper-class men (Rendon, 1996). Historically, psychotherapy has excluded and 'othered' individuals in poverty, leading to interpersonal and cognitive distancing from the poor (Lott, 2002). Psychoanalysts have described this distancing as clinicians participating in a social and dynamic unconscious that renounces the poor and protects the status quo of the middle and upper class (Altman, 2010; Layton, 2006). Therapists' unacknowledged negative attitudes towards poorer clients have been suggested to limit the development of trust and rapport in the therapeutic relationship, in turn limiting the effectiveness of the treatment (Siassi & Messer, 1976).

Adapting psychotherapy to suit particular populations is well-established, for example research has shown that culturally adapted interventions lead to more positive outcomes in psychotherapy (e.g. Benish, Quintana, & Wampold, 2011). Whilst many ethnic and minority groups may also experience poverty-related stressors, there is a lack of robust and reliable literature that explores the role of adapting psychotherapy for clients living in poverty, regardless of race or ethnicity.

The best available guidance for clinicians stems from the British Psychological Society (BPS, 2017) which makes suggestions for working with people who may be socially excluded (included but not limited to individuals living in poverty); however these are relatively general suggestions that apply to a wide variety of disadvantaged groups. Furthermore, they recommend that psychologists "*make adjustments where possible and needed, to enable people to fully participate e.g. … adaptation to materials and psychological assessment and interventions"* (p. 36) with neither clear guidance, nor reliable evidence, on how to make such adaptations or the effectiveness of using such adaptations.

Considering the clear evidence that suggests individuals experiencing poverty are at a higher risk of experiencing mental illness, are less likely to access psychological support, are more likely to drop-out, and less likely to improve; it is concerning that there is no clear, nor well-evidenced guidance set out for clinicians or commissioners on how to adapt psychotherapy to support this population. Therefore, the following systematic literature review has two aims:

- The primary aim is to scope what adaptations, if any, are being made to individual psychotherapy for low-income adults/adults living in poverty.
- The secondary aim is to examine the empirical evidence supporting such adaptations.

Methods

Systematic Scoping Review

Scoping studies aim to map the key concepts underpinning a research area and the main sources and types of evidence available (Mays, Roberts, & Popay, 2001). Scoping reviews are useful when there is a lack of research, or a variety in the types of literature available (Arksey & O'Malley, 2005). The following review will follow Arksey and O'Malley's (2005) methodological framework for conducting scoping reviews. They highlight the iterative nature of the process, in contrast to traditional systematic literature reviews; in a systematic scoping review, the search terms, inclusion/exclusion criteria and study selection criteria may be adapted as the author becomes more familiar with the literature. The framework follows five stages: identifying the research question; identifying relevant studies; study selection; charting the data; and collating, summarising, and reporting the results. An additional stage will be completed in the present review, in which the papers will be quality appraised.

Searching

A recent study found that systematic reviews should search at least Embase, MEDLINE, Web of Science and Google Scholar for efficient coverage, suggesting specialised databases can add unique references in relevant fields of study (Bramer, Rethlefsen, Kleijnen, & Franco, 2017). Therefore, a systematic search was conducted on Medline, Embase, Web of Science, PsychInfo and PsychArticles from the database start point until 19th June 2020. Google Scholar was used to check for any papers not found via the database searching. References of the selected studies were also hand-searched. Search terms are shown in Table 1. Duplicates were removed and the first author screened the titles and abstracts of each paper. If the inclusion/exclusion criteria were met, the full-text articles were reviewed. Data relevant to the review aims were collated from each full text paper by SB.

Table 1: Search Terms

(“adapt*” OR “modif*” OR “adjust*” OR “alter*” OR “optimi#*” OR “consider*” OR “approach*” OR “recommend*” OR “inform*” OR “tailor*”)
AND
(“psychotherapy* OR “psycho-therap*” OR “psychological ADJ3 therap*” OR “psychological ADJ3 treat*” OR “psychological ADJ3 intervention*”)
AND
(“low income” OR “low-income” OR “socioeconomic status” OR “socio-economic status” OR “SES” OR “poverty” OR “social class*” OR “income ADJ3 inequalit*” OR “working class*” OR economic* ADJ3 disadvantage*”

Study Selection

For the primary aim studies were included if they:

- Were published in an English language peer-reviewed journal
- Focused on adaptations to psychotherapy (e.g. do not just discuss possible adaptations as recommendations in discussion)
- Include extractable adaptations specific to clients who are identified as low-income / living in poverty
- Focused on working-age adults in individual psychotherapy

Studies were excluded if they:

- Focused on clients who were classified as ‘low-income/experiencing poverty’ due to war and/or natural disaster (e.g. hurricane, flood) due to the likely different experiences of such individuals
- Did not specify what adaptations were made
- Focused on cultural adaptations that did not consider or focus on the adaptations specifically relating to low-income (See other reviews for this e.g. Benish, Quintana, & Wampold, 2011)

For the secondary aim, any paper selected using the above criteria that referred to a related paper published by the authors describing an empirical study of outcomes of the adapted psychotherapy this will be considered when examining the empirical evidence for adaptations. It was intended that any empirical evidence from within the papers would be examined, but only a limited number of papers included such evidence.

Quality Appraisal

The Mixed Methods Appraisal Tool (MMAT; Hong, et al., 2018) was deemed the most appropriate appraisal tool to review the selected studies, due to the range of methods in selected papers. The MMAT was adapted by SB to be more applicable to the research question. Firstly, as the only empirical studies included were either randomised control trials or qualitative studies, these, alongside the screening questions, were the only categories included. The two screening questions were adapted to include aims as well as research questions, as some of the screened papers were not primary research. Alongside this, three questions were added: is a definition of the term poverty/low-income included? Are there extractable adaptations specific to poverty / income? Is empirical evidence for such adaptations reported? Alongside this, a 'not applicable' option was added to avoid critiquing studies for criteria that they were not designed to meet.

The authors of the MMAT discourage calculating an overall quality appraisal score, but instead suggest a more detailed description of the quality appraisal is more suitable. As scoping systematic reviews do not require a quality appraisal due to the difficulties of comparing multiple types of literature, the MMAT was deemed the most appropriate to at least consider the quality of the papers included to both contextualise the results and inform future research. SB appraised the included papers using the MMAT.

Results

The search results are available in Figure 1 (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009).

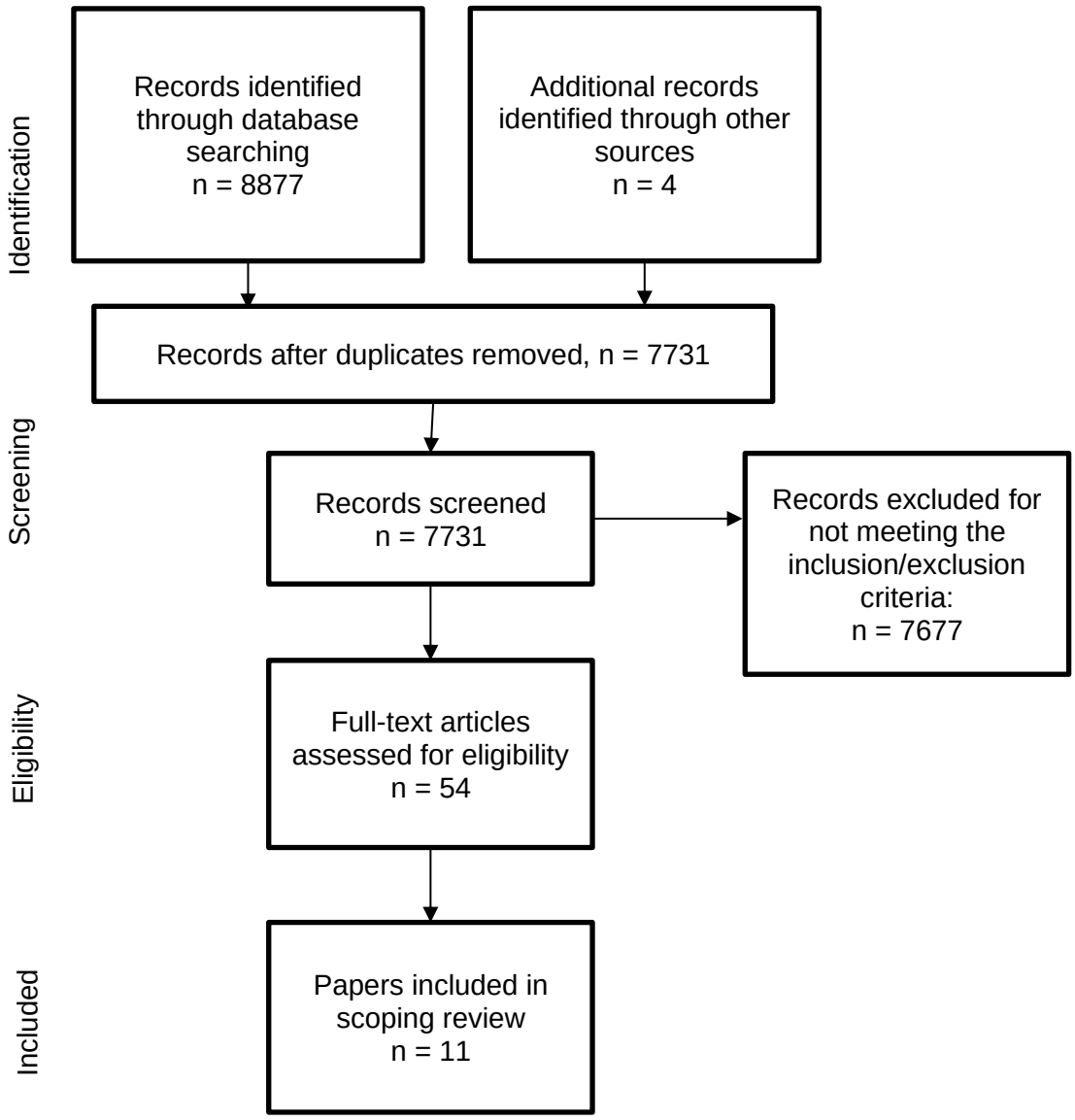


Figure 1. PRISMA diagram showing search results.

Paper Characteristics

The key characteristics of each paper are reported in Table 2, grouped by type. Each paper is assigned a reference number, used throughout the review. Four papers were original research studies (3, 4, 5, 6), three referred to original research from which they developed the adaptations (1, 2, 7), and four were based on clinical opinion (8, 9, 10, 11). Almost all the included papers were based in North America, with one Canadian paper (9). Four focused solely on low-income women (1, 2, 3, 5).

Table 2: Summary of Paper Characteristics

	Authors (Year) and location	Type of paper	Aims of study	Type of psychotherapy	Sample (details where available)	Empirical evidence	Adaptations identified
1	Grote, Swartz & Zuckoff (2008) USA	Description of adapted Interpersonal Psychotherapy (IPT) used in a Randomised Control Trial (RCT)	To describe several adaptations and additions made to a brief form of interpersonal psychotherapy (IPT) to meet the needs of mothers and expectant mothers living on low incomes.	IPT	Mothers and expectant mothers on low incomes suffering from depression	Yes	Shorter interventions; selection of only one problem to focus on; use behavioural activation strategies; assigning weekly homework; endings as graduation (*focus on accomplishments and future needs*); adding a pre-treatment engagement session (*elicit story, hopes for treatment, addressing barriers, psychoeducation, elicit commitment*); and adding a case-management component (*assessment of/meeting basic needs such as childcare/transportation, facilitation to access social services in community, advocacy*); flexibility (*in the length and order of the session content*).
2	Beeber, Cooper, Van Noy, Schwartz, Blanchard, Canuso, Robb, Laudenbacher, & Emory (2007) USA	Content analysis based on RCT	To explore what advanced strategies practice psychiatric mental health nurses used to engage and retain low income mothers.	IPT	29 low-income mothers (8 black, 3 white, 17 Latino, 1 Native American)	Yes	Ongoing group supervision (*identifying personal biases and expanding understanding*); Making in-person contact (*working from clients homes; persistent and flexible outreach*), flying under the radar (*reduction of stigma*); focus on empathy; use of gestures (*facial expressions, physical touch);* facilitate catharsis whilst emphasising proactive strategies; and controlling intensity.

	Authors (Year) and location	Type of paper	Aims of study	Type of psychotherapy	Sample (details where available)	Empirical evidence	Adaptations identified
3	Miranda, Chung, Green, Krupnick, Siddique, Revicki, & Belin (2003) USA	RCT	To determine the impact of an intervention to deliver guideline-based care for depression compared with referral to community care with low-income and minority women.	Cognitive Behavioural Therapy	267 low-income women	Yes	Educational meetings (*psychoeducation, encouraging informed decisions about treatment*); adapting location to suit client; intervention and written materials offered in client's first language; transportation and childcare funds provided.
4	Borges and Goodman (2019) USA	Qualitative description	To use a qualitative design to explore whether and how experienced psychologists committed to working with low-income clients adapt the way they practice to meet the needs of their clients.	Integrative (10/12) Psychodynamic (2/12)	12 diverse urban psychologists (8 women; 5 white, 3 Latinx, 2 Asian/Indian, 1 African American, 1 mixed race) Average years working with clients in poverty: 22.8	Yes	Addressing power dynamics with clients in poverty (*recognising the power differences and address these differences*); negotiating boundaries with clients in poverty (*considered verbal self-disclosure but often did not, necessary to modify time boundaries, offering food, many describe giving clients' money, breaking agency/insurance rules*); practices for working with the relationship between intrapsychic and contextual poverty-related stressors (*maintaining awareness of the relationship between intrapsychic issues and poverty-related stressors, flexibility in the focus of the therapy hour, accounting for poverty in conceptualising and interpreting the therapy process and the source of the client's problem, acting on awareness of the relationship between intrapsychic and poverty-related stressors through advocacy and case-management*)

	Authors (Year) and location	Type of paper	Aims of study	Type of psychotherapy	Sample (details where available)	Empirical evidence	Adaptations identified
5	Pugach and Goodman (2015) USA	Qualitative description	To use qualitative descriptive methodology to explore low income women's subjective experiences of outpatient psychotherapy.	Outpatient – no specified model	10 low income women (age range: 25-54; 5 African American, 2 White, 1 Latina, 2 Multiracial)	Yes	Awareness (*therapist is aware of the nature of poverty-related stressors, therapist has exposure to low-income communities*); Practices (*structure of therapy is flexible, therapist provides instrumental support, strength-based approach)* and relational quality (*participants feel heard, therapists attempt to share power e.g. self-disclosure/avoid jargon, therapists show authenticity e.g. emotion, meaningful gestures*).
6	Thompson, Cole & Nitzarim (2012) USA	Qualitative, Grounded Theory Research	To explore psychotherapy experiences among a diverse group of clients who self-identified as low income or poor.	Not specified	16 low-income clients (12 women; age range 31-60 years; 11 white, 1 Latina, 2 African American, 1 black, 1 Native American)	Yes	Therapists to be aware of experiences common to low-income clients and attend to subjective personal accounts; increase knowledge and awareness of social class as a specific cultural identity; acknowledge social class in therapy (*inquiry and integration in intervention*); consider social class differences as sources of transference and countertransference to be addressed in the room; and importance of acts of advocacy or meaningful moments to enhance the '50 minute hour' (*e.g. self-disclosure, extensive outreach, advocacy from therapist, flexibility with payment*)

	Authors (Year) and location	Type of paper	Aims of study	Type of psychotherapy	Sample (details where available)	Empirical evidence	Adaptations identified
7	Appio, Chambers & Mao (2013) USA	Summary of authors' qualitative theses	To present findings from qualitative studies that illustrate lived experienced and insights from poor and working-class people in the community and in therapeutic settings. Drawing from these narratives, recommendations are made to psychologists.	Not specified	Low-income adults in psychotherapy	Yes	Expand awareness of class issues (*personal and systemic classism, power differences, acknowledging class in therapeutic context*); draw from treatment modalities that attend to the issues raised by persons in poverty; attend to material needs (*inquire about clients' basic needs as a standard and on-going component of clinical assessment; be an advocate: actively assist clients in obtaining needed resources*); and support clients in acts of self-advocacy.
8	Gould (1967) USA	Clinician opinion	Psychotherapy with union auto workers is evaluated and an attempt is made to delineate differences between techniques needed for the "lower-class" patient and those commonly used with "middle-class" patients.	Psychodynamic	23 lower-class (union auto-workers) men offered psychodynamic therapy through a union contract	No	Ensure congruence in therapeutic goals (*consider symptom-reduction*); take a more directive approach (*specific and concrete questions);* informality and an easy 'give and take' (*open session with comment, use common interests*); establishing contact with the patient on a nonverbal level (*chose less formal location for therapy, behave more actively in sessions*); flexibility in the 'analytical hour' (*longer/shorter sessions as appropriate);* role-playing (*break down doctor-patient relationship, develop verbal skills*); increased education and guidance; and using personality traits of the blue collar worker (respect for authority, lack of sophistication in defences such as not using isolation and intellectualisation as defences).

	Authors (Year) and location	Type of paper	Aims of study	Type of psychotherapy	Sample (details where available)	Empirical evidence	Adaptations identified
9	Pope and Arthur (2009) Canada	Literature review / discussion	To explore socioeconomic status (SES) in relation to psychosocial wellbeing and the provision of psychological services. Recommendations for practice, advocacy, research, and teaching are provided for psychologists.	Not specified	Adults classified as being from a low socioeconomic status	No	Systemic perspective; focus on internalised classism/self-esteem; consider impact of low SES on familial relationships; recognising classism (*individual and systemic*); use of reflection and supervision; expanding cultural identities in practice frameworks; advocacy and political involvement; and meeting the needs of low-SES clients (*awareness of and sensitivity to interplay of SES, cultural variables and psychological well-being; inquire about the client's worldview; use a strength-based approach; and work collaboratively with other professionals*).
10	Santiago, Kaltman & Miranda (2013) USA	Literature review / Clinician opinion	To review the link between poverty and mental health, common barriers to obtaining mental health services and treatment studies with low-income groups. Finally, to discuss the implications of the research and offer recommendations for clinicians.	Varied	Low income adults and children (N.B. recommendations specifically focused on children not included)	No	Use evidence-based treatments (*flexibility and tailoring are needed*); high degree of outreach; offer an educational meeting before starting therapy; understanding and respect; cultural sensitivity; and relational engagement.

	Authors (Year) and location	Type of paper	Aims of study	Type of psychotherapy	Sample (details where available)	Empirical evidence	Adaptations identified
11	Overholser (2016) USA	Literature review / Clinician opinion	To describe six strategies found useful when working with depressed clients who are struggling with severe financial imitations.	Not specified	Clients living below the poverty level experiencing depression	No	Help clients maintain a sense of hope even during the darkest times; rely on empathy to understand the client's struggles (*maintain consistent contact*); help clients shift to a more adaptive perspective; focus on specific coping skills (e.g. problem-solving, stress management); help clients to improve and utilise the available social support; and interventions can benefit from a multi-disciplinary collaboration.

Table 3: Quality assessment of papers using an adapted Mixed Methods Appraisal Tool (MMAT; 2018).

Category of study design		Methodological quality criteria	Paper										
			1	2	3	4	5	6	7	8	9	10	11
Screening questions (for all types)	S1.	Are there clear research questions? *or aims?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	S2.	Do the collected data allow to address the research questions? *or aims?	C	C	Y	Y	Y	Y	C	-	-	-	-
	*S3.	Do they define the term poverty/low-income?	N	N	Y	Y	Y	Y	C	Y	Y	Y	N
	*S4.	Are there extractable adaptations?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	*S5.	Is there empirical evidence for such adaptations?	Y	Y	Y	Y	Y	Y	Y	N	N	N	N
Qualitative	1.1.	Is the qualitative approach appropriate to answer the research question?	-	Y	-	Y	Y	Y	C	-	-	-	-
	1.2.	Are the qualitative data collection methods adequate to address the research question?	-	Y	-	Y	Y	Y	C	-	-	-	-
	1.3.	Are the findings adequately derived from the data?	-	Y	-	Y	Y	Y	C	-	-	-	-
	1.4.	Is the interpretation of results sufficiently substantiated by data?	-	C	-	Y	Y	Y	C	-	-	-	-
	1.5.	Is there coherence between qualitative data sources, collection, analysis, and interpretation?	-	C	-	Y	Y	Y	C	-	-	-	-
Quantitative randomized control trials	2.1.	Is randomization appropriately performed?	C	C	Y	-	-	-	-	-	-	-	-
	2.2.	Are the groups comparable at baseline?	C	C	Y	-	-	-	-	-	-	-	-
	2.3.	Are there complete outcome data?	C	C	Y	-	-	-	-	-	-	-	-
	2.4.	Are outcome assessors blinded to the intervention provided?	C	C	Y	-	-	-	-	-	-	-	-
	2.5.	Did the participants adhere to the assigned intervention?	C	C	Y	-	-	-	-	-	-	-	-

*Note. * indicates additional quality checklist item, Y indicates 'yes', N indicates 'no', C indicates 'can't tell', - indicates 'not applicable'. Paper 2 referred to an RCT in from which the data was gathered, and also included qualitative content analysis of such data, therefore both aspects were considered in the appraisal. See Appendix A.2 for appraisal of the original research referred to in papers 1, 2, and 7.*

Quality Appraisal

The MMAT (2018) results are shown in Table 3. All papers described a research question or an aim of the paper that fit with the subsequent research or discussion. All included extractable adaptations. Only four directly collected data in relation to the research question/aims (3, 4, 5, 6), three referred to alternative publications that described the data collection (1, 2, 7). Four did not collect data or include any empirical evidence for the adaptations they discussed (8, 9, 10, 11), limiting the potential to appraise the quality of these papers; these papers included a mixture of clinician opinions and considerations of existing literature and theory.

Three papers did not define what they meant by poverty/low-income or it was unclear (1, 2, 7, 11). The eight that did define low-income/poverty (3, 4, 5, 6, 7, 8, 9, 10) gave various definitions, including: participants' self-identification as low-income or poor (6); receiving county health and welfare services (3); living below the U.S. poverty line (4, 5, 10); 'blue-collar autoworkers' (8); and individuals whose lives are affected by socioeconomic disparity (9).

Two papers (1, 2) referred to RCT studies from which the adaptations discussed were evidenced. However, neither gave sufficient information to assess the quality of this research. One simply described in detail the adaptations used in the RCT (1). One (2) completed a content analysis on data gathered from the RCT, the method was adequately described, some participant quotes were included, but not for every adaptation referred to, and the overall coherence between the data, method, and results was difficult to gauge. One (3) described an RCT, and the adaptations in sufficient detail to extract them. This paper appropriately reported randomisation, baseline comparisons, complete outcome data, blinded outcome assessment, and participant adherence to the intervention.

Three of the qualitative studies were of reasonably high quality (4, 5, 6). One (7) referred to other publications from which the data was collected which did not meet the selection criteria making it difficult to establish the quality of the original research. Three used a suitable method to address the research question, with a clear explanation of the methodology (4, 5, 6). Two used a qualitative description (4, 5) and adequately described the process. All four developed themes based upon the

gathered data and utilising participant quotes to evidence this (4, 5, 6, 7). Only two included a reflective section (4, 5).

Of note, one paper (8), incidentally the oldest included, used relatively derogatory language to describe the population such as referring to a lack of 'verbal skills' and 'lack of sophistication'. These were deemed to be an indication of the time period within which the paper was written, however perhaps indicate a greater level of bias from the author towards the population.

Four papers met all the related criteria (3, 4, 5, 6), therefore could be considered the highest quality papers in this review. Three (1, 2, 7) referred to alternative publications that specified the details of the empirical study from which the adaptations derived, this suggests that these would be of medium quality in this review, however the papers themselves did not offer enough information to be able to fully appraise the quality of this research. Finally, four (8, 9, 10, 11) did not gather, or report any empirical evidence in relation to the adaptations discussed, therefore these were deemed to be of the poorest quality included in the review.

What adaptations are being made?

In collating the results found, the types of adaptations being made to psychotherapy for low-income adults can be grouped into two main themes: 1) Clinicians to understand and acknowledge poverty and 2) Clinicians to be flexible and adaptive to the needs of the client. These themes each produced several subthemes (Table 4) and will be explored in more detail below. Each theme and subtheme had contributions from at least one higher quality paper.

1) Clinicians to understand and acknowledge poverty

Seven papers highlighted the importance of clinicians increasing their understanding and awareness of the impact of living in poverty, classism, and the ways in which this may impact their clients (1, 2, 4, 5, 6, 7, 9). Alongside this, it was highlighted that clinicians should acknowledge the poverty within the therapeutic room alongside engaging in reflective practice and/or supervision to enhance this understanding. Three of the papers that contributed to this theme were assessed as being of the highest quality involved in this review, three were of medium quality, and one of lower quality.

Table 4: Papers contributing to themes and subthemes

Themes and *subthemes*	Paper										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
	M	*M*	*H*	*H*	*H*	*H*	*M*	*L*	*L*	*L*	*L*
Clinicians to understand and acknowledge poverty	•	•		•	•	•	•		•		
Clinician to actively expand understanding of poverty		•		•	•	•	•		•		
Acknowledge poverty in the therapeutic room	•			•	•	•	•				
Clinician to reflect upon own understanding and biases		•		•			•		•		
Clinicians to be flexible and adaptive to needs of the client	•	•	•	•	•	•	•	•	•	•	•
Clinician to negotiate traditional boundaries	•		•	•	•	•	•	•		•	
Be an advocate and promote self-advocacy	•			•		•	•		•		
Focus on practical engagement and education	•	•	•	•		•		•		•	
Engage in multi-disciplinary/integrated approaches	•			•					•		•
Other techniques	•	•			•			•	•	•	•

Note: • indicates the paper contributed to the theme, H indicates a higher quality paper, M indicated a medium quality paper, L indicates a lower quality paper.

Clinicians to actively expand understanding of poverty

Due to the likely disparity between middle-class clinicians and their low-income clients it is unsurprising that six papers considered the importance of the clinician working with clients experiencing poverty to actively expand upon their knowledge and awareness of experiences common to low-income individuals alongside the subjective experiences of the client (4, 5, 6, 7, 9). For example, this includes developing an understanding of the role poverty-related stressors have on psychological wellbeing (4, 5), and the impact of experiencing poverty and subsequent classism on decreasing self-esteem and straining familial relationships (9) by reading relevant literature and attending training where possible. This appears to be an important factor for service users (5, 6, 7) who described how *"comforting and useful it was when the therapist 'got' the nature of the emotional and practical hardships they faced in trying to meet their most crucial needs"* (5).

Acknowledge poverty in the therapeutic room

Five papers discussed how clinicians not only need to be aware of the impact of poverty, but also use this as a source of information in conceptualising and interpreting the therapeutic process and the client's presentation (4, 6, 7) and use it as a source of transference and countertransference (6). Acknowledging this in the room also lends itself to a continual assessment of the client's basic needs as a way in which to address barriers to therapy (1) for example, transportation costs or childcare needs. Furthermore, this was another important factor for service users (5, 6, 7) who raised that "*an explicit acknowledgement of social class by their therapist"* and *"willingness to incorporate social-class related content into therapy"* both "*contributed to a sense that … (they)… understood the complexities related to being a low-income person"* (6). Clinicians also felt this was an important adaptation (4), however highlighted the tact needed in bringing up class differences to avoid eliciting feelings of shame. There were no clear suggestions on how to achieve such tact, only commenting on the importance of doing so.

Clinician to reflect upon own understanding and biases

It is not enough for clinicians to simply learn about the experiences of those living in poverty but to actively reflect upon their own internalised biases to avoid alienating their clients. This can be done through the use of regular supervision and/or reflective practice in order to identify any internalised classism, stigma or personal biases towards their low-income clients (2, 7, 9) and the power differences between themselves and their clients (4, 7) and to consider how these may impact their work. This was considered in relation to a variety of frameworks including considering poverty-related trauma (4) and relational-cultural theory (7) which focuses on issues surrounding disconnection in therapy, controlling images or stereotypes, and shame.

2) Clinicians to be flexible and adaptive to the needs of the client

All papers contributed to this theme, with a wide variety of ways in which the clinician can make their practice more flexible and appropriate for clients in this population. This included a wide range of adaptations, from negotiating boundaries, advocacy, to other well-established techniques and adaptations such as taking a multidisciplinary approach.

Clinician to negotiate traditional boundaries

Eight papers considered the ways in which therapists can negotiate the traditional boundaries of psychotherapy to empower or support their clients. This included acts such as acquiring funding for transportation and childcare (1, 3), to therapists reporting giving money to clients (4), being more flexible with payments for treatment (4, 6), or breaking agency/insurance provider rules to ensure clients can access treatment (4). However, clinicians reported varying views of the usefulness of such financial adaptations such as giving money, which in turn can further elicit feelings of shame and hopelessness or breaking agency rules leading to patient mistrusting the clinician (4). Another common adaptation focused on being more flexible with the time boundaries of sessions, being willing to shorten or lengthen sessions as appropriate for the individual (4, 8). These negotiations of boundaries seem to focus on assisting with some of the practical barriers that low-income individuals face in accessing psychological services.

Another traditional boundary that was considered for adaptation was the use of self-disclosure from the therapist (4, 5, 6, 8). The type of self-disclosure varied and lacked clarity in description at times, ranging from disclosing personal feelings about injustice (4) to disclosing their own class background (4, 5). Interestingly, two papers from service user perspectives (5, 6) found that self-disclosure was a positive adaptation that they saw as the therapist trying to "*share power*" (5) and "*enhance the '50 minute hour'*" (6), whilst the one paper exploring therapists' perceptions showed that the majority of participants considered self-disclosure, but in fact decided not to do so (4); this suggests some inconsistency in the use of this adaptation and perhaps a lack of understanding of the impact self-disclosure has on the therapeutic relationship.

Be an advocate and promote self-advocacy

Five papers highlighted that therapists should advocate on behalf of their clients, using their position of power to assist clients in acquiring their basic needs (1, 7), as a way in which to act upon their awareness of the relationship between poverty-related stressors and the clients intrapsychic stressors (4), and to enhance the therapeutic hour (6). Alongside this, advocacy and political involvement were highlighted as a way in which clinicians can promote systemic change (9). One paper also highlighted the

importance of encouraging clients to self-advocate (7) as a way in which to develop skills that can be used following the end of treatment.

Focus on practical engagement and education

Considering the number of practical barriers that low-income individuals face in accessing psychological support, it is unsurprising that most papers considered adaptations that focused on trying to reduce these barriers. This was conducted using educational meetings prior to attending therapy (1, 3, 10), this in turn increased clients' ability to make an informed decision about participating in treatment. Some advocated for increased psychoeducation during treatment (8) due to the population's likely underexposure to psychoeducation. Other practical engagement strategies included the use of extensive outreach such as telephone calls or letters (2, 6, 10, 11); such persistent and flexible outreach was considered to support clinicians to develop a good therapeutic alliance and show clients that they cared. Flexibility in the location of therapy (e.g. in clients homes, community centres, parks, cafe) (2, 3, 4, 8) was an important consideration; conducting sessions in clients' homes removed some practical barriers such as arranging transportation or childcare, however would also raise difficulties for the clinician who had to manage more distractions and confidentiality issues. Another example is that conducting meetings in cafes gave therapists the opportunity to offer clients food (4) which may help assist in their ability to concentrate if they have not eaten for some time. More well-established adaptations were also used, such as ensuring intervention and written materials are available in the clients first language (3).

Engage in multi-disciplinary/integrated approaches

Several papers either directly (9) or indirectly (4, 6, 7) refer to the use of systemic principles as a more appropriate way to conceptualise low-income clients' problems or distress. Given this consideration, it is unsurprising that four papers considered the role of multi-disciplinary approaches to enhance psychotherapy. These included the addition of a case-management component, to increase clients' access to community services (1, 4) and/or for the therapist to work with other professionals to help clients access needed resources such as psychiatry (to assist in acquiring needed medication, or a diagnosis to support with accessing required benefits) (9, 11).

Other techniques

Seven papers referred to the use of other, more well-established therapeutic techniques, emphasising the importance of such techniques with the population at hand (1, 2, 5, 8, 9, 10, 11). Three suggested the use of a strength-based, rather than deficit-based approach when working with low-income adults (5, 9, 11) highlighting that such clients enter therapy with a number of strengths including but not limited to resilience; this is in contrast to other papers which instead highlight and focus on the perceived deficits of the population (8). Whilst the majority of papers referred to the importance of developing a good rapport and strong therapeutic relationship, three papers highlighted this in more depth (2, 5, 10); a variety of well-established techniques were considered to enhance this including the use of empathy (2, 5, 10, 11) gestures, facial expressions and physical touch (2, 5), and showing authenticity (5, 8). Other traditional techniques include use of behavioural activation (1), roleplay (8), homework (1), ensuring congruence in therapeutic goals (8), and focus on specific coping skills such as stress-management, relaxation, and problem-solving (11). However, each paper highlighted the importance of tailoring such techniques to the population, for example, setting achievable homework and considering what may not be possible (e.g. go out for a meal, buy a birthday present) due to limited resources.

What is the evidence for such adaptations?

Three papers included in the review referred to empirical studies from which they drew their adaptations (1, 2, 7), these papers did not meet the selection criteria for the primary aim of the scoping review but in exploring the secondary aim were useful to consider. A brief overview of the content (Table 5) and quality appraisal (Table 6) of these papers is available in the appendices.

Table 5: Study Characteristics

	Authors (Year) and location	Identified in which paper	Current selection criteria not met	Type of paper	Aims of study	Type of psycho-therapy	Sample	Results
A	Grote, Swartz, Geibel, Zuckoff, Houck, & Frank (2009) Pittsburgh, USA	1	Does not describe adaptations in detail (described in detail elsewhere)	Randomised Control Trial (RCT)	Does culturally relevant, enhanced interpersonal therapy lead to greater outcomes to low-income, pregnant women than those receiving enhanced usual care?	Interpersonal Therapy	Mothers and expectant mothers on low incomes suffering from depression	Enhanced IPT led to significant reductions in depression diagnoses and symptoms compared to enhanced usual care.
B	Beeber, Holditch-Davis, Belyea, Funk, & Canuso (2004) USA	2	Does not describe adaptations in detail	RCT	To test the feasibility of a short-term, individualized, home-based intervention for mothers with depressive symptoms who do not typically seek mental health services.	Interpersonal Therapy	16 African-American and White, Non-Hispanic low-income mothers	The intervention group, in comparison to the care as usual group, shows a significant decrease in depressive symptom severity.
C	Beeber, Holditch-Davis, Perreira, Schwartz, Lewis, Blanchard, Canusa, & Goldman (2010) USA	2	Does not describe adaptations in detail	RCT	To test the efficacy of a 5-month, in home, culturally appropriate adaptation of IPT on reducing depressive symptoms in low-income Latina mothers.	Interpersonal Therapy	Low-income Latina Mothers	Intervention, compared to care as usual, led to a decrease in depressive symptoms and mother's reports of child's aggressive behaviours.

	Authors (Year) and location	Identified in which paper	Selection criteria not met	Type of paper	Aims of study	Type of psycho-therapy	Sample	Results
D	Appio (2013) USA	7	Not peer-reviewed	Thesis, Qualitative, Grounded Theory	To explore how poor and working-class people experience, understand, and negotiate class issues/differences with their therapist.	Counselling	22 low-income adults (15 women)	Findings showed that social class issues are important for poor clients in their interactions with their therapist.
E	Chambers (2012) USA	7	Not peer-reviewed / Does not focus on psychotherapy / Does not describe adaptations in detail	Thesis, Consensual Qualitative Research	To examine the experiences of unemployed individuals living in poverty, and to explore the psychological impact of these experiences.	N/A	21 Unemployed adults living in poverty	Results showed unemployed poverty disrupts daily, social and family life. Financial hardship and social isolation were common and financial hardship was expressed to be the most stressful.

Table 6: Quality Appraisal

Category of study design		Methodological quality criteria	Study A	B	C	D	E
Screening questions (for all types)	S1.	Are there clear research questions? *or aims?	Y	Y	Y	Y	Y
	S2.	Do the collected data allow to address the research questions? *or aims?	Y	Y	Y	Y	Y
	*S3.	Do they define the term poverty/low-income?	N	Y	N	Y	Y
	*S4.	Are there extractable adaptations?	N	N	N	Y	-
	*S5.	Is there empirical evidence for such adaptations?	Y	Y	Y	Y	-
Qualitative	1.1.	Is the qualitative approach appropriate to answer the research question?	-	-	-	Y	Y
	1.2.	Are the qualitative data collection methods adequate to address the research question?	-	-	-	Y	Y
	1.3.	Are the findings adequately derived from the data?	-	-	-	Y	Y
	1.4.	Is the interpretation of results sufficiently substantiated by data?	-	-	-	Y	Y
	1.5.	Is there coherence between qualitative data sources, collection, analysis, and interpretation?	-	-	-	Y	Y
Quantitative randomized control trials	2.1.	Is randomization appropriately performed?	Y	C	Y	-	-
	2.2.	Are the groups comparable at baseline?	Y	N	N	-	-
	2.3.	Are there complete outcome data?	Y	Y	Y	-	-
	2.4.	Are outcome assessors blinded to the intervention provided?	N	C	C	-	-
	2.5.	Did the participants adhere to the assigned intervention?	Y	Y	Y	-	-

*N.B. * indicates additional quality checklist item, Y indicates 'yes', N indicates 'no', C indicates 'can't tell', - indicates 'not applicable*

The evidence for adapting individual psychotherapy for low-income adults is limited. Results from two RCTs suggest that adapted brief interpersonal therapy (IPT) leads to a decrease in depressive symptomatology (1, 2) for low-income mothers (1, 2) in comparison to care as usual. Individuals who took part in either adapted cognitive behavioural therapy or medical interventions showed a statistically significant decrease in depressive symptoms and increase in social and instrumental functioning (effect sizes not reported) compared to participants referred to community mental health services (3); it is unclear what community referral consisted of (e.g. non-adapted psychotherapy, general support). Community referral uptake was low (17%), medication adherence was significantly higher (66%) than psychotherapy adherence (36%) in this study. One study reported a large effect size for reduction of depressive symptoms (1; *Cohen's h= 1.17*), two failed to report effect sizes (2, 3). All three RCTs failed to provide a non-adapted therapy group comparison, limiting the ability to conclude that the adaptations led to a decrease in symptoms, nor an increase in adherence. It could be suggested from such results that therapy led to such improvements, not adapted therapy. It is difficult to draw any reliable conclusions on the effectiveness or acceptability of adapted psychotherapy from such studies. Tentative conclusions would suggest that adapted therapy may help to decrease depressive symptomology, however it is unknown if this is at a higher rate than that of non-adapted therapy. Similarly, it is hard to conclude if adapted psychotherapy leads to greater adherence than non-adapted psychotherapy due to a lack of clarity in reporting the results.

Three qualitative papers explored service user perspectives on psychotherapy (5, 6, 7), which highlighted a range of ways in which therapists have adapted psychotherapy for their clients. Whilst the results from these studies lack generalisability, they suggest that adapted psychotherapy may be more acceptable to service users, who reported positive experiences of therapy when they perceived the therapist to both understand and acknowledge poverty in the therapeutic room (5, 6, 7), when therapists were more flexible with traditional boundaries (5, 6, 7) and were perceived to advocate for their clients (6, 7). It is important to note that client experiences may not necessarily correlate to clinical outcomes, therefore such results cannot comment on the effectiveness of such adaptations. One qualitative paper explored experienced clinicians' perceptions on adapting psychotherapy (4), this paper evidenced that

clinicians are adapting their therapy for this population, however that such adaptations are often based on clinical judgement and experience and vary from clinician to clinician.

Overall, there is limited evidence to suggest adapting traditional psychotherapy leads to better outcomes in psychotherapy. Some research indicates adapted psychotherapy leads to a decrease in symptomology, but does not compare this to non-adapted psychotherapy (1, 2, 3), there is some evidence that clients find adapted psychotherapy more acceptable (5, 6, 7), and some evidence suggesting experienced clinicians working with this population are likely to adapt psychotherapy (4), albeit without any reported empirical evidence that this improves outcomes or retention. There are several papers that detail a wide range of adaptations but offer no empirical evidence as to whether these adaptations are successful (8, 9, 10, 11). Generally, there is a lack of detail about how decisions to adapt are made, how they might be made, and the decision process regarding when and how to introduce them.

Discussion

The present systematic scoping review aimed to explore the current literature to find out what, if any, adaptations are being made to individual psychotherapy for low-income adults / adults living in poverty. Secondary to this, the review aimed to explore what, if any, empirical evidence there was for the use of such adaptations. The results of the present review suggest that there is some evidence that clinicians are adapting psychotherapy for this population by increasing their understanding and acknowledgement of poverty within the therapeutic setting, by being more flexible with the traditional boundaries of therapy, and finally by utilising existing therapeutic techniques that suit the population at hand. However, these adaptations lack a robust empirical evidence base, limiting the ability to conclude whether adapting therapy helps to improve acceptability or efficacy of psychotherapy.

In line with the BPS guidance for treating individuals experiencing social exclusion, the present review found several adaptations that could be used with this population; however, it has also highlighted the concerning lack of empirical evidence for such adaptations. The papers included in the review were primarily based in North America, the BPS is UK based, where therapy can be free at the point of access (although this ignores the possible financial barriers of having to arrange transport or childcare in order to access such free services), reducing the ability to generalise the already limited evidence to the UK healthcare setting. Secondly, as found in the guidelines, and the papers included in the review, many adaptations are suggested without any clarity on how to implement such adaptations. This may lead to individuals adapting psychotherapy in vastly different ways, leading to vastly different outcomes. Finally, many adaptations mentioned could be considered basic good practice (e.g. use of empathy, considering context, authenticity), without a clear rationale for how these are adapted or used differently for this population.

Whilst it is encouraging that the evidence suggests that numerous well-meaning clinicians are attempting to adapt psychotherapy to better suit low-income individuals, the lack of reliable and valid evidence for such adaptations is concerning. Considering the plethora of evidence that suggests low-income individuals are significantly more likely to experience poorer mental health (e.g. Jenkins et al., 2008), less likely to access mental health services (e.g. Saxon et al., 2007), more likely to drop out when they do access services (e.g. Barret, Chua, Crits-Christoph, Gibbons, & Thompson,

2008), and are less likely to experience positive outcomes when they complete therapy (e.g. Finegan, Firth, Wojnarowski, & Delgadillo, 2018), there is a clear need for professionals to systematically develop and test adaptations that can make interventions more accessible and effective for this population. Furthermore, even evidence-based psychotherapies have been found to lead to a deterioration in psychological wellbeing in some instances, for example Hansen, Lambert, and Forman (2002) found that in a sample of over 6000 patients, 5-10% deteriorated. Poorly evidenced adaptations to evidence based treatments may in fact be increasing the risk of contributing to clients' poor mental health, perhaps alienating them from reaching out for further support in the future and contributing to the maintenance of a class system that aims to keep the undeserved undeserving.

This lack of evidence, coupled with the biased nature of the development of the majority of well-established psychological theory (e.g. Rendon, 1996) and the likelihood of clinicians experiencing an unconscious bias towards low-income clients (e.g. Siassi & Messer, 1976; Lott, 2002) further highlights the need for the psychotherapy profession as a whole to acknowledge the duty they have to address such problems. Reflective practice is one way such unconscious biases can be explored, a key competency of the psychological profession (BPS, 2017). Furthermore, the evidence highlighted by this review suggests training should incorporate the need to acknowledge such well-established health disparities and encourage the development of skills in working with low-income clients, so that therapists can make appropriate adaptations. However, perhaps the most important step for the psychotherapy profession, is the need for research and subsequent evidence so clinicians can adapt their therapy with the knowledge and security that it will help, not hinder their clients' progress.

Limitations

There are several limitations of the present review. Primarily the review has an inherently high risk of bias due to the lack of a second author during the screening, data extraction, and quality appraisal process. Such bias may have meant important papers were missed during the screening leading to an incomplete review of the literature. Finally, this bias may have impacted the papers that were included, for example, what the first author would consider extractable adaptations may differ from

a secondary reviewer; similarly, the quality appraisal may be biased and not accurately reflect the quality.

Another finding from this review showed how limited the published literature regarding adaptations for this population is. For example, many papers were found that referred to adapting psychotherapy but failed to describe such adaptations in sufficient detail or made suggestions towards adaptations without empirical evidence. Even within the papers that were deemed to describe adaptations in enough detail for the present review, many of these adaptations were not described in enough detail to adequately replicate. This makes it difficult to trust such findings, or even assess the role of such adaptations. In line with findings from Finegan, Firth, Wojnarowski and Delgadillo (2018), the present review highlights the lack of consistency in defining low-income/poverty/SES. Such inconsistencies in the research further limit the ability to reliably compare or review literature, raising concerns about the validity of the findings of the published literature and the present review.

Another limitation of the present review is that all but one of the papers were from the USA, with one paper from Canada. This could suggest that either there was a problem with the screening criteria and non-western papers were not picked up, or that the majority of the research is being conducted in one area of the world, further reducing the generalisability of the research. Another explanation for this finding may be that USA researchers are more interested in such findings due to the need to pay for care, whereas in the UK researchers assume the barriers are reduced or non-existent due to the services being ‘free’ at the point of access. This could also be due to the screening criteria of excluding papers not written in English, alongside screening out papers that focused on cultural adaptations that did not focus on the low-income aspect of the population. Perhaps future systematic reviews with a larger scope could explore both cultural adaptations alongside adaptations for low-income individuals. Further limitations to the generalisability of the results stems from the fact that four of the papers focused solely on low-income women and the fact that the majority of original research papers had small sample sizes, further reducing the ability to generalise the findings to the low-income population as a whole.

Recommendations

The primary recommendation from the present review is that robust research should be undertaken to explore the utility of adapting psychotherapy for low-income adults. Furthermore, such research should be considered in different contexts, for example in the UK where the healthcare system differs vastly from that of North America. To begin, more qualitative research should be conducted to explore service user perspectives to understand what adaptations they consider important. Furthermore, qualitative research could explore the role of experienced clinicians' perspectives to consider adaptations that are perhaps less obvious to service users, for example the use of psychological theory. Following this, quantitative research could be conducted to explore whether adapting psychotherapy leads to improved outcomes, higher retention, and/or higher acceptability from service users. Following the outcomes of the research, guidelines could be developed to allow clinicians a structure to follow when working with this population, a list of clear, well-evidenced adaptations. In doing so, psychotherapy may be able to better support a population experiencing greater health inequalities. In creating clear, well evidenced guidelines, clinicians will be better placed to avoid unintentional acts of classism/oppression and be better prepared to support their clients and alleviate psychological distress.

References

Altman, M. (2010). Jobs and the budget: easing poverty and unemployment. *Human Sciences Research Council Review, 8*(1), 10-11.

Appio, L. (2012). *Class-related experiences of poor and working-class clients in therapy with class-privileged therapists.* (Unpublished doctoral dissertation). New York: Teachers College, Columbia University.

Appio, L., Chambers, D. A., & Mao, S. (2013). Listening to the voices of the poor and disrupting the silence about class issues in psychotherapy. *Journal of Clinical Psychology, 69(*2), 152-161. doi: 10.1002/jclp.21954

Araya, R., Lewis, G., Rojas, G., & Fritsch, R. (2003). Education and income: which is more important for mental health?. *Journal of Epidemiology & Community Health*, *57*(7), 501-505. doi: 10.1136/jech.57.7.501

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19-32. doi: 10.1080/1364557032000119616

Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, *45*(2), 247. doi: 10.1037/0033-3204.45.2.247

Beeber, L. S., Cooper, C., Van Noy, B. E., Schwartz, T. A., Blanchard, H. C., Canuso, R., ... & Emory, S. L. (2007). Flying under the radar: engagement and retention of depressed low-income mothers in a mental health intervention. *Advances in Nursing Science, 30*(3), 221-234. doi: 10.1097/01.ANS.0000286621.77139.f0

Beeber, L., Holditch-Davis, D., Belyea, M., Funk, S., & Canuso, R. (2004). In-Home Intervention for Depressive Symptoms with Low-Income Mothers of Infants and Toddlers in the United States. *Health Care for Women International, 25(*6), 561-580. doi: 10.1080/07399330490444830

Beeber, L. S., Holditch-Davis, D., Perreira, K., A. Schwartz, T., Lewis, V., Blanchard, H., ... & Goldman, B. D. (2010). Short-term in-home intervention reduces

depressive symptoms in Early Head Start Latina mothers of infants and toddlers. *Research in Nursing & Health*, *33*(1), 60-76. doi: 10.1002/nur.20363

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*(3), 279. doi: 10.1037/a0023626

Borges, A. M., & Goodman, L. A. (2019). Considering poverty in the therapeutic process: experienced therapists' adaptations. *Counselling Psychology Quarterly.* Advance online publication. doi: 10.1080/09515070.2019.1589420

Bramer, W. M., Rethlefsen, M. L., Kleijnen, J., & Franco, O. H. (2017). Optimal database combinations for literature searches in systematic reviews: a prospective exploratory study. *Systematic Reviews, 6*(1), 245. doi: 10.1186/s13643-017-0644-y

Breslau, J., Lane, M., Sampson, N., & Kessler, R. C. (2008). Mental disorders and subsequent educational attainment in a US national sample. *Journal of Psychiatric Research, 42(*9), 708-716. doi: 10.1016/j.jpsychires.2008.01.016

British Psychological Society (2017). *Practice Guidelines: Third Edition*. Retrieved from: https://www.bps.org.uk/news-and-policy/practice-guidelines

Cambridge International Dictionary of English. (1995). In *Cambridge International Dictionary of English.* Cambridge: Cambridge University Press.

Chambers, D. (2012). *Coping with unemployed poverty; A qualitative study.* (Unpublished doctoral dissertation). New York: Teachers College, Columbia University.

Delgadillo, J., Asaria, M., Ali, S., & Gilbody, S. (2016). On poverty, politics and psychology: the socioeconomic gradient of mental healthcare utilisation and outcomes. *The British Journal of Psychiatry*, *209*(5), 429-430. doi: 10.1192/bjp.bp.115.171017

Finegan, M., Firth, N., Wojnarowski, C., & Delgadillo, J. (2018). Associations between socioeconomic status and psychological therapy outcomes: A

systematic review and meta-analysis. *Depression and Anxiety*, *35*(6), 560-573. doi: 10.1002/da.22765

Gould, R. (1967). Dr. Strangeclass: Or How I stopped worrying about the theory and began treating the blue-collar worker. *American Journal of Orthopsychiatry, 37*(1), 78. doi: 10.1007/BF02110058

Grote, N. K., Swartz, H. A., & Zuckoff, A. (2008). Enhancing interpersonal psychotherapy for mothers and expectant mothers on low incomes: Adaptations and additions. *Journal of Contemporary Psychotherapy, 38*(1), 23-33. doi: 10.1007/s10879-007-9065-x

Grote, N. K., Swartz, H. A., Geibel, S. L., Zuckoff, A., Houck, P. R., & Frank, E. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatric Services, 60*(3), 313-321. doi: 10.1176/appi.ps.60.3.313

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329–343. doi: 10.1093/clipsy/9.3.329

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., ... & Rousseau, M. C. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information, 34(*4), 285-291. doi: 10.3233/EFI-180221

Jenkins, R. Bhugra, D., Bebbington, P., Brugha, T., Farrell, M., Coid, J., Fryers, T., Weich, S., Singleton, N., & Meltzer, H. (2008). Debt, income and mental disorder in the general population. *Psychological Medicine, 38*(10)*,* 1485-1493. doi: 10.1017/S0033291707002516

Kabeer, N. (2000). Social exclusion, poverty and discrimination towards an analytical framework. *Institution of Development Studies Bulletin, 31*(4), 83-97. doi: 10.1111/j.1759-5436.2000.mp31004009.x

Kessler, R. C., Chiu, W. T. Delmer, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity

survey replication. *Archives of General Psychiatry, 62*(6), 617-627. doi: 10.1001/archpsyc.62.6.617

Krieger, N., Quesenberry Jr., C., Peng, T., Horn-Ross, P., Stewart, S., Brown, S., … & Ward, F. (1999). Social class, race/ethnicity, and incidence of breast, cervix, colon, lung, and prostate cancer among Asian, Black, Hispanic, and white residents of the San Francisco Bay area, 1988-92 (United States). *Cancer Causes and Control, 10*(6)*,* 525-537. doi: 10.1023/a:1008950210967

Layton, L. (2006). Attacks on linking: The unconscious pull to dissociate individuals from their social context. In L. Layton, N. C. Hollander, & S. Gutwill (Eds.), *Psychoanalysis, class, and politics* (pp. 107–117). London, UK: Routledge.

Levy, L. B., & O'Hara, M. W. (2010). Psychotherapeutic interventions for depressed, low-income women: A review of the literature. *Clinical Psychology Review, 30*(8)*,* 934-950. doi: 10.1016/j.cpr.2010.06.006

Lott, B. (2002). Cognitive and behavioral distancing from the poor. *American Psychologist, 57(*2), 100-110. doi: 10.1037/0003-066X.57.2.100

Mays, N., Roberts, E., & Popay, J. (2001). Synthesising research evidence. In N. Fulop, P. Allen, A. Clarke, & N. Black (Eds.), *Studying the organisation and delivery of health services: Research methods.* London: Routledge.

Menec, V. H., Shooshtari, S., Nowicki, S., & Fournier, S. (2010). Does the relationship between neighborhood socioeconomic status and health outcomes persist into very old age? A population-based study. *Journal of Aging and Health, 22,* 27-47. doi: 10.1177/0898264309349029

Mickelson, K. D., & Kubzansky, L. D. (2003). Social distribution of social support: The mediating role of life events. *American Journal of Community Psychology, 32*(3-4), 265-281. doi: 10.1023/B:AJCP.0000004747.99099.7e

Miranda, J., Chung, J. Y., Green, B. L., Krupnick, J., Siddique, J., Revicki, D. A., & Belin, T. (2003). Treating depression in predominantly low-income young minority women: a randomized controlled trial. *Journal of the American Medical Association, 290*(1), 57-65. doi: 10.1001/jama.290.1.57

Moher, D., Liberati, A., Tetzlaff, J., Altman, D., G., & The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *Journal of Clinical Epidemiology, 62*(10), 1006-1012. doi: 10.1016/j.jclinepi.2009.06.005

Overholser, J. C. (2016). When words are not enough: Psychotherapy with clients who are living below the poverty level. *Journal of Contemporary Psychotherapy, 46(*2), 89-96. doi: 10.1007/s10879-015-9313-4

Patel, V., Araya, R., De Lima, M., Ludermir, A., & Todd, C. (1999). Women, poverty and common mental disorders in four restructuring societies. *Social science & medicine*, *49*(11), 1461-1471. doi: 10.1016/S0277-9536(99)00208-7

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organisation, 81*(8), 609-615.

Pope, J. F., & Arthur, N. (2009). Socioeconomic status and class: A challenge for the practice of psychology in Canada. *Canadian Psychology, 50*(2), 55. doi: 10.1037/a0014222

Pugach, M. R., & Goodman, L. A. (2015). Low-income women's experiences in outpatient psychotherapy: A qualitative descriptive analysis. *Counselling Psychology Quarterly, 28*(4), 403-426. doi: 10.1080/09515070.2015.1053434

Rendon, M. (1996). Psychoanalysis in an Historic-Economic Perspective. In R. M. P. Foster, M. Moskowitz, and R. A. Javier (Eds.) *Reaching across boundaries of culture and class* (pp. 21-46). Northvale, NJ: Jason Aronson, Inc.

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy?. *Journal of Clinical Psychology, 69(*2), 115-126. doi: 10.1002/jclp.21951

Saxon, D., Fitzgerald, G., Houghton, S., Lemme, F., Saul, C., Warden, S., & Ricketts, T. (2007). Psychotherapy provision, socioeconomic deprivation, and the inverse care law. *Psychotherapy Research*, *17*(5), 515-521. doi: 10.1080/10503300601063246

Schwartzman, S. (2000). *The statistical measurement of poverty*. Retrieved from: https://unstats.un.org/unsd/statcom/doc99/rio.pdf

Siassi, I., & Messer, S. B. (1976). Psychotherapy with patients from lower socioeconomic groups. *American Journal of Psychotherapy, 30,* 29-40. doi: 10.1176/appi.psychotherapy.1976.30.1.29

Smith, J. P., Kington, R. (1997). Demographic and economic correlates of health in old age. *Demography, 34*(1), 159–170.

Thompson, M. N., Cole, O. D., & Nitzarim, R. S. (2012). Recognizing social class in the psychotherapy relationship: A grounded theory exploration of low-income clients. *Journal of Counseling Psychology, 59*(2), 208. doi: 10.1037/a0027534

Wilkinson, R. G., & Pickett, K. E. (2007). The problems of relative deprivation: why some societies do better than others. *Social Science & Medicine, 65*(9), 1965-1978. doi: 10.1016/j.socscimed.2007.05.041

World Health Organization (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* World Health Organization: Geneva.

World Health Organisation (2007). *Breaking the vicious cycle between mental ill-health and poverty.* Retrieved from: https://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf?ua=1

JOURNAL PAPER

"My values keep me well… would they help other people?": A thematic analysis exploring the values and valued behaviours of people facing severe and multiple disadvantage

Sophie Buckley[1]

Dr Anna Tickle[1&2]

Robert Eagle[2]

Dr David L Dawson[3]

[1]Trent Doctorate in Clinical Psychology, School of Medicine, Division of Psychiatry and Applied Psychology, University of Nottingham

[2]Opportunity Nottingham, National Fulfilling Lives Programme

[3]Trent Doctorate in Clinical Psychology, University of Lincoln

Word Count: 5844

Prepared for submission to: Journal of Social Distress and Homelessness
https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=ysdh20

Original Research Paper: 6000 words *(excluding tables and references)*

Abstract

Individuals facing Severe and Multiple Disadvantage (SMD) have experience of at least 3 of the following: homelessness, substance use, mental illness, offending, and domestic violence. There is a push towards providing better support for people facing SMD and yet little research on what the “best” support looks like. Values motivate behaviour across various contexts, and helping an individual identify their values can lead to greater enactment of positive behavioural change. This study aimed to identify and explore the values of people facing SMD, the barriers and facilitators to enacting these values, and the perceived helpfulness of service provision in encouraging valued behaviour or change. Twelve participants took part in semi-structured interviews. Reflexive thematic analysis resulted in four themes: values are idiosyncratic and interconnected; the benefits of value identification and enactment; the risks and challenges of value identification and enactment; and the relationship between values and support. Results offer preliminary evidence for the potential use of values in providing helpful, person-centred support for people facing SMD. Values work could arguably be integrated into any level of support for those facing SMD to support valued living and change. Further research on the use and efficacy of values-focused interventions in SMD is needed.

Keywords: homelessness, severe and multiple disadvantage, multiple complex needs, values, valued behaviour, qualitative, thematic analysis

Introduction

Severe and Multiple Disadvantage (SMD) can be defined as having experienced at least 3 of the following: homelessness, substance use, mental illness, offending, and domestic violence (Bramley et al., 2015; Sosenko et al., 2020)[1]. People may experience further sources of disadvantage outside this definition, such as physical health problems, abuse, racism, and/or community isolation (Everitt & Kaur, 2019). Although accurately gauging the prevalence of SMD in England is difficult, estimates range from 58,000 (Making Every Adult Matter; MEAM, 2018) to 336,000 (Sosenko et al., 2020), depending on the number of SMD domains used as criterion.

Psychological trauma is often experienced by individuals who are homeless[2] and is both a precursor (Taylor & Sharpe, 2008) and an outcome of homelessness (Goodman et al., 1991). Although likely underestimated[3], an estimated 85% of individuals facing SMD experienced trauma in early childhood (Bramley et al., 2020); 55% have a diagnosed mental illness (Bramley et al., 2015), compared to 45% of the homeless population and 25% in the general public (Homeless Link, 2014).

Individuals facing SMD endure challenges grounded within local contexts and wider inequalities[4] (Shinn & Toohey, 2003). Services are commissioned to provide specific support, often siloed to one SMD domain such as mental health or substance use (Everitt & Kaur, 2019) which can fail to acknowledge the complex and interconnected facets that contribute to the maintenance of SMD. Reduction in spending on services has increased pressure on service providers with limited resources, and relationships often characterised by conditionality and disconnection (Watson et al., 2018). Service accessibility is limited for people facing SMD due to policies that may indirectly discriminate against those experiencing homelessness such as requiring an address for admission criteria and resource allocation for instance mental health services not commissioned to work with comorbid substance use (Moore et al., 2011).

The intricacies of service provision together with the complexities of presenting difficulties, such as individuals actively using substances to cope with poor mental health (Homeless Link, 2014), may lead to limitations to assessment and treatment

[1] See Extended Introduction 1.1
[2] See Extended Introduction 1.3
[3] See Extended Introduction 1.4
[4] See Extended Introduction 1.2

coherence (Moore et al., 2011). Arguably, the manner in which services aim to help (i.e., siloed services focused on specific behavioural changes) may not cohere or resonate with those most in need of the service. To assume what people may need, or what would best facilitate them to make positive changes, likely produces false assumptions and interventions with poorer outcomes.

There is an emphasis on improving support for those experiencing SMD[5], including using psychological frameworks to improve service provision (Homeless Link, 2017); such as Psychologically Informed Environments (PIE; PIElink, 2020) and Trauma-Informed Care (TIC; Burge et al., 2021). The numerous individual and systemic factors that contribute to and sustain each aspect of SMD complicates services' ability to offer efficacious support. The various facets of SMD are often discussed and understood by service providers in relation to behaviours exhibited regarding each SMD domain, such as using substances or appointment non-attendance due to fluctuating mental health. However, services may not fully understand barriers to changing such behaviours. Considering the critical role of behaviour in experiencing and sustaining SMD, it seems pertinent to explore the factors that influence a person's behaviour.

Values[6] are "freely-chosen verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which establish predominant reinforcers for that activity that are intrinsic in engagement in the valued behavioural pattern itself" (Wilson & Dufrene, 2009, p.64) or in other words, "global, desired, and chosen life directions" (Dahl et al., 2005, p.61). They are typically associated with long-term personal goals and are ordered in terms of their importance by the person (Schwartz & Bilsky, 1987; Schwartz, 1992). Values act as distal reinforcers of congruent behaviours (Hayes et al., 2012a), or put simply, values act as a key source of human motivation (Hitlin & Piliavin, 2004). Although values are generally considered stable over a lifetime, they may change in response to trauma (Tedeschi & Calhoun, 2004) or major life transitions (Johnson, 2001); for those experiencing SMD it could be hypothesised that becoming homeless, or the trauma and social exclusion likely experienced whilst being homeless, may produce a shift in their values.

[5] See Extended Introduction 1.5.
[6] See Extended Introduction 1.6.

Whilst many psychotherapies recognise that values serve an important function and are a powerful motivator in clients' lives (Engle, 2017), Acceptance and Commitment Therapy[7] (ACT; Hayes et al., 2012b), which aims to increase psychological flexibility, places particular importance on values. ACT treatment focuses on identifying values and orientates clients towards making positive behavioural changes related to what matters most to them (Yadavia & Hayes, 2009). By supporting clients to identify and work towards values, regardless of therapeutic model, arguably, therapists can support people to connect with what is most meaningful to them, even within their context of suffering (LeJeune & Luoma, 2019, p.2).

Studies show that bringing focused attention to values leads to increased enactment (Fitzpatrick et al., 2016) and sustainment (Gregg et al., 2007) of behavioural changes. Connecting with values helps clients to persist with difficult, painful tasks (Grumet & Fitzpatrick, 2016; Paez-Blarrina et al., 2008) and can help with treatment adherence (Forman et al., 2009; Woods et al., 2006). Interestingly, valued action (enacting behaviours that align with one's values) predicts decreases in suffering, whereas decreases in suffering do not predict increased valued behaviour (Gloster et al., 2017). There is emergent, albeit limited, evidence for the use of ACT, which places focus on valued action, in homelessness settings (Murthy et al., 2020; 2021). One study offers preliminary evidence for the use of ACT with an individual facing SMD; the intervention played a key role in increasing psychological flexibility, alongside the impact of the therapeutic relationship and psychopharmacological interventions (Shepherd et al., 2021).

Rationale[8]. Research previously focused on the importance people attribute to values and less on how people live in line with them (Sheldon & Krieger, 2014). This is particularly important for people experiencing social disadvantages, such as social exclusion and limited resources, that may hinder their ability to engage in valued living. Therefore, if a lack of clarity about values and enactment of values-based behaviours leads to poorer psychological outcomes, then individuals experiencing SMD may be less willing to change behavioural strategies that are partially working (such as using substances to manage poor mental health), likely increasing the conflict between the

[7] See Extended Introduction 1.8.
[8] See Extended Introduction 1.9

individual and service providers in terms of enacting values-related behavioural changes.

Research shows that value identification and exploration can lead to increased behavioural changes and improved wellbeing in various populations, however it is difficult to transfer such findings to the lives of people facing SMD. Given that service provision for individuals experiencing SMD typically focuses on encouraging behavioural changes, it seems pertinent to explore whether values act as motivators for this population consistent with theory. If services are presuming what a person's values are or should be (or not even considering the role values may play), they may be creating unnecessary barriers that reduce the individual's confidence in the service provider's ability to understand, and therefore, help them. Services may not fully understand the barriers to enacting valued behaviour or change; often associating failure with lack of motivation or substance addiction. Alternatively, if service providers can understand the barriers and facilitators to engaging in valued behaviour, including responses to offers of support, they may be able to better support people to live in personally meaningful and important ways, increasing the likelihood of positive change, such as improved wellbeing and engagement.

The following research aims to:

i. identify and explore the personally held values of individuals experiencing SMD, and the barriers and facilitators to enacting such values in their daily lives
ii. explore the perceived helpfulness of service provision in encouraging individuals' ability to engage in values-based behaviours and/or change

Method[9]

Procedure[10]. The study received ethical approval from the University of Nottingham (ref-1659). Experts by experience were involved in the development of the study. An outreach approach was taken, recruiting participants through purposive sampling: mangers and staff from several charity and third-sector services that support individuals facing SMD were approached by the researcher(s) and asked to support with study recruitment.

Recruitment[11]. The study recruited twelve individuals who are facing/have faced SMD to participate in a semi-structured interview. The interview schedule, developed and refined by the primary researcher and a lived-experience consultation group, is outlined in Table 7. Five interviews were completed over video-chat; six face-to-face; and one via telephone. Participants were given a multi-store £10 gift voucher for taking part. The interviews were audio-recorded and transcribed verbatim by the researcher with the aid of transcription software. Interviews lasted between 1hr 8 mins and 2hr 3 mins; on average lasting just under 90 minutes (M = 87.08, SD = 15.78).

Analysis[12]. This study utilised a critical realist (Bhaskar, 1979) reflexive thematic analysis (TA; Braun & Clarke, 2006; 2021) based on semi-structured interviews. The data was coded using a hybrid inductive-deductive design. Initially all data was coded inductively, retaining participant language, focusing on the individual's experience. Subsequently, data was re-coded using a deductive framework developed by the researchers, allowing flexible inclusion of existing research. Codes were grouped and themes developed and refined through supervision and reflection.

Reflection[13]. The primary researcher kept reflective journals and regularly attended supervision throughout the research process. One supervisor has no experience of working with individuals experiencing SMD, which allowed for interpretations driven solely by the data, rather than experience. Contrastingly, two supervisors have direct experience to draw upon in understanding the data within the wider context.

---

[9] See Extended Method 2
[10] See Extended Methods 2.4
[11] See Extended Methods 2.5
[12] See Extended Method 2.6
[13] See Extended Reflection 5

Table 7. Semi-Structured Interview Stages and Procedure

Stage of Interview	Procedure
1. Open exploration of values	Participants were read a short definition of values. They were then asked open-ended questions to elicit their values. These included “what has always been important to you?”, “do you have a personal motto?”, and the miracle question (Bennett & Oliver, 2019), an exercise often used in ACT to support value identification.
2. Structured exploration of values	Participants then completed the Personal Values Checklist (PVC; Harris, 2010). The PVC is a list of 58 values with a short definition of each. The researcher would read each value and definition aloud and ask participants to rate each value in terms of its importance (Very, Quite, or Not). Participants were able to skip any value they did not want to rate or discuss. After the 58 values had been rated or skipped, the participant was asked to choose three ‘Very Important’ values that they would be happy to potentially discuss in more detail.
3. Open-ended questions related to the research aims*	Participants would then choose one of their three chosen values to discuss in detail. Participants were asked to explore this value in more detail through questions such as “what does (insert value) mean to you”, “why is (value) important to you”, and “are you able to live in line with (value) in your day-to-day life”. Following this, participants were asked questions exploring the barriers and facilitators to enacting these values such as “what helps you to live in line with (value)” or “what gets in the way of enacting (value) behaviour”. Finally, participants were asked about their perception of the helpfulness of services’ in supporting them to enact their value e.g., “has anyone/any service helped you in enacting (value)” and “has anyone/any service got in the way of enacting (value)”. Dependent on participant ability/wishes, at least one and a maximum of three values were discussed in detail.

**Participants whose experience of SMD is historical were asked to clarify whether examples offered related to when they were experiencing SMD and/or their current context.*

Results[14]

Table 8 provides contextual information about participants. Ages ranged from 26-59 (*M* = 43.5, *SD* = 9.1). All participants experienced homelessness, mental illness, and substance use; 10 had experience with the criminal justice system; and 9 experienced domestic violence. Of those whose experience of SMD was historical, estimated time since meeting the definition ranged from 1 month to 10 years ago (*M* = 15.91 months, *SD* = 35.78 months).

TA resulted in four themes with nine subthemes, outlined in Figure 2. Every participant identified at least one value during the open-exploration phase of the interview. Values mentioned not in the PVC included: family, friends, morality, discipline, wisdom, and living itself. In completing the PVC, on average participants each identified 36 of a possible 58 values as very important (*M* = 35.58, *SD* = 10.15), 18 as quite important (*M* = 18.25, *SD* = 9.18), and 4 as not important (*M* = 3.83, *SD* = 3.27). Of the PVCs 58 values, each value was rated as very important by at least one participant and 57 rated as quite important. In contrast, only 23 values were rated as not important by someone. Table 9 outlines the five most-rated values categorised by importance.

[14] See Extended Results 3

Table 8. Participant Demographics and Context

Pseudonym	Gender & *Age Range*	SMD Domains Met & *When*	Values Number Rated*		Top Three Chosen
Chloe	Female *25-34*	3SMD *Historical*	Very: Quite: Not:	36 16 6	Freedom Forgiveness Spirituality
Chris	Male *35-44*	4SMD *Historical*	Very: Quite: Not:	52 5 1	Trust Assertiveness Forgiveness
Emily	Female *35-44*	5SMD *Current*	Very: Quite: Not:	33 24 1	Encouragement Fairness Trust
Hannah	Female *25-34*	5SMD *Current*	Very: Quite: Not:	30 26 2	Courage Humour Mindfulness
Harry	Male *55-64*	5SMD *Current*	Very: Quite: Not:	28 26 1	Acceptance Kindness Self-awareness
Helen	Female *45-54*	5SMD *Current*	Very: Quite: Not:	55 1 2	Generosity Fun Respect
Jack	Male *45-54*	4SMD *Historical*	Very: Quite: Not:	29 25 4	Adventure Creativity Fun
Jess	Female *35-44*	5SMD *Current*	Very: Quite: Not:	34 12 12	Respect Courage Honesty
Kate	Female *35-44*	5SMD *Historical*	Very: Quite: Not:	35 18 5	Caring Trust Persistence
Megan	Female *55-64*	4SMD *Historical*	Very: Quite: Not:	45 12 1	Creativity Fitness Mindfulness
Paula	Female *35-44*	5SMD *Current*	Very: Quite: Not:	21 30 6	Assertiveness Forgiveness Fairness
Tom	Male *45-54*	5SMD *Current*	Very: Quite: Not:	29 24 5	Adventure Humour Respect

*The number of values participants had rated by importance out of the total 58 on the PVC

Figure 2. Thematic Map

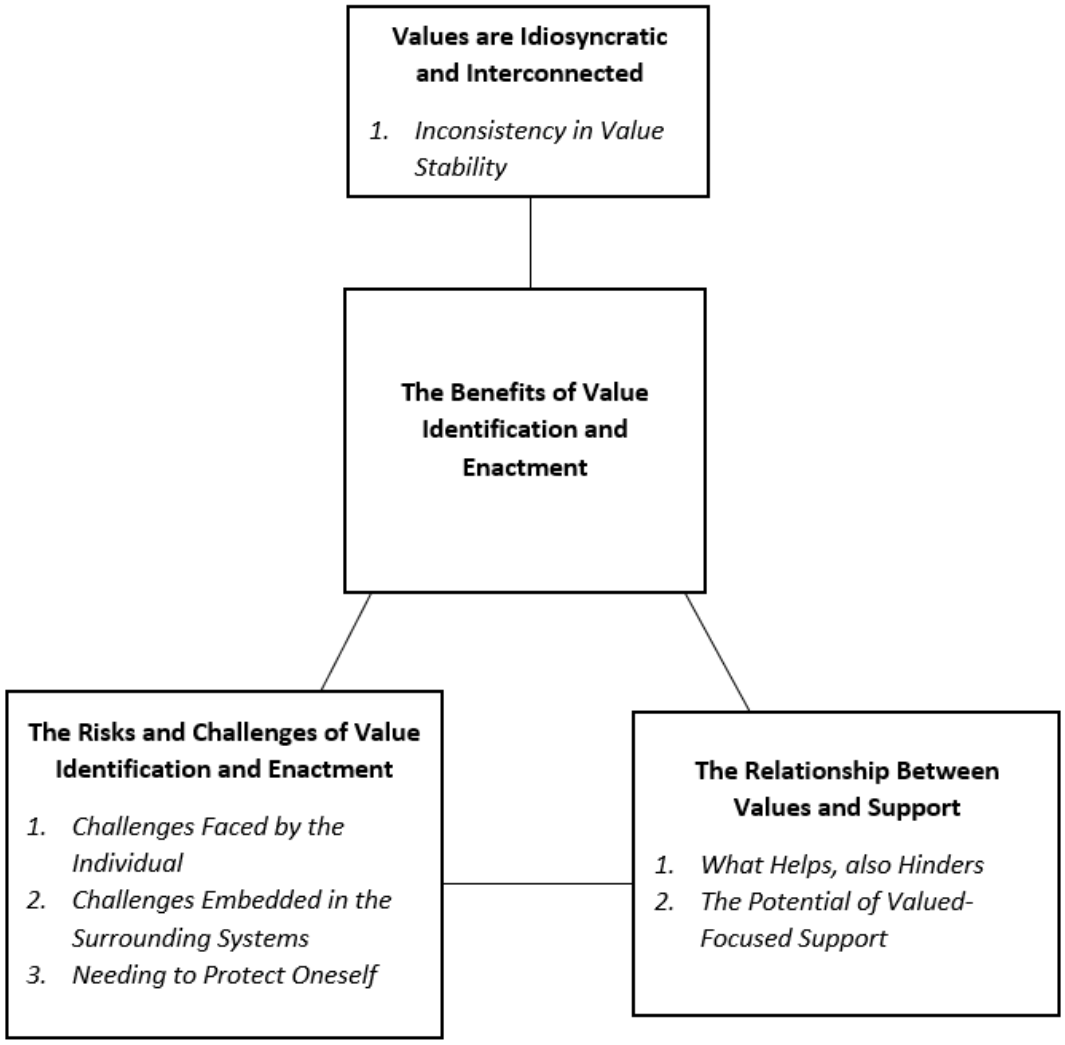


Table 9. The Five Most-Rated Values by Category of Importance on PVC (Harris, 2010)

	Importance as Rated by Participants					
	Very		**Quite**		**Not**	
Value & *Number of Ratings*	Humour	*12*	Cooperation	*8*	Power	*8*
	Acceptance	*11*	Sensuality	*8*	Sexuality	*5*
	Fairness	*11*	Challenge	*7*	Conformity	*3*
	Gratitude	*11*	Pleasure	*7*	Excitement	*3*
	Respect	*11*	Self-Development	*7*	Romance	*3*

Values are Idiosyncratic and Interconnected

Every participant had numerous, interconnected, personally meaningful values. Although commonalities existed, individuals conceptualised their values in different ways; forgiveness, for instance, was described by several people as *"letting go of the past"* (Chris) or being able to *"move forward"* (Kate), whereas only Chloe described it as a tool to extinguish rage:

> *Forgiveness is like a ball of rage that I just need to put out, I need to find the right extinguisher… to find out what puts (that) fire out inside me.*

Many noted that *"there's a few (values) that cross over"* (Jack). Jess struggled to whittle down which to discuss in detail: *"(different values) fall into the same category… in one way or another they're all together"*. Everyone pulled in numerous values when talking about one in detail; Paula associated assertiveness with being able to *"communicate"* and being *"safe"*. Hannah expressed that mindfulness is embedded with *"connection… spiritual interest… self-awareness as well".*

Inconsistency in Value Stability. Most describe at least one value as remaining consistent across their life and one as having been less stable. For instance, Chris outlined that "*even though I became a drug addict … I still always kept my morals of being respectful"*. However, regarding conformity, Chris reflected that this had never been important to him before, but now was very important:

> *I broke the rules all my life…so now… it makes me feel better to maintain and stick by them… I feel like I'm living right instead of wrong.*

Hannah, discussing caring, reflected *"see this has shifted… I've done too much of that. It's not getting me anywhere... it's time to try not caring about caring"*. Similarly, Emily reported a new relationship with freedom, *"at the time it was very important but now it's quite important"*.

In some instances, the value itself remained stable yet participants' attitudes or behaviours changed. Jack described that whilst living in a hostel, he necessarily limited the amount of compassion he enacted in order to keep himself safe:

> *To survive, I mean, people take your kindness as weakness…You've got to be on your toes, really cautious… not being so removed with no connection to people, but you've got to be reserved in a way.*

The process of re-identifying values led some to evaluate themselves, "*my values are changing, definitely for the better I hope."* (Tom, discussing self-improvement). Others were surprised at these changes' significance:

> *Gosh, do you know what, if you asked me this even just a couple of months ago it would have been so different … Now I'm trying to evaluate my values (laughs)... have they improved or got worse?*
> Hannah (discussing justice)

All participants identified a wide range of personally meaningful and interconnected values. It appears that individual values and their associated behaviours are likely to be viewed very differently by each person. Whilst values generally remain stable, an individual's current living context and their relational experiences can shape and change the importance and behavioural expression of certain values. As such, people facing SMD may experience numerous shifts in their values across their lifespan.

The Benefits of Value Identification and Enactment

Everyone offered numerous examples of valued living; the way in which people enact values are as varied and individualistic as the people and values themselves. From taking *"circus classes"* (Hannah, discussing courage and curiosity), *"mentoring"* (Chris, discussing compassion and caring), and *"growing pumpkins"* (Emily, discussing environmental beauty). At other times, valued-living means *"not doing something"* (Hannah, discussing courage) so as not to behave in ways that contradict personally meaningful values, for instance, *"if I'm in a bad mood, if I'm not going to be out there showing people respect… I won't go out"* (Jess, discussing respect).

Harry shared his experience of enacting creativity and excitement by attending a theatre group, which appeared to have a positive effect on himself and others, further aligning with his values of cooperation and connection:

> *I absolutely loved it… mentioned it to a couple of individuals, they subsequently came along and absolutely loved it and started doing it… when you do something and it follows on, the ripple effect.*

Participants described valued behaviour as something that increases their wellbeing and helps them to connect to meaning, "*spirituality, the more I talk about it, the more I think wow, I've really come a long way... it gives me hope, it makes me believe that there is something to come out of all of this … I've hit rock bottom and there's still a light"* (Chloe). Emily reflects upon how enacting and observing her value of encouragement brightens her day:

> *Obviously, I wake up for a lot of things, but encouragement, when I see encouragement, it brightens up my day. Cause someone is out there trying to help me… and encourage me to do things on my own.*

Although some participants began the interview already well-aware of their values, *"I do this all the time in my own mind"* (Paula), others needed more scaffolding to identify their values, *"I don't know what else my values would be. I've never really thought about this before"* (Chloe). Discussing values appeared to help some participants make sense of their experience, for instance whilst exploring adventure, Tom commented "*I didn't know you was going to speak about this… it's made me feel, like I had a jigsaw piece and now you've put the other one into it"*.

Several people reported increased motivation to enact valued behaviour, for instance after discussing spirituality, Chloe commented that *"talking to you now has made me want to go upstairs after and read my (spirituality) book".* Every participant offered examples of living consistently with their values, as well as times when doing so has increased their wellbeing. It also appears that value identification and valued action itself can facilitate further valued action; perhaps there is something important or potentially motivating about the process of considering and enacting values.

The Risks and Challenges of Value Identification and Enactment

Challenges Embedded in the System. Many described the negative impact of "*cutbacks and austerity"* (Megan) on services' ability to support them with valued living, especially regarding limited resources; *"(there are no) opportunities to do exercise or activities, they need to be there"* (Megan, discussing fitness).

Some describe feeling that certain services restrict their ability to enact personal values, *"this service has made me feel like I have to change my whole personality and my whole self (to access support)"* (Kate, discussing persistence). This strained relationship with services can hinder how able participants feel to engage with support offered. Chloe, discussing trust, reflects on her experience of services':

> *I hate services if I'm honest… they clock off, they make easy mistakes that could end your life in a moment… I didn't even realise I needed to forgive services as well.*

Participants indicated that placement in supported living can challenge their ability to enact or maintain valued behaviour or change "*there doesn't seem to be a great deal of… engaging with the possibility of moving on to employment and a bit more stability"* (Harry, discussing industry and stability). Several people noted that peers can be a barrier, *"they're not coming up to me to do anything positive or good with me, it's always negativity or distractions or deceitfulness"* (Kate, discussing persistence). For those with historical experience of SMD, challenges did not disappear, but seemed to change. Chris for instance, discussing self-care, highlighted the impact of wider stigma and accessing further support to continue enacting values:

> *Now I've not got support workers it's even harder to get that secondary mental health help… people like myself who have been addicts and stuff in the past, a lot of people like to just fob you off.*

Participants appear to need support from services in connecting with and enacting their values; however, this is complicated by the various systemic barriers in place. Furthermore, people's connection with and subsequent expression of values might be shaped by their interaction with services which may in turn influence people's attitudes towards any further interaction or engagement with services.

Challenges Faced by the Individual. Everyone described how the intricacies of experiencing SMD hinder their ability to enact valued behaviour, *"it's something I can't do when I've been… getting beaten up"* (Helen, discussing fun). All described the negative impact mental illness can have "*I'd love for my mental health to be better… it holds me back from doing a lot"* (Jess, discussing self-care). Substance use was highlighted by most as a barrier to valued living, *"I'm not really interested (in*

mindfulness) … if my only goal of the day is to get drunk" (Hannah); conversely, only Helen felt substances supported her in living an exciting life, "*I drink all the time so yeah, (excitement is) very (important)"*.

Participants reflected on how individual factors not necessarily related to experiencing SMD can also hinder valued living. Many acknowledged the impact of their own beliefs, attitudes, and behaviours: "*my biggest culprit would probably be me"* (Megan, discussing fitness) and "*it's so easy to… go ugh I'm not going to do this and forget about my values"* (Chloe, discussing self-care). Hannah reflected "*at the end of the day I can use anything as a justification to not do something"*. Others link this to their early experiences, Chris, for instance, described what hinders enacting forgiveness:

> *Obstacles… it's not anything out there, it's all inside me… It's all to do with my upbringing and stuff.*

It appears that whilst a lack of resources associated with SMD is a clear barrier to valued action, simply increasing resources may not attend to the psychological barriers experienced by participants. It is possible that opportunities to identify and enact values may support people to overcome their psychological barriers, however these individual factors may simultaneously impact people's ability to accept such support when offered.

Needing to Protect Oneself. Additional to the individual and systemic challenges, participants describe the need to protect themselves both physically and psychologically when identifying or enacting values. For some, particular values were too challenging to think about. Jess, reflecting upon self-awareness, reported *"I do need to learn but… it's a new can of worms and I don't even want to go there at the moment".* Hannah reflected on the process of identifying her values through the PVC:

> *Part of the reason I've got in the situation I'm in is because I've not been living with my values. So, it can feel quite out of reach at times … like quite a luxury… it's a bit uncomfortable to think about.*

Understandably, valued living is harder when people are facing both real and perceived threats. Emily, discussing assertiveness and when to enact this, highlighted "*you expect to get some backlash… (you) might get too confident against the wrong*

person". Hannah reflected upon her value of courage and when it is appropriate to enact:

> *It's no longer a sensible or courageous decision if actually I'm putting myself in danger, you know? Whether that's perceived or real danger.*

Tom describes a scenario in which he tried to enact his value of compassion by helping someone, who tried to take advantage, leaving him needing to put boundaries in place:

> *I've been on the streets, I know what it's like… this person, I put him up for the night, and they just thought they could take over… I had to show them the door… I felt bad about it, but I wasn't allowing it.*

The importance of self-protection is highlighted by this them, with participants needing to protect themselves physically and emotionally, which at times can override their motivation or ability to engage in valued behaviour. In other words, people make an active choice about whether enacting a value might lead to harm. The complex, interlinking, and nuanced challenges to identifying and enacting values in the context of experiencing SMD must be carefully considered before engaging in any valued-focused work.

The Relationship Between Values and Support

What Helps, also Hinders. Everyone offered an example of a time when support helped them to enact valued behaviour. Discussing trust, Chris highlighted that his support had allowed him to enact trust in other areas of his life: "*none of them have let me down… they've put that trust back in me"*. Chloe considered how her support worker motivates her to self-care by showing compassion and understanding, *"it's not like a lecture, it's self-understanding… I don't feel dirty, I feel like I need to nurture myself"*. Hannah, discussing mindfulness, outlined that such experiences often rely on individually motivated staff:

> *My observation is that it's something that they personally use as a tool and… incorporate into their work with service users generally.*

Clashes between individual and staff values were raised as barriers, for instance power, *"(staff) like to feel like they're over you… they're more important… more educated"* (Paula). Hannah reported uncertainty regarding service values, "*this feels*

a little bit awkward, because I don't know what (services') values are". Participants described the negative impact this has on their engagement "*people don't say much to the staff… you're just telling them a story really because you know they aren't going to help"* (Helen, discussing trust).

Tom highlighted the risk of exclusion from services when enacting his values of honesty and trust. He spoke about how services are set up to achieve specific outcomes or 'ticks'. In his experience, when he prioritises honesty over other values, such as conformity, he is kicked out of the service or gotten 'rid of':

> *In these kinds of jobs, they need ticks, and I won't give them a tick unless they're doing the job right… it's easy to get rid of that person… I'm not going to do that; I'm not going to lie to you.*

Again, participants highlight the importance of support staff in encouraging or dissuading valued action. At times it appears that enacting a value can come at a personal cost, for instance, Tom being excluded from services, even when that value (trust) is generally seen as moral and right. Of course, the manner in which people enact a value may impact the way in which staff respond, such as whether or not staff can identify that the person is taking valued action or perceive their behaviour to be driven by other motivators such as aggression or impulsivity instead.

The Potential of Value-Focused Support. Participants felt that if services were to find out what is important to them and use it to support them in enacting corresponding changes, that such value-focused support would increase their engagement; *"myself personally… I can't speak for everyone, but I generally in my heart think you'd find a lot of other people do want that"* (Harry, discussing acceptance). Jack, considering adventure, reflected that *"I think there should be a… side to services which are based around other lived experience that aren't related to drugs or health"*. Hannah, discussing courage, outlined how this may lead to increased wellbeing, "*my values keep me well… would (they) help other people?",* and better outcomes:

> *The difference it would make is what I could actually do within those sessions, probably how effective they would be because I'm actually… tuned into what I'm trying to get out of it, what we're working on.*
> Hannah (discussing mindfulness)

Several people felt such an approach would allow them to further connect with meaning, "*it's absolutely necessary… you're not just a problem… you're a person… it makes you feel valued, heard and respected"* (Megan, discussing mindfulness). Chloe, reflecting on forgiveness, highlighted that such an approach feels achievable:

> *It's like so basic, why do (services) not understand? Why can't they find people's hobbies and turn that into a practice to help them?... Their values, what they care about.*

Conversely Hannah reflecting on courage, states *"I'm sure it would be great, but I cannot imagine if financially… that would ever be possible"* and that value-focused work *"seems quite an intimate thing"* that may not be possible with all staff.

Although it appears that staff, at times, are seen as supporting people to enact their values, it is evident that this is not common practice. Whilst the realities and risks of offering value-focused support need to be well considered, participants feel favourably towards such an approach potentially improving service provision and their ability to engage with support on offer.

Discussion[15]

The present study explored the values and valued behaviours of individuals facing SMD, including the barriers and facilitators to enacting valued behaviour, as well as participants' perceptions of the helpfulness of service provision in encouraging valued living. The results suggest that the type of values and process of value identification and enactment is similar for people facing SMD to that of the general population, suggesting key theories can be applied to this population. Crucially, however, the results highlight the importance of not only understanding the complex context of SMD in enacting any behavioural changes, but that the varied and significant risks and challenges that occur regarding valued action when facing SMD are more extreme and impeding than within the general population.

Extant literature outlines the complex individual and systemic challenges that create and maintain SMD (Sosenko et al., 2020), which in turn also appear to act as barriers to valued action. Although the individual and systemic challenges were separated into different subthemes, it is important to recognise how different levels of the system contribute to trauma, exclusion, disadvantage, and conversely, recovery (Bronfenbrenner, 1979; Everitt & Kaur, 2019). Given that participants highlighted individual psychological barriers as another contributing challenge, the results highlight the need for individually tailored, psychosocial approaches to providing services for people facing SMD. As such, although value-focused approaches could be helpful interventions for people facing SMD, people's ability, or lack thereof, to identify and enact values should be carefully considered.

ACT theory posits that immediate contingencies often override the distal reinforcers associated with values (Hayes et al., 2012a), or in other words, a person's immediate context can interfere with valued action. It appears that such theoretical understandings of behaviour and motivation can be applied to the SMD population; with the caveat of significantly more complexity and threat associated within the immediate contingencies than would be expected in the general population. In trying to understand these risks, it could be that people's realisation of their historical or current inability to engage in valued living leads them to evaluate themselves. Perhaps value identification and exploration can increase people's sense of hopelessness,

[15] See Extended Discussion 4

whereas exploring and enacting valued action could play a role in intervening utilising 'creative hopelessness' (Hayes et al., 2012a) as a rationale for engaging in contextually-appropriate meaningful activity regardless of the challenges.

Contrary to what might be assumed about people experiencing SMD not being able to value certain things due to, for instance, prioritising survival over perceived luxuries such as sexuality or creativity[16], the results indicate that people experiencing SMD have numerous complex, meaningful, and interconnected values. This corroborates previous literature suggesting values are intrinsic, acting as key human motivators across populations (Fitzpatrick et al., 2016; Coppola et al., 2017). In support of the description of values as freely chosen, verbally constructed, and dynamic (Wilson & Dufrene, 2009), participants, when discussing one value, would describe numerous other related values. This suggests that values do not stand alone, they exist within a complex web of personal meanings, attitudes, and behaviours. It could be argued that people were primed to connect values after completing the PVC; regardless, it is notable that completing a short values exercise led to people connecting their values in a complex web of understanding.

Corroborating extant theory, results show that whilst generally stable, values can change in response to trauma (Tedeschi & Calhoun, 2004); people experiencing SMD appear likely to have experienced a shift in at least one value. This appears to, at times, be associated with the risk of enacting values or significant changes in their lifestyle. It could therefore be suggested that people facing SMD are more likely to benefit from re-evaluating and re-identifying their values at different times along their journey of recovery; perhaps needing more support to find ways of enacting values that do not put them at risk. Interestingly there is a lack of literature exploring the limitations of value enactment, suggesting a widely held assumption that there are few limitations or risks to identifying or enacting values.

Participants offer examples that indicate a positive relationship between enacting value-behaviour and wellbeing, corroborating previous research (LeJeune & Luoma, 2019; Grumet & Fitzpatrick, 2016; Gloster et al., 2017). In contrast, additionally indicating that, when experiencing SMD, value identification and enactment might also lead to decreased wellbeing, including physical, mental, and social wellbeing (World

[16] See Extended Reflection 2.2

Health Organisation, 2012). As such, the present study shows that the relationship between values and wellbeing is not as simple (i.e., valued behaviour leads to increased wellbeing) as previously assumed.

Although considerably more challenging, the content and process of values and values action is not fundamentally different for people facing SMD, therefore, value-integrated support may be an appropriate intervention for this population. People expressed the opinion that value-focused support could help them to orientate towards making positive behavioural changes (Yadavia & Hayes, 2009), potentially increasing motivation and engagement with services, increasing treatment adherence (Woods et al., 2006). Such findings do not, however, evidence the efficacy of such interventions, which would warrant further investigation.

Limitations.[17] The primary limitations of the study are recruitment and response biases. Self-selection bias (Heckmann, 1990) likely occurred, with people who are more aware of or interested in their values indicating interest in participating. All participants were recruited from the same city and twice as many females were recruited as males, likely due to a high level of interest from a female-only service. Although several steps were taken to reduce social-desirability bias, it can never be completely removed from research (Bergen & Labonté, 2020). Several people mentioned areas of disadvantage not captured by the definition used in the study. It may have been helpful to gather additional demographic data like ethnicity or disability to further contextualise the findings.

Clinical and Research Implications.[18] The present study is the first step in evidencing the role values could play in supporting people facing SMD. Whilst further research is needed, values could arguably be integrated into various levels of service provision. Values are a relatively easy to understand concept that can be integrated in any intervention (LeJeune & Luoma, 2019). Professionals completing psychotherapy or psychosocial interventions with people experiencing SMD may benefit from considering ACT or value-informed interventions, ideally also completing evaluative research. Given the role services and staff play in helping or hindering people's valued action, it would be interesting to explore the relationship between the values of staff

[17] See Extended Discussion 4.1
[18] See Extended Discussion 4.2 – 4.3

members, teams, services, and service users. Furthering our understanding of the match, or mismatch, of values on the impact of care.

Given that values identification alone can increase motivation to enact valued behaviour (Fitzpatrick et al., 2016), staff members working with people facing SMD may benefit from integrating values into their support sessions. This could be a short conversation about what is important to the person, or a structured support session; the current study indicated that such sessions are, at least, tolerable for a number of people facing SMD. Whilst further research is needed, the present results indicate this may strengthen rapport and increase engagement. Such interventions could potentially increase people's motivation to do something challenging, but essentially important for instance assessment for a service; supporting literature that suggests values help people persist with difficult or painful tasks (Grumet & Fitzpatrick, 2016; Paez-Blarrina et al., 2008).

Finally, there is a systems-level drive to provide better and more cohesive support to individuals experiencing SMD (Everitt & Kaur, 2019). Could values potentially be an accessible, inexpensive way to increase engagement, motivation, and change in individuals facing SMD? For instance, values training could be provided for staff to incorporate values into their work, and/or explore their own values in relation to their role. Values could also be integrated into the implementation of PIE and TIC into homelessness services, regardless of the primary psychological model being used. Again, the efficacy of such interventions should be evaluated and disseminated.

In conclusion, the present study offers a novel insight into the values and valued behaviour of people facing SMD, a population underrepresented in the current literature base. The type, variety, and complexity of values, alongside the process of value identification and enactment, when experiencing SMD, corresponds with extant theory and literature. The challenges and risks associated with value identification and enactment are more severe for people facing SMD; highlighting the importance of exploring and attempting to mitigate any potential risks. Whilst more research is needed, the present results offer preliminary evidence to suggest that integration of values-work into service provision for SMD may be an effective, person-centred intervention to support people in making meaningful change.

References

Bergen, N., & Labonté, R. (2020). “Everything Is Perfect, and We Have No Problems”: Detecting and Limiting Social Desirability Bias in Qualitative Research. *Qualitative Health Research, 30*(5), 783-792. https://doi.org/10.1177%2F1049732319889354

Bhaskar, R. (1979). *The possibility of naturalism: A philosophical critique of the contemporary human sciences.* Humanities Press.

Bramley, G., Fitzpatrick, S., & Sosenko, F. (2020). Mapping the “hard edges” of disadvantage in England: Adults involved in homelessness, substance misuse, and offending. *The Geographical Journal, 186*(4), 390-402, https://doi.org/10.1111/geoj.12358

Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard Edges: Mapping Severe and Multiple Disadvantage.* https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality in practice in (reflexive) thematic analysis?, *Qualitative Research in Psychology, 18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Burge, R., Tickle, A., & Moghaddam, N. (2021). Evaluating trauma informed care training for services supporting individuals experiencing homelessness and multiple disadvantage. *Housing, Care and Support, 24*(1), 14-25, https://doi.org/10.1108/HCS-01-2021-0002

Coppola, A., Verneau, F., Caracciolo, F., & Panico, T. (2017). Personal values and pro-social behaviour. *British Food Journal*, *119*(9), 1969-1982. https://doi.org/10.1108/BFJ-10-2016-0474

Dahl, J., Wilson, K. G., Luciano, C., & Hayes, S. C. (2005). *Acceptance and Commitment Therapy for Chronic Pain.* Context Press.

Engle, J. L. (2017). *A Comparison of ACT Values Procedures to Increase Values Behaviours* (Unpublished doctoral dissertation). University of Nevada.

Everitt, G., & Kaur, K. (2019). *Severe Multiple Disadvantage (Multiple Needs).* https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/joint-strategic-needs-assessment/children-and-young-people/severe-multiple-disadvantage-multiple-needs-2019/

Fitzpatrick, M., Henson, A., Grumet, R., Poolokasingham, G., Foa, C., Comeau, T., & Prendergast, C. (2016). Challenge, focus, inspiration and support: processes of values clarification and congruence. *Journal of Contextual Behavioral Science*, *5*(1), 7-15. https://psycnet.apa.org/doi/10.1016/j.jcbs.2016.02.001

Forman, E. M., Butryn, M. L., Hoffman, K. L., & Herbert, J. D. (2009). An open trial of an acceptance-based behavioral intervention for weight loss. *Cognitive and Behavioral practice*, *16*(2), 223-235. https://psycnet.apa.org/doi/10.1016/j.cbpra.2008.09.005

Gloster, A. T., Klotsche, J., Ciarrochi, J., Eifert, G., Sonntag, R., Wittchen, H. U., & Hoyer, J. (2017). Increasing valued behaviors precedes reduction in suffering: Findings from a randomized controlled trial using ACT. *Behaviour Research and Therapy*, *91*, 64-71. https://doi.org/10.1016/j.brat.2017.01.013

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist*, *46(*11), 1219-1225. https://psycnet.apa.org/doi/10.1037/0003-066X.46.11.1219

Gregg, J. A., Callaghan, G. M., Hayes, S. C., & Glenn-Lawson, J. L. (2007). Improving diabetes self-management through acceptance, mindfulness, and values: a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *75*(2), 336-343. https://doi.org/10.1037/0022-006x.75.2.336

Grumet, R., & Fitzpatrick, M. (2016). A case for integrating values clarification work into cognitive behavioral therapy for social anxiety disorder. *Journal of*

Psychotherapy Integration, *26*(1), 11-21. https://psycnet.apa.org/doi/10.1037/a0039633

Harris, R. (2010). *Values Checklist: 60-item List.* https://www.actmindfully.com.au/free-stuff/worksheets-handouts-book-chapters/

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012a). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, 40*(7), 976-1002. https://doi.org/10.1177%2F0011000012460836

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012b). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change* (2nd ed.). Guilford Press.

Heckman, J. (1990). Varieties of Selection Bias. *The American Economic Review, 80*(2), 313-318. https://www.jstor.org/stable/2006591

Hitlin, S., & Piliavin, J. A. (2004). Values: Reviving a dormant concept. *Annual Review of Sociology*, *30*(1), 359-393. http://dx.doi.org/10.1146/annurev.soc.30.012703.110640

Homeless Link (2014). *The Unhealthy State of Homelessness: Health Audit Results*. https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Homeless Link. (2017). *An introduction to psychologically informed environments and trauma informed care.* https://www.homeless.org.uk/sites/default/files/siteattachments/TIC%20PIE%20briefing%20March%202017_0.pdf

Johnson, M. (2001). Change in Job Values During the Transition to Adulthood. *Work and Occupations, 28*(3), 315-345. https://doi.org/10.1177%2F0730888401028003004

LeJeune, J., & Luoma, J. B. (2019). *Values in Therapy: A Clinician's Guide to Helping Clients Explore Values, Increase Psychological Flexibility, and Live a More Meaningful Life*. New Harbinger Publications.

MEAM. (2018). *About Multiple Disadvantage*. http://meam.org.uk/multiple-needs-and-exclusions/

Moore, G., Manias, E., & Gerdtz, M. F. (2011). Complex health service needs for people who are homeless. *Australian Health Review*, *35*(4), 480-485. https://doi.org/10.1071/ah10967

Murthy, V. E., Hussey, I., & McHugh, L. (2020). A single-session Acceptance and Commitment Therapy intervention targeting shame in people experiencing homelessness: A randomized multiple baseline design. Advance online publication. http://dx.doi.org/10.31234/osf.io/3hpuq

Murthy, V. E., Stapleton, A., & McHugh, L. (2021). Self and rules in a sample of adults experiencing homelessness: Relationships to shame, well-being, and psychological inflexibility. *Journal of Contextual Behavioural Science, 21,* 88-97. https://doi.org/10.1016/j.jcbs.2021.06.003

Paez-Blarrina, M., Luciano, C., Gutiérrez-Martínez, O., Valdivia, S., Ortega, J., & Rodríguez-Valverde, M. (2008). The role of values with personal examples in altering the functions of pain: Comparison between acceptance-based and cognitive-control-based protocols. *Behaviour Research and Therapy*, *46*(1), 84-97. https://doi.org/10.1016/j.brat.2007.10.008

PIElink. (2020). *PIEs 2.0 – the basics*. http://pielink.net/pies-2-0-the basics/

Schwartz, S. H. (1992). Universals in the content and structure of values: Theoretical advances and empirical tests in 20 countries*. Advances in Experimental Social Psychology*, *25*(1)*,* 1-65. https://doi.org/10.1016/S0065-2601(08)60281-6

Schwartz, S. H., & Bilsky, W. (1987). Toward a universal psychological structure of human values. *Journal of Personality and Social Psychology, 53(*3), 550-562. https://psycnet.apa.org/doi/10.1037/0022-3514.53.3.550

Sheldon, K. M., & Krieger, L. S. (2014). Walking the talk: Value importance, value enactment, and well-being. *Motivation and Emotion, 38*(5), 609-619. https://psycnet.apa.org/doi/10.1007/s11031-014-9424-3

Shepherd, K., Pritty, B., Tickle, A., & Moghaddam, N. (2021). “I don’t want to take buprenorphine for the rest of my life”: Acceptance and Commitment Therapy for a Client Struggling to Reduce Low-Dose Buprenorphine (a Hermeneutic Single-Case Efficacy Design). *International Journal of Mental Health and Addiction.* https://doi.org/10.1007/s11469-021-00729-2

Shinn, M., & Toohey, S. M. (2003). Community contexts of human welfare. *Annual Review of Psychology*, *54*(1), 427-459. https://doi.org/10.1146/annurev.psych.54.101601.145052

Sosenko, F., Bramley, G., & Johnsen, S. (2020). *Gender Matters.* https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf

Taylor, K., & Sharpe, L. (2008). Trauma and Post-Traumatic Stress Disorder Among Homeless Adults in Sydney. *Australian and New Zealand Journal of Psychiatry*, *42(*3), 206-213. https://doi.org/10.1080%2F00048670701827218

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1-18. https://psycnet.apa.org/doi/10.1207/s15327965pli1501_01

Watson, C., Nolte, L., & Brown, R. (2018). Building connection against the odds: Project workers relationships with people experiencing homelessness. *Housing, Care and Support, 22*(2), 129–140. https://doi.org/10.1108/HCS-10-2018-0030

Wilson, K. G., & DuFrene, T. (2009). *Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy*. New Harbinger.

Woods, D. W., Wetterneck, C. T., & Flessner, C. A. (2006). A controlled evaluation of acceptance and commitment therapy plus habit reversal for trichotillomania. *Behaviour Research and Therapy*, *44*(5), 639-656. https://doi.org/10.1016/j.brat.2005.05.006

World Health Organisation (2012). *WHO and wellbeing at work.* https://www.hsl.gov.uk/media/202146/5_kim_who.pdf

Yadavaia, J. E., & Hayes, S. C. (2009). Values in acceptance and commitment therapy: A comparison with four other approaches. *Hellenic Journal of Psychology, 6*(3), 244-272. https://pseve.org/wp-content/uploads/2018/03/Volume06_Issue3_Yadavaia.pdf

EXTENDED PAPER

1. Extended Introduction

1.1. Severe and Multiple Disadvantage

Also referred to as Multiple Complex Needs, Multiple Disadvantage, Chronic Exclusion, or Multiple Needs; SMD is the most commonly used term in the academic literature (Everitt & Kaur, 2019). Unlike alternative terms, SMD avoids putting the onus of blame and/or change solely on the individual, instead placing the individual's experience within their context. The number of domains an individual meets can be differentiated for example by using 3SMD and 5SMD to define meeting 3 and 5 domains respectively.

Perhaps the most commonly used definition of SMD is "people facing multiple disadvantages experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health" (MEAM, 2018). However, research on SMD, alongside this definition have often been critiqued for bias towards recruiting males (Bramley et al., 2015) and as such, underestimating the prevalence and minimising the experience of SMD amongst women. Whilst previous research estimated 8 out of 10 people facing SMD are men (Bramley et al., 2015), more recent estimates suggest roughly equal numbers of men and women are experiencing SMD: 167,000 and 169,000 respectively. Interestingly, of those experiencing 4SMD, 70% were female (Sosenko et al., 2020).

In an attempt to combat this, the recently published Gender Report (Sosenko et al., 2020) explored the gender differences in SMD. They found that whilst men were most commonly affected by poor mental health and substance misuse, women were most commonly affected by poor mental health and being a victim of interpersonal violence and abuse (Sosenko et al., 2020, p. 36-37). Given the prevalence of violence and abuse experienced by women facing SMD, it was deemed appropriate to include this domain in the present study's definition of SMD.

Finally, although there is no 'official' consensus, in most regards to access services or be included in research, individuals must meet at least 3 of the domains to meet the threshold. Although using only 2 domains would likely increase recruitment opportunities, the researcher felt that given services and commissioners are likely to

use the more stringent criteria e.g., the Fulfilling Lives Criteria (MEAM, 2019), using the 3+ domains criteria was deemed the most appropriate.

Prevalence. Until recently, the best available prevalence figures for SMD estimated that 364,00 individuals were experiencing 1SMD, 164,000 experiencing 2SMD, and 58,000 experiencing 3SMD or more (Bramley et al., 2015). More recent estimates suggest that 5.2% of the general population experience 2SMD, roughly 336,000 people experience 3SMD, and 17,000 experience 4SMD (Sosenko et al., 2020). However, it should be noted that the two primary sources available at present exploring the prevalence of SMD in the UK, both use a different definition of SMD. As such, it is unlikely that either study fully captures the true extent of the prevalence of SMD, if utilising the definition as used in the present study. Bramley and colleagues (2015) utilised the traditional domains of SMD (homelessness, mental illness, offending, substance use), whilst Sosenko and colleagues (2020), focusing primarily on the experience of women facing SMD, used slightly different domains (homelessness, mental illness, substance use, and domestic violence). Offending behaviours were still explored, albeit in less detail; they found that there is a clear association between substance (particularly drug) use and offending, and this is slightly stronger for women than men (Sosenko et al., 2020, p. 46-51).

1.2. Further Context

The challenges embedded in the experience of SMD, and provision of adequate support have been further exacerbated by the impact of COVID-19, leading to growing concern over funding in both the immediate and long-term and highlighting pre-existing structural barriers (Boobis & Albanese, 2020). That being said, the 'Everyone In' initiative (Crisis, 2020) in the first lockdown, led people to be housed in temporary accommodation rather than sleeping on the streets. In the immediate this may have led to better provision of support for homeliness in the first lockdown. SMD is conservatively estimated to cost £10.1 billion per year, but the cumulative cost - cost of services including criminal justice, physical and mental health, substance use - of SMD could be as high as £58 billion per year (Bramley et al., 2015). The average local authority might expect to have roughly 1470 individuals actively experiencing SMD over the course of a year (Bramley et al., 2015).

Research tends to focus on the individual factors, rather than the complex systemic and social causes that can contribute to the causation and sustainment of homelessness and SMD. The latter include, but are not limited to affordable housing, poverty, lack of support for individuals exiting prison (Crisis, 2021), unemployment and the prevalence of part time roles and temporary contracts (Shier et al., 2012). Shinn and Toohey (2003) highlight such tendencies to ignore the influence of ongoing social context on behaviour as "context minimization error".

The 'New Public Management' paradigm of resourcing social interventions focuses on markets, managers, and measurement of 'outcomes', limiting responsiveness to 'the reality of our complex world and the knottiness of people's lives' (Knight et al., 2017, p.5) or the importance of relationships. Data is not kept by healthcare or social services on who and how many individuals are refused a service, as such there is no precise way to pinpoint the level of exclusion faced by individuals experiencing SMD (Cockersell, 2018, p.209).

Given the complexities of homelessness service provision, it is difficult to elicit results that align with the strict parameters of research and clearly quantifiable and definable 'hard' outcomes e.g., sobriety (Knight et al., 2017). Furthermore, targets such as sobriety may be both unrealistic and also unnecessary, many people in the general population do not maintain sobriety, suggesting that total sobriety is not necessary to maintain good health. As such, expecting to start with a problem, provide a service, and then achieve clear results narrows one's ability to focus on real outcomes for people (Knight et al., 2017). Research into homelessness and SMD faces the challenge of balancing the need for comparable and robust studies with being realistic about what is possible, and what will be helpful for the stakeholders involved. It has been argued that such practice-based evidence linked to theory and tested against hypotheses is more of a "gold standard" for evidence compared to randomised control trials (Cartwright, 2007).

Local Context. Nottingham has the 8th highest prevalence of SMD in England (Bramley et al., 2015), it is estimated that over 5,000 individuals in Nottingham currently experience at least 2SMD, with roughly 1620 meeting 3SMD, and 294 meeting 4SMD (Everitt & Kaur, 2019). Nottingham City has a range of services that work with individuals facing SMD, from those with a specific brief (such as charity

funded outreach programmes and population specific accommodation services), to those without a specific brief, but working mainly with people who face SMD (such as non-specific accommodation services, such as hostels that are commissioned to support anyone who is experiencing homelessness, not specifically people facing SMD), and agencies who may often come into contact with individuals experiencing SMD (such as primary and secondary health care, police, city council housing services).

Nottingham City Council highlights that domestic abuse related incidents (survivor or perpetrator) relating to people facing SMD is higher than amongst the general population (Everitt & Kaur, 2019). They conservatively estimate a prevalence of 1.75% based on local police data, however the national average is slightly higher at 2.5% (Everitt & Kaur, 2019); given the likelihood of underreporting, the national average is likely a better benchmark.

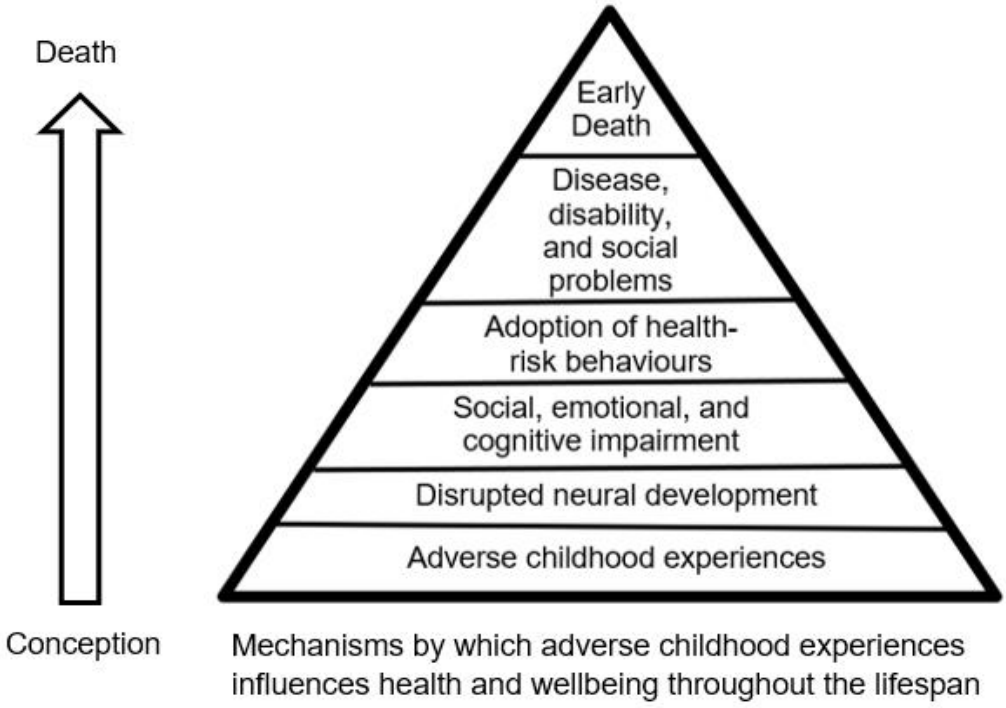
1.3. Trauma

Cumulative disadvantage theory offers an understanding of the increased risk of mental health and other difficulties being the result of an accumulation of past and contemporaneous stressors, risk, and trauma, which leads to persistently increased stress levels (Dannefer, 2003) and chronic hyper-stress reactions (D'Andrea et al., 2011). Common symptoms of post-traumatic stress disorder, social disaffiliation and learned helplessness, are often seen in individuals experiencing homelessness (Goodman et al., 1991). 'Compound trauma' is the term used to describe the common experience within the homeless population of experiencing several traumatic events without the time, support, or capacity to process each of them, or to recover (Cockersell, 2018).

A socio-ecological (Bronfenbrenner, 1979) understanding of trauma recognises the role of different levels of the system around the individual, considering how the system contributes towards trauma, but also recovery. This impacts more than just service users; chronic stress and adversity on organisations supporting individuals who have experienced trauma can impact service delivery (Bloom, 2010). As such, the need for homelessness services to adopt trauma-informed care is evident (Hopper et al., 2010) to support service users and staff alike.

Adverse Childhood Experiences (ACEs) have been reliably associated with greater risk of substance misuse, mental illness, and poorer physical health in later life (Felitti et al., 1998; Figure 3). Half of all people experiencing homelessness have experienced four or more ACEs (De Bellis et al., 2014), whilst repeated homelessness is associated with higher ACE rates (Bassuk et al., 2001; De Bellis et al., 2014). Evidence for the relationship between ACEs and compound trauma is overwhelming (Cockersell, 2018). Furthermore, there is a well-established proportional 'dose-response' between ACEs/compound trauma and addictions i.e., the more ACEs/compound trauma experienced, the higher the likelihood of addiction including a 500% increase in likelihood of alcoholism and 4600% increase for injecting drug use (Felliti, 2004; Cockersell, 2018).

Figure 3. ACEs across the lifespan (Felitti et al., 1998).



It should be noted however that the ACEs movement has received backlash, with many arguing that the increase in interest in ACEs and subsequent literature base (often using retrospective, self-report data) has been decontextualised from the wider socio-political landscape (Kelly-Irving & Delpierre, 2019). As such, it is crucial that ACEs are contextually understood, intervening at a systemic level, and avoiding

placing blame on parents, or the onus of change on individuals (Kelly-Irving & Delpierre, 2019).

Trauma, Values, and Wellbeing. Research suggests that experiencing significantly decreased wellbeing (because of trauma or major life events) can lead to a shift in values (Tedeschi & Calhoun, 2004; Johnson, 2001). It is suggested that this occurs as part of posttraumatic growth, a process by which people experience an increased appreciation for life, more meaningful interpersonal relationships, an increased sense of personal sense, changed priorities, and a richer existential and spiritual life (Tedeschi & Calhoun, 2004). Literature exploring values and behaviour has primarily focused on the impact that values have on increasing an individual's behaviour and/or wellbeing (LeJeune & Luoma, 2019), rather than the impact behaviour and wellbeing (particularly in relation to living in a traumatic and or dangerous context) have on values. It is therefore possible that the experiences of people who are facing SMD may contrast with previously held assumptions about values.

1.4. Mental Health

Roughly 16% of people facing SMD rate their quality of life as either good or very good, compared to over 70% of the general population (Bramley et al., 2015). These figures (along with those in the Journal Paper: Introduction) likely underestimate the true prevalence of mental illness in this population for several reasons including services excluding those who use alcohol or drugs, inability to get an assessment or referral without GP registration, and difficulties in making and keeping appointments (St Mungo's, 2016). For example, St Mungo's found that whilst 70% of rough sleepers had sought help for their mental health, only 11% received treatment (St Mungo's, 2009). The characteristically disconnected and conditional services (Watson et al., 2018), together with the high prevalence of compound trauma (Cockersell, 2018) amongst individuals experiencing SMD may contribute to distrust of services and negatively impact engagement.

1.5. Improving Support

Although often commissioned to support with trauma, homelessness services are frequently found to be an additional source of trauma for individuals accessing them as well as for those staff supporting such individuals (Coates & McKenzie-Mohr, 2010; Hopper et al., 2010; Yatchmenoff et al., 2017; Bloom & Farragher, 2010). Nationally, the House of Commons (2019) reported their plans to increase homeless individuals' access to accommodation, health services, welfare benefits, food assistance, training and employment, and registering to vote. Furthermore, there is a local drive from Nottingham City Council (Everitt & Kaur, 2019) towards improving support for individuals facing SMD, utilising strengths-based approaches towards:

> *No longer seeing a person facing SMD as a 'set of needs to be fixed' - but rather supporting them to achieve their aspirations and build on their strengths. It involves asking people 'what does a good or fulfilled life look like for you?' This enables people accessing services to be treated as a 'whole person', who can access holistic support that addresses multiple, interacting factors that impact their life, rather than 'siloed' services that each deal with a specific 'problem'.* (Everitt & Kaur, 2019, p. 32)

Arguably, it is more important than ever to provide evidence-based support that accounts for the systemic and individual complexities that exist for people facing SMD. Yet there remains a lack of literature exploring what the 'best' support looks like to those receiving it. That being said, there is growing interest in applying psychological theory to improve support for homeless individuals and people facing SMD, two of which are outlined below:

Trauma Informed Care (TIC) can be broadly understood as having four components: 1) acknowledge the impact of trauma and recovery, 2) identify trauma signs and symptoms, 3) use knowledge of trauma to improve practice, and 4) avoid and prevent re-traumatisation (Homeless Link, 2017). Emergent research indicates that TIC training has a beneficial effect on some components of TIC in frontline homelessness staff, however a wider cultural shift is needed to fully embed the practice (Burge et al., 2021). More anecdotal observations of a TIC approach in homelessness services suggest improved relationships with service users and greater

efficacy of the service (Prestidge, 2014); however, such claims are largely unsupported empirically at present.

Psychologically Informed Environments (PIE) are a framework for a system-wide approach to working, rather than a specific intervention and have five key elements: psychological awareness; staff training and support; learning and enquiry; spaces of opportunity; and the three R's (the roles, rules, and responsiveness of the service). Crucially, these elements are underpinned by a central focus on developing and maintaining trusting and positive relationships across the system (PIElink, 2020). No two PIEs look the same, whilst the underlying elements are consistent, the ways to implement them are as varied as the individuals accessing the service (Keats et al., 2012). The evidence base for PIE is emergent, but as PIEs rely on 'innovative localism' (Haigh et al., 2012), there is a lack of comparable data available to rigorously answer the question 'are PIEs effective?' (Cockersell, 2016). Nevertheless, one can tentatively conclude from the emergent evidence-base that PIEs can benefit staff and service users alike and achieve more positive outcomes than services not run as PIE (Cockersell, 2016; Breedvelt, 2016; Phipps, 2016; Homeless Link, 2018).

1.6. Values

Values have been considered within psychotherapy for a number of years: within a humanistic approach, Rogers (1959) speaks of actualisation; Skinner (1976) conceptualized values as positive reinforcers that serve various functions (see Yadavia & Hayes, 2009); modern psychoanalysts such as Zinberg (1967) argue values consist of multifaceted motivations that relate to drive states. Perhaps a more accessible definition, comes from LeJeune and Luoma (2019, p.11):

1) Values are behaviours. They are ways of living, not words.
2) Values are freely chosen. They are not the result of reasoning, outside pressures, or moral rules.
3) Values are life directions, not goals to achieve. They are always immediately accessible, but you'll never complete them.
4) Values are about things you want to move toward, not what you want to get away from.

Values vs Value Domains. One way to clarify the definition of values can be to consider what is a value versus what is a valued domain, “if values are qualities of action, then you could describe valued domains as being the arena in which those values are enacted” (LeJuene & Loama, 2019, p. 12). Value domains could include family, marriage, parenting, friends and social life, work, education/training, recreation, spirituality, community life, physical self-care, the environment, and aesthetics (art, music). For instance, the Valued Living Questionnaire-2 (VLQ-2; Wilson & Dufrene, 2009) is an ACT measure that assesses valued living utilising the aforementioned domains. Other value-identification exercises focus on specific values, such as the Personal Values Card Sort (PVCS; Miller et al., 2001) and the Personal Values Checklist (PVC; Harris, 2010).

Identification of Values. There is an emphasis within ACT of the importance of the individual’s choice in values identification. Choosing values freely is crucial as it begins the process of understanding values, which in turn would encourage engagement in values-based behaviours, allowing for increased psychological flexibility (Engle, 2017). Identifying values relies on things such as dreaming, creating, choosing, and assuming more so than weighing out a list of pros and cons (Luoma et al., 2017). Whilst identifying one’s values can lead to increased behavioural change (Fitzpatrick et al., 2016), simply identifying or knowing one’s values does not typically improve one’s life but acting in line with them does (Bramwell & Richardson, 2018), as such people may benefit from support in both identifying and continually enacting values.

1.7. Values and Behaviour

Research suggests that values influence individuals’ attitudes, which in turn, can influence their behaviour (Homer & Kahle, 1988). The value-justification effect suggests than to appear consistent, people with different attitudes cite different values as being relevant to their attitudes (Kristiansen & Zanna, 1988); notable as this suggests people use values to justify their attitudes (Maio & Olson, 1994).

Relational Frame Theory (RFT; Barnes-Holmes et al., 2001) uses the term “augmenting” to describe the way in which language reinforces behaviour; this can be understood as “rule-governed behaviour under the control of apparent changes in the

capacity of events to function as reinforcers or punishers" (Hayes et al., 2004, p.206). When something establishes or alters the reinforcing consequences of a behaviour, it is seen as 'augmental' (Hayes et al., 2001; Törneke, 2010). As such, values can function as 'augmentals', in other words, supporting and reinforcing value-consistent behaviour (LeJeune & Luoma, 2019).

Benefits of Valued Living. Living in line with values is related to a wide range of positive outcomes including increased pro-social behaviour in relation to ethical food consumption (Coppola et al., 2017); more positive attitudes and behaviours in regard to e-shopping (Jayawardhena, 2004); and students achieving higher scores in academic work (Chase et al., 2013). Alternatively, feeling disconnected from any sense of meaning or purpose has been associated with decreased physical and psychological well-being (Creswell et al., 2005; McCracken & Yang, 2006). However, such research exploring the role of values in behaviours like e-shopping or ethical food consumption are far removed from the lives of individuals experiencing SMD, as such limiting the generalisability of such theories.

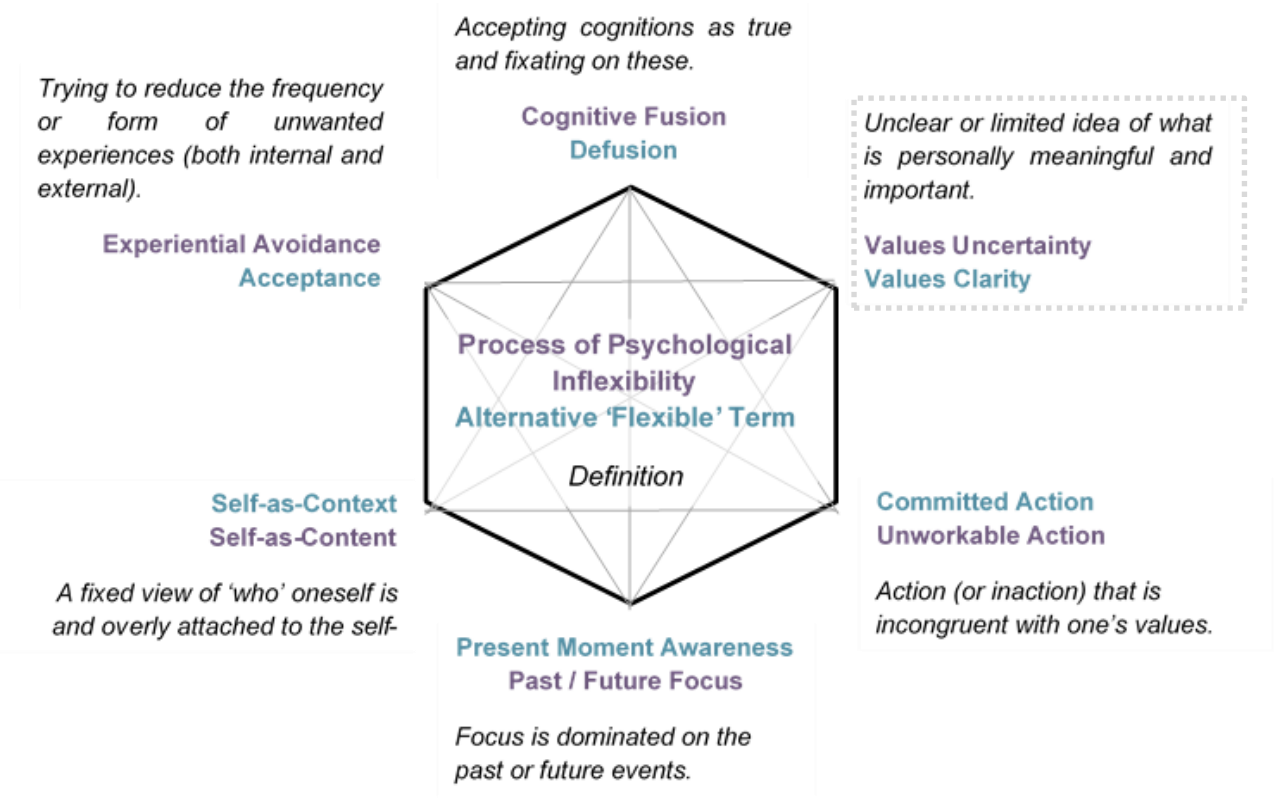
1.8. Acceptance and Commitment Therapy

ACT (Hayes et al., 2012a; Hayes et al., 2012b) is a transdiagnostic, contextual behavioural approach based on RFT (Barnes-Holmes et al., 2001). ACT theory posits that psychological pain is normal and does not necessarily cause psychological difficulties (Harris, 2006), but being psychologically inflexible or rigid in responding to distress is what leads to psychological suffering (Luoma et al., 2017). ACT is grounded in functional contextualism and highlights the importance of accepting any behaviour as helpful if it is contextually functional. As such the context and underlying function of the person's behaviour must be explored before being deemed problematic or maladaptive (Hayes et al., 2012a; Hayes et al., 2012b; Vilardaga et al., 2007). As such it can be used as a method of coaching people to aid behavioural change, or in psychotherapeutic interventions.

Psychological inflexibility is made up of six intertwined processes: lack of values clarification, past/future focus, cognitive fusion, self-as-content, experiential avoidance, and unworkable action (Hayes et al., 2012a; Figure 4). Each of these processes is considered on a spectrum, with an alternative psychologically 'flexible'

process. These flexible processes have been further condensed into three key dyads: openness to experience (made up of defusion and acceptance); valued action (made up on values clarity and committed action); and behavioural awareness (made up of present moment awareness and self-as-context; Harris, 2009). Such flexibility processes that underlie and support valued living appear to be relevant across different contexts and cultural groups (Masuda, 2014; Skinta & Curtin, 2016).

Figure 4. Defining the ACT Processes of Psychological Inflexibility.



Efficacy. A recent review of 20 meta-analyses suggest that ACT is an effective intervention for anxiety, depression, substance use, pain, and transdiagnostic groups. ACT was generally superior to placebo, waitlist, treatment as usual, and most intervention conditions, excluding Cognitive Behavioural Therapy (Gloster et al., 2020). ACT interventions, which focus on improving psychological flexibility, lead to decreased stress and increased wellbeing in various populations (Fledderus et al., 2013; Kashdan & Rottenberg, 2010; Räsänen et al., 2016). Based on data from mediational analyses of ACT, values are a more effective strategy in sustaining behavioural change than education alone (Gregg et al., 2007) or 'supportive therapy' in which a professional creates an open, reflective space (Lundgren et al., 2006).

ACT in Homelessness Settings. The published evidence base for the use of ACT within homelessness services and directly with people facing homelessness and SMD is scarce. A single-case experimental design (SCED) series was completed with four frontline homelessness staff members, each of whom took part in three ACT sessions (based upon the three dyads of psychological flexibility). Results suggest the intervention was effective, reporting that all staff experienced reduced exhaustion, increased work-engagement, and increased psychological flexibility (Reeve et al., 2021).

One study explores the use of ACT directly with homeless individuals, using a SCED, they offered nine people a single-session intervention. It is unclear if any participants met the definition for SMD, all nine experienced homelessness, three reported currently using substances, no other demographic data related to the SMD domains was available. Their results indicated significant improvements in both experiential avoidance and shame both within and between participants (Murthy et al., 2020).

Another example of the use of ACT comes from a single-case efficacy design (Shepherd et al., 2021) with an individual who meets the definition of SMD as outlined in the present study (homelessness, substance use, and mental illness). This study found that ACT played a key role in increasing psychological flexibility, alongside the therapeutic relationship and the possible impact of psychopharmacological interventions (Shepherd et al., 2021).

Interestingly, although not the primary aim of the research, Murthy and colleagues (2021), offered some tentative support for the use of values with homelessness individuals. No demographic information regarding whether the 22 participants were facing other domains of SMD were highlighted. The researcher's included *"having an active severe mental health difficulty (e.g., currently experiencing symptoms of psychosis)"* as an exclusion criterion (p.90), perhaps reducing the likelihood of people facing SMD being eligible for the research and/or indicating interest. Using the Functional Self-Discrimination Measure to explore the relationship between occurrences of self/other discriminations and shame, well-being, and psychological inflexibility. Regarding the preliminary evidence supporting values and wellbeing, the results of this study showed an association between wellbeing and individuals who made greater reference to values-orientated self-rules and beliefs. Of course, this

evidence alone is not robust enough to conclude a relationship between values and wellbeing in individuals experiencing SMD.

Whilst these results are encouraging, there is far from enough research to reliably conclude whether ACT or ACT-informed interventions are an efficacious intervention model for use specifically within the homelessness setting or more specifically for people facing SMD.

1.9. Extended Rationale and Aims

Services are likely being driven by commissioning-related targets that may influence what they focus on with service users, rather than being service user led. The aforementioned complexities of service provision, and the challenges faced by individuals experiencing SMD when trying to access services, may leave people perceiving themselves as having little autonomy in their care and potential recovery. Instead, such individuals may feel pressured to conform to the values of service providers in order to access much needed support. If services do not understand a person's values and the challenges in enacting them, they may be more likely to assume how a person should enact values-based behaviours or change without considering the impact this may have on the individual. Services assuming what people value may in fact reduce an individual's desire or ability to make meaningful changes, alter their perception on the helpfulness of the service, and subsequently impact their motivation or ability to engage with that service.

LeJeune and Luoma (2019) indicate that in any values-based therapy "the aim is to create a sense that therapy (and the client's life in general) could be focused on something bigger or more encompassing than their struggles" (p.55). In relation to the present study, the researcher expands upon this idea in suggesting that when working with individuals facing SMD, any values-based intervention (whether brief and informal through support workers, or a structured ACT-informed psychological intervention) may help create a sense that their life could be focused on something bigger or more encompassing than their significant struggles including social exclusion and multiple disadvantages.

It is hoped that the findings of the present study may also support professionals or services implementing values-based interventions by increasing their understanding

of why people may not be able to behave in ways that feel congruent to their values, and how they can better support individuals to do so if they wish. Furthermore, the findings of the proposed study may increase recognition of what adaptions could be made on both a service and individual level, promoting a more cohesive, person-centred, and strengths-based provision of support. It could be possible that this may promote more positive outcomes for those experiencing SMD, such as improved wellbeing and engagement.

2. Extended Method

2.1. Rationale for Methodology

Broadly speaking, quantitative research can be understood as seeking to identify and explain (or predict) relationships between variables, it often seeks consensus, norms, or general patterns. Conversely, qualitative research seeks to understand and interpret meaning, recognises the data as gathered in a context, and generates 'narrow' but rich data, seeking patterns and divergences within the data (Braun & Clarke, 2013). The present research aims to identify and explore the individual values and experiences of people experiencing SMD, a glaringly under researched population. Given the complex individual and systemic factors at play, it is imperative to consider any findings within the context in which the participants are placed. As such, a qualitative methodology was deemed the more appropriate choice for the present study.

Epistemological Stance. Critical realism (CR) aims to develop deeper insight and understanding (McEvoy & Richards, 2006), recognising the conditional nature of results and fallibility of knowledge (Bhaskar, 1979; Barker et al., 2002), encouraging 'responsible rationality' to be practised within research (Manicas, 2009); in other words, ensuring that findings are interpreted critically, within the wider context, and accepting that all findings may in fact be wrong. It is assumed that data informs us about a reality, without being a direct mirroring of reality (Harper, 2011), as such other evidence needs to be drawn upon to explain the driving and maintaining factors of the reality (Willig, 2012).

CR actively accepts that knowledge is limited and cannot be understood as uninfluenced by social structures and pressures that cannot be controlled (Benton & Craib, 2010); as such, research is more applicable to the complex world in which it is conducted. Therefore, as the research aims to explore the values and experiences of participants, it must also acknowledge the social contexts in which they occur (Cook & Campbell, 1979). This is of particular importance when exploring the experiences of individuals who are highly disadvantaged by our current socioeconomic and political climate. It is likely that there are a range of views about the 'truth' of both their context,

and the role that values play (or do not play) within their lives, fitting well with a CR epistemological stance.

Choosing a qualitative methodology. In considering the most appropriate way to address the research question, a number of qualitative methodologies were considered as outlined below.

Discourse Analysis (DA) is concerned with the study of the construction and function of language, in line with social constructionism, where reality is constructed through social and interpersonal processes such as language (Georgaca & Avdi, 2012). DA was deemed an inappropriate methodology for the present study of which the aims are not to understand the language used to construct meaning around SMD and values, but to explore participant's experience of these things. Furthermore, DA contrasts starkly with the critical-realist epistemological stance taken by the researcher.

Grounded Theory (GT) aims to construct a theory or general conclusion that is inductively driven by the data (Charmaz & Henwood, 2008). Research questions often focus on meaning and process (Charmaz, 2006). In GT, the researcher avoids reviewing the literature prior to data collection in order to maintain independence from the data. Given that the researcher had already conducted extensive literature reviews and did not aim to develop a theory about values and SMD, GT was deemed an inappropriate methodology for this project. *Interpretative Phenomenological Analysis* (IPA) focuses on exploring, in detail, how people perceive and make sense of major life experiences (Smith et al., 2009). IPA focuses on the meanings that individuals attach to their experience, as well as how they make sense of it (Smith, 2011). IPA research is subject to double hermeneutics: acknowledging that the researcher is interpreting the participant's interpretation, or in other words, making sense of the participants sense-making (Smith et al., 2009; Smith, 2011). It often uses small, homogeneous sample sizes, and analysis in IPA is intensive, more in-depth, and meaning focused, taking a stepwise approach in analysing participant data one-by-one (Larkin & Thompson, 2012). IPA would have been an appropriate choice coming from a critical realist epistemological stance.

Although an IPA approach could have been taken and would have arguably made an interesting piece of research, IPA was not chosen primarily due to its focus on meaning

and sense-making not being consistent with the aims of the current study which aimed to both identify and explore values, not understand the sense-making process of identifying values or focus in specifically on the experience of a values-based behaviour. Given the paucity of literature exploring values in homelessness, even more so people experiencing SMD, the research aims were kept broad with the aim to avoid assuming what may or may not be important or significant for participants, for instance, values themselves.

Framework Analysis (FA) is a 5-stage model (Ritchie & Spencer, 1994) often used in social and health sciences (Parkinson et al., 2016). FA systematically analyses data by participants and themes, without prescribing any particular epistemological or theoretical stance (Gale et al., 2013). FA provides highly structured outputs of summarised data, which can support researchers to manage large datasets or working as part of a research team with varying experience (Gale et al., 2013). Given the flexibility of FA, it would have been an appropriate methodology to apply to the present study.

Reflexive Thematic Analysis (TA; Table 10) is a method of identifying and analysing patterns by searching for themes across the data set in a systematic and transparent manner; TA provides a method for analysing qualitative data without prescribing data collection methods, or theoretical and epistemological positions (Braun & Clarke, 2006; 2013; 2014; 2019; 2021). Although TA can face criticism for often being used inappropriately, it is a flexible approach that, if used well, is capable of delivering a rich, detailed, and complex account for almost any qualitative research question (Braun & Clarke, 2013; Byrne, 2021). TA allows for data-driven inductive analysis, as well as theoretically driven deductive analysis (Braun & Clarke, 2006), including dual inductive-deductive analysis (Joffe, 2012).

TA was deemed the most appropriate choice for the study, allowing for a CR epistemological stance to be adopted. Furthermore, TA is a methodology that allows for an inductive-deductive approach, allowing the research framework to be informed by extant theory on SMD and values, but still remaining open and true to the data and the individual experiences of the participants. Given the absence of literature specific values and homelessness, or values and SMD, the use of such a flexible approach felt appropriate in ensuring any analysis could remain true to the complex reality faced

by individuals experiencing SMD. In order to align with the reflexive TA approach, the researcher outlines numerous examples and insights into the development and progress of the study throughout the extended paper.

Table 10. Six-Stages of Thematic Analysis (Braun & Clarke, 2006)

Stage of Analysis	Description of the process
Familiarisation with Data	Transcribing data, reading and re-reading the data, noting down initial ideas.
Generating Initial Codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
Searching for Themes	Collating codes into potential themes, gathering all data relevant to each potential theme
Refining Themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis
Defining and Naming Themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Producing the Report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

2.2. Ethical Considerations

The study was conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki (World Health Organisation, 2013), the principles of Good Clinical Practice, and the UK Policy Framework for Health and Social Care (Department of Health and Social Care, 2017). Ethical approval was granted by the University of Nottingham's (UoN) Division of Psychiatry & Applied Psychology research ethics sub-committee on 3rd February 2021 (Appendix A). An amendment

was submitted on 22nd April 2021 and subsequently approved on 29th April 2021 (Appendix B). The amendment consisted of changing the proposed transcription software from a subscription service (i.e., pay-monthly) to a university-approved automated transcription service (i.e., pay per interview). This aimed to reduce research costs and increase flexibility in terms of transcribing interviews as and when needed.

Information Management. All researchers endeavoured to protect the rights of the study's participants to privacy and informed consent and adhered to the Data Protection Act (UK Government, 2018). Access to the information gained from the study was limited to the study researchers and any relevant regulatory authorities. Computer-held data including the study database was held securely and password protected on the UoN OneDrive. In compliance with the GCP guidelines, regulations, and in accordance with the UoN Code of Research Conduct and Research Ethics, the primary researcher will maintain all records and documents regarding the conduct of the study. These will be retained for at least seven years. If the responsible researcher is no longer able to maintain the study records, a second person will be nominated to take over this responsibility.

Informed Consent and Right to Withdraw. Each participant was given a copy of the participant information sheet (Appendix C), recruitment poster (Appendix D), and consent form (Appendix E) to read before agreeing to take part in the study. These documents were also shared with staff who agreed to support potential participants in ensuring they understood and were ab le to give informed consent. The primary researcher also ensured to ask if the participant had any questions and would still like to take part prior to beginning the interview. Participants were all informed of their right to withdraw before, during, or up to two weeks after the interview. To withdraw, participants were informed they could contact the researcher directly, or choose a trusted other such as a staff member to do so for them.

Only one participant chose to withdraw from the study shortly after beginning the interview, their data (i.e., the recording of the start of the interview) was subsequently destroyed. The participant informed the researcher roughly 10 minutes into the interview that they had changed their mind and they were not feeling up to completing the interview; they then left the interview. As this interview was face to face in a supported accommodation service, I approached the staff team and asked

someone to check on the participant to ensure that they were not experiencing any distress. Someone did so and fed back to me that the participant was having a tough week with a number of unforeseen issues arising and that the participant felt too emotionally uncontained to talk in detail about themselves today. They explained the person was feeling okay and simply had changed their mind about their ability to engage in an interview. The primary researcher respected the participant's wishes and asked staff to pass along their well wishes. This example indicates that the researcher successfully explained and implemented participants' informed consent and right to withdraw. This person showed that they felt the autonomy in choosing to take part in the study and changing their mind, furthermore, feeling able to share this with the researcher and staff, rather than feel pressure into completing the interview and potentially jeopardising their wellbeing.

Confidentiality. To ensure participant confidentiality, any identifiable data gathered (e.g., consent form) was held securely and only accessible to the primary researcher. Each participant was given a unique pseudonym ensuring that if anyone withdrew from the study, the correct data could be found and removed. Throughout transcribing the interviews, the primary researcher anonymised any identifiable data such as names and places.

Risk of Harm. It was not expected that there would be any physical or psychological harm caused by the study. The researcher acknowledged that discussing personally meaningful values in the context of facing SMD might mean discussing potentially sensitive topics such as mental health, substance use, experiences of exclusion. In light of this, participants were informed (and reminded throughout the interview) that they could choose to skip any question, and that they could share as much or as little as they would like. The researcher remained observant throughout the interviews for any signs of potential distress. Whilst no participants became significantly distressed during the interviews, some became slightly tearful when discussing difficult past experiences. In each of these cases, the researcher prioritised the participant's wellbeing and checked in (e.g., asking if they are ok, suggesting a break, moving on to the next question). Furthermore, the researcher liaised with staff members to ensure appropriate support would be available following the interview if needed; to the researcher's knowledge, other than the previously discussed example, no participant required such support.

Reimbursement of Participants. The Health Research Authority (2014) offers advice on participant incentives, they suggest that they reduce the impact of power imbalances between the researcher and participant, by making the participation seem like less of a "favour". The use of gift cards in the proposed study is not only the preferred means of incentive suggested by UoN but also reduced any potential strain placed on participants who may currently be receiving benefits and would be legally required to declare any monetary income. Whilst there is perhaps ongoing debate regarding the ethical implications of giving monetary incentives to individuals who are drug users, it is suggested that studies do not exclude such individuals from receiving the same incentives as non-drug users (Health Research Authority, 2014). Given the exclusion already faced by individuals facing SMD, it was deemed inappropriate to exclude those currently using substances from taking part in the study, assuming they were able to give informed consent and participate.

To show participants that their time was valued, they each received a £10 Love2Shop gift card with a hand-made thank you card upon completion of the interview. The researcher felt that this was an appropriate additional 'touch' to show participants that their time was valued. Participants who took part in face-to-face interviews were given the gift card immediately following the interview, those who completed the interview virtually received their gift card through their preferred method (i.e., posted to home address, given to trusted staff member to pass along). One participant reported not receiving their gift card via post, to ensure they received a gift card; a gift card was sent directly to their support worker who confirmed the participant received the second gift card.

2.3. Participants

Sample Size. There is no set standard to calculate a sample size in qualitative research (Malterud et al., 2016); the primary goal is to ensure that the sample size is large enough to provide a rich understanding of experience, but small enough to manage the material (Sandelowski, 1995). It has been argued that 12 interviews are sufficient to produce all themes and over 90% of codes in a TA (Ando et al., 2014). It can be useful to review previous research in similar areas to estimate the number of participants needed to complete a useful analysis. However, given the limited research conducted directly with individuals experiencing SMD, this was impossible.

Furthermore, the researcher(s) anticipated a number of challenges in recruiting individuals facing SMD[19]. Given these factors, the study aimed to recruit between 12-16 participants to take part in a one-off interview. The recruitment period ended when 12 interviews had been completed.

Inclusion Criteria. The following inclusion criteria were applied, these remained broad to support recruitment of a range of participants experiencing SMD. To take part in the study, participants must:

- have historically faced/be currently facing SMD i.e., experience of at least 3 of the following: homelessness, mental health, substance use, offending, and domestic violence
- be able to provide informed consent
- be aged ≥ 18 years old
- be able to communicate in English sufficiently enough to partake in an interview

2.4. Recruitment Procedure

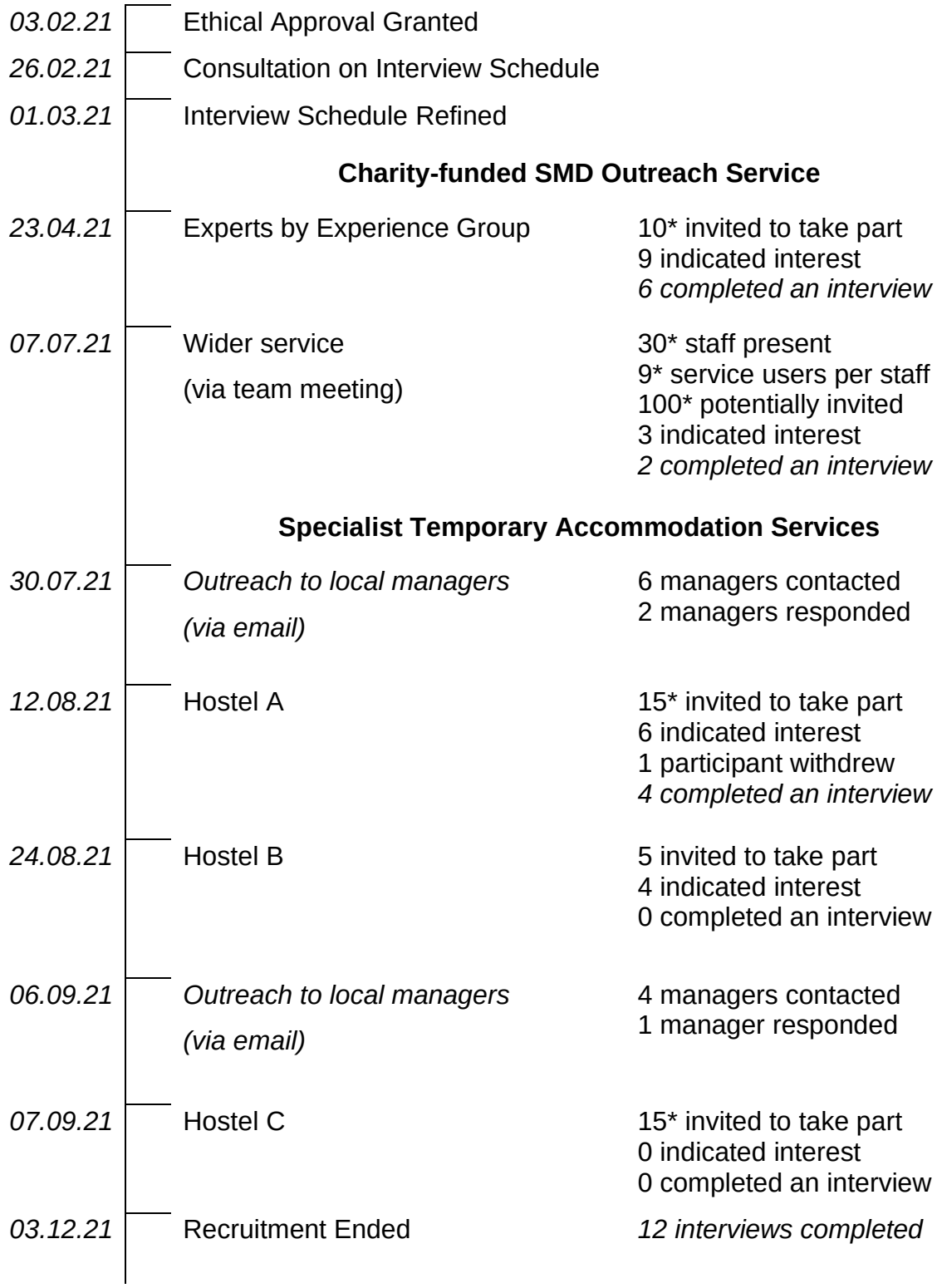
Purposive sampling is commonly used in qualitative research to enhance understanding of a particular group's experience, enabling greater insight into the research question (Devers & Frankel, 2000). As such, the study's primary method of recruitment was purposive sampling. Snowball sampling was also completed by asking each participant who completed the interview to inform any other people they may know who meet the criteria and may wish to take part, however no participants were recruited in this manner. A timeline of the recruitment process is available in Figure 5. This indicates roughly how many people met the inclusion criteria and as such, may have been informed about the study, how many individuals indicated interest in taking part in the study, and how many individuals took part in the study.

It is important to note that even though some services have a seemingly large pool of potential participants, that a large proportion of them would not be considered able or appropriate to invite either because of risk issues, national lockdowns[20], or the

[19] See Extended Reflection 5.4
[20] See Extended Reflection 5.2

individual's current circumstances for example, other support may take priority over research when engagement is already limited).

Figure 5. A Timeline of the Recruitment Procedure.



*Note. * = estimated figure.*

2.5. Data Collection

Data was collected through the use of semi-structured interviews, which allow for consistency between participants, whilst flexible enough to allow the researcher to follow the lead of the participant (Willig, 2013). The interview schedule (Appendix F) was initially developed by the researcher following an extensive literature review on SMD and values. This was subsequently refined through supervision and consultation with an expert by experience group.

The primary researcher began each interview by checking if the participant had any questions and engaging in small talk to develop rapport, a crucial part of data collection (Reinharz, 1993). The participant would then be asked to complete the consent form (via a separate recording if not able to physically sign the consent form), and the interview recording would begin.

Demographic Information (participant age and gender) was verbally collected at the beginning of the interview; such information is useful to give additional context to the data. To ensure participants met the inclusion criteria, each participant was asked to confirm which of the criteria for SMD they meet/have met, as well as asked to estimate when they last met the criteria for SMD as defined by this study.

Explanation of Values. To ensure participants understood what the researcher meant by values, a short paragraph, adapted from a range of values-identification exercises by the primary researcher and refined during consultation with experts by experience, was read aloud to the participant (See Appendix F).

Open Exploration of Values. Given the importance of values identification being a personal choice (LeJeune & Luoma, 2019), it was deemed appropriate to begin the interview with an open exploration of values. The researcher included a number of open-ended questions to explore participants' values as well as asking people the 'miracle question', a common exploratory technique used in ACT to support values-identification (Bennett & Oliver, 2019, pp. 146-147).

Structured Exploration of Values. The Personal Values Checklist (PVC; Harris, 2010) was utilised as a structured exercise to support the identification of participants' personally meaningful values. The PVC (Appendix G) consists of 58 values alongside a short definition of each. Each participant was read the list of values and asked to

categorise each value as ‘Very Important’, ‘Quite Important’, or ‘Not Important’; participants were reminded they could skip any value they did not want to discuss. Following completing the PVC, the researcher would ask participants to choose three ‘very important’ values. Participants were reminded they would be asked further questions on these values and were encouraged to pick values they were happy to discuss in more detail. After three values were identified, participants were encouraged to choose one and the next stage of the interview would commence.

Exploration of Values and Valued Behaviour. The final stage of the interview focused on the remaining research aims, to explore participant’s values in more depth, the barriers and facilitators to engaging in valued-behaviour, and the perceived helpfulness of service provision in support valued-behaviour. After the participant had answered all questions for at least one, or a maximum of three values[21], the interview was concluded. Participants were thanked and given another chance to ask any questions, reminded about withdrawal, gift-card receival was completed/arranged, and asked to mention the study to anyone else they know who may be interested.

2.6. Data Analysis

Familiarisation with Data began prior to analysis, the primary researcher completed and transcribed (verbatim) all twelve interviews. Although supported by an automated transcription service, this was not always accurate; as such, the researcher ensured to listen to each interview in full at least twice. This was to ensure the transcriptions were accurate, as well as becoming more familiar with the data. The researcher then continued to immerse themselves in the data by re-reading the transcripts. Throughout this phase, the researcher noted any ideas of interest in their reflective diary; some examples are illustrated in Table 11.

[21] See Extended Reflection 5.5.

Table 11. Example of Preliminary Data Analysis Notes.

Initial ideas of note	Further thoughts
Values do not stand alone	Participants seem to be pulling in various other values when talking about one in detail. Many have commented on how linked they are. Participants potentially primed due to PVC?
Values are individualistic	They're multifaceted, some are easier, some harder to enact. Some people very in touch with values, others need more scaffolding via PVC.
Valued behaviour is harder in context	There seems to be something about the risk of values and valued living? Knowing what you don't have maybe? Or the emotional connection to values? There are also practical barriers and psychological barriers across the dataset to valued living.
Some evidence of good practice and some bad	There seems to be something regarding it being down to particularly good individual staff members and/or the availability of systemic approaches/support? (e.g., activities, inclusion)
Value applicability to service provision	Some participants found the questions regarding services helping/hindering valued behaviour difficult to answer in relation to a particular value e.g., humour, fun. Perhaps less relevant in providing a service compared to others e.g., trust

Generating Initial Codes comprised two stages: inductive and deductive. The initial inductive phase consisted of the researcher systematically coding each data set, retaining participant language wherever possible (Appendix H). This allowed the researcher to preserve meaning and context within the codes, ensuring that as analysis progressed the researcher could recollect the context of the code in relation to the dataset. Given the position of the researcher in exploring the literature and developing the research questions, they were mindful of how their knowledge may bias code-creation in a way that fits with the existing literature. In an attempt to combat this, multiple supervision sessions were attended by the researcher and supervisors in which codes were checked for accuracy and specificity, whilst biases within the codes, such as framing a code within the aims of the research (e.g., negative thinking is barrier, when in fact the participant did not mention 'barrier') were highlighted and discussed.

Once inductive coding was completed, the researcher then systematically re-coded each dataset using a deductive coding framework developed by the researcher based upon the available literature and theory (See Table 6). The coding framework was

discussed in supervision and refined with support from supervisors. Participants were not asked specific questions based upon the literature and theories outlined in Table 12. Given this, the questions asked may not elicit information that would fit with these deductive codes and the absence of these codes being found within the data does not necessarily disconfirm the existence of such theory in participants' experiences. Each deductive code was assigned a number and colour which was used to note any relevant data pertaining to the code (See Appendix I).

Table 12. Deductive Coding Framework

Coding Framework *Does the data show evidence for or against…*	**Link to Literature** *Research suggests that…*
Value stability	Although generally stable, values can change in response to trauma (Johnson, 2001). Given the likelihood of participants experiencing compound trauma (Cockersell, 2018) it could be apparent that values in this population are not as stable as generally taken for granted.
Values motivating behaviour	Values are a key source of motivation (Hitlin & Piliavin, 2004). Bringing attention to values leads to increased valued-behavioural enactment (Fitzpatrick et al., 2016) and values are an effective strategy in maintaining behavioural change (Gregg et al., 2007).
A relationship between values and wellbeing	The World Health Organisation (WHO; 2012) define wellbeing as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Valued behaviour is associated with decreased psychological suffering (Gloster et al., 2017). Conversely, feeling disconnected from meaning/purpose has been associated with poorer psychological and physical well-being (Creswell et al., 2005; McCracken & Yang, 2006). Given the link between values stability and trauma, it could be hypothesised that decreased wellbeing influences values, as well as vice versa.
Connection to meaning	By identifying and working with values, arguably people can be supported to connect with meaning within their context of suffering (LeJeune & Luoma, 2019). Given the context of experiencing SMD, it would be interesting to see whether the data shows participants connecting to meaning within their context of significant suffering.

Construction of themes began after all data had been coded. Whilst prevalence was considered, in line with suggestions, a theme was developed when it was considered to answer something important related to the research question (Braun & Clarke, 2006). As such, the researcher kept the research aims in sight throughout the analysis, reflecting on whether the themes were related to the aims. To organise and maintain the significant amount of data, codes were copied into an Excel sheet with the corresponding pseudonyms and line numbers (See Appendix J). The primary researcher then systematically reviewed each code, beginning to group codes that had commonalities. This process led to the development of the initial themes (Appendix J, Image 2).

Refining Themes began after the initial themes had been developed. The data was reorganised by grouping the initial themes and the researcher then considered each theme, checking that the codes and original transcripts related to the theme. Some themes at this stage were grouped, whilst others were separated into distinct themes or subthemes. Thematic maps were created throughout this stage and examples of the progression of these maps is available in Appendix J. The primary researcher utilised supervision and reflection throughout this stage of analysis. This allowed the researcher to question theme construction, re-organisation, and re-naming. Considering where the primary researchers biases may have affected the analysis or subsequent results.[22]

Defining and Naming Themes. As the researcher began to structure a results section, identifying quotes from the transcripts, they reflected upon whether or not the themes and subthemes correlated with the dataset as a whole. After numerous iterations of the refining themes stage, supervision, reflection, and critical evaluation; the themes and subthemes were named and defined.

Producing the Report began prior to analysis with the introduction and methods section. After data analysis was completed, the researcher wrote up the results section using interesting extracts to tell the ‘story’ of the data, going beyond description to build an argument that answers the aims of the research. This involved

[22] See Extended Reflection 5.4

interpretation of the data, then followed by the discussion section where the data is framed within the context of previous literature and theory.

2.7. Expert Involvement

Involvement of experts by experience was considered throughout the study. Primarily a field supervisor was recruited who has lived experience and is employed by a charity-funded outreach organisation in a role dedicated to facilitating the involvement in services of those facing SMD. The field supervisor attended the majority of research supervision meetings and supported with recruitment, analysis, and write-up. Following development of the interview schedule, this was then taken to a lived-experience consultation group where a number of individuals offered comments on the schedule. Although the interview schedule remained mostly the same, some language was simplified or changed, and some of the longer sections such as the explanation of what values are, were shortened, in line with the recommendations made by the consultation group.

2.8. Quality Monitoring

Unlike quantitative research, replication, objectivity, or consistency are not necessarily the benchmarks of success in qualitative research; yet qualitative research should still be subject to a certain level of quality appraisal. Instead, ideas such as credibility and rigour are believed more important to consider (Spencer & Ritchie, 2012). As such, numerous steps were taken to monitor the quality of the research from the initial conception of the project.[23]

Credibility refers to being transparent about how the findings were reached and their defensibility (Spencer & Ritchie, 2012). To show credibility, the process of analysis has been shown, including outlining the process and presenting extracts of the raw data and subsequent analysis (Appendix H - J). Further to this, credibility checks were completed throughout the data analysis process by the three supervisors.

Supervision was held regularly between the primary researcher, two academic supervisors, and one field supervisor. Supervision logs were maintained and stored by UoN to provide an accurate summary of each meeting. Furthermore, research

[23] For examples see 5. Extended Reflection

journals were kept by the primary researcher throughout the project, these were used to note important discussions had during supervision, the researcher's ideas, note any interesting responses on the researcher's part (i.e., strong emotional responses such as joy or shame), and to keep track of decisions made throughout the process.

Finally, the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2018) was used by the primary researcher (Appendix K) to monitor the quality of the research. This checklist aided in guiding the research, prompting reflection on the process, and considering quality throughout. Given the likelihood of the researcher viewing their project with a positive bias, they enlisted the support of a peer (another Trainee Clinical Psychologist) with experience publishing qualitative research to complete a separate checklist (Appendix L).

2.9. Dissemination of Results

The completed study will be disseminated in a variety of ways to ensure the results can be utilised by staff, services, professionals, and researchers alike. The shorter journal paper will be submitted for publication in a peer-reviewed journal. All but one participant requested a copy of the results following completion of the research; as such, a service-user friendly report will be created and shared with participants. This will also be presented at a meeting of the expert by experience group that consulted on the interview schedule.

Finally, the findings will be shared with various local and national services including the Practice Development Unit in Nottingham, Homeless Link, and Research Steering Groups within the services recruited from. If possible, the researcher will present the research in appropriate settings to further consolidate the findings into local practice and the research base.

3. Extended Results

Participant responses to the PVC are available in Figure 6, showing the wide range of responses in regard to the 58 values. It should be noted that participants were able to skip rating any value, as such, not all values have a total of 12 ratings. The remainder of this section describes themes and subthemes in more detail, using additional illustrative quotes not included in the main journal paper.

Values are Idiosyncratic and Interconnected

Further examples of the individual nature of participants' values are illustrated; for instance, adventure represented Tom's childhood *"exploring different things… going places… you're not really meant to go"*, whereas for Jack, it represented something more current, and his belief in always *"trying something new"*. Hannah was the only person who labelled humour as *"a reframing tool"*, whilst Megan was the only person who identified creativity as something internal, *"I can be sort of creative in my head"*. For some, spirituality symbolised organised religion, however for others this represented something different:

> *I've tried going to church. Church isn't for me… When I was going to church, I was just crying all the time, but when I read my spirituality books it brings something else out of me. It's really hard to explain. I think church is like an emotional place for me because it makes me think 'why me'. But then my spirituality books are like you're chosen, that's the reason why.*
> Chloe

Many participants found it challenging to pick just three values to potentially discuss in detail, *"it's hard I'm trying to pick some that aren't all tied together"* (Hannah); highlighting the importance of values identification being fluid, understanding the nuances of the individual's value, exploring exactly what it means to them.

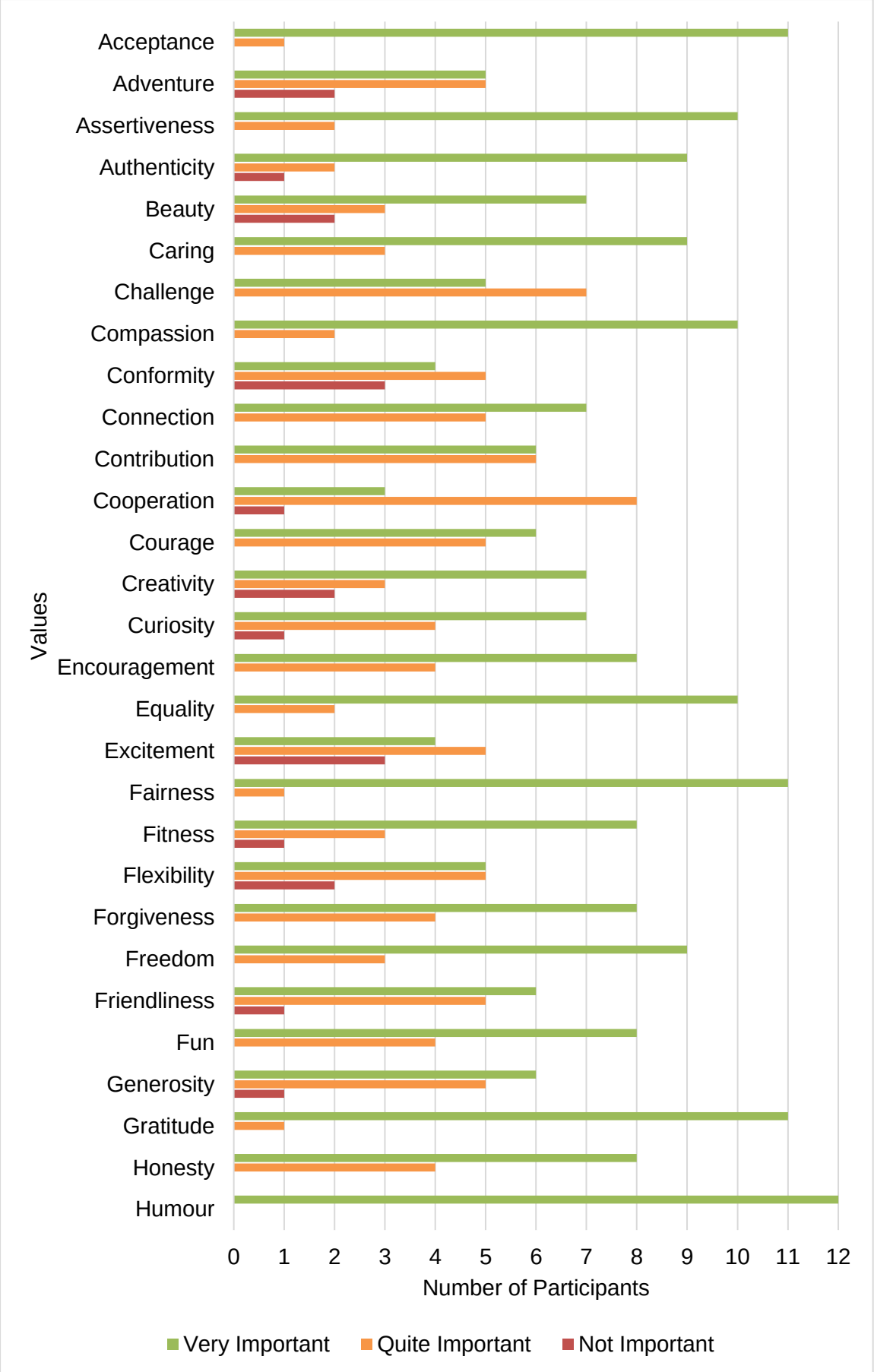


Figure 6a: Values Checklist Ratings

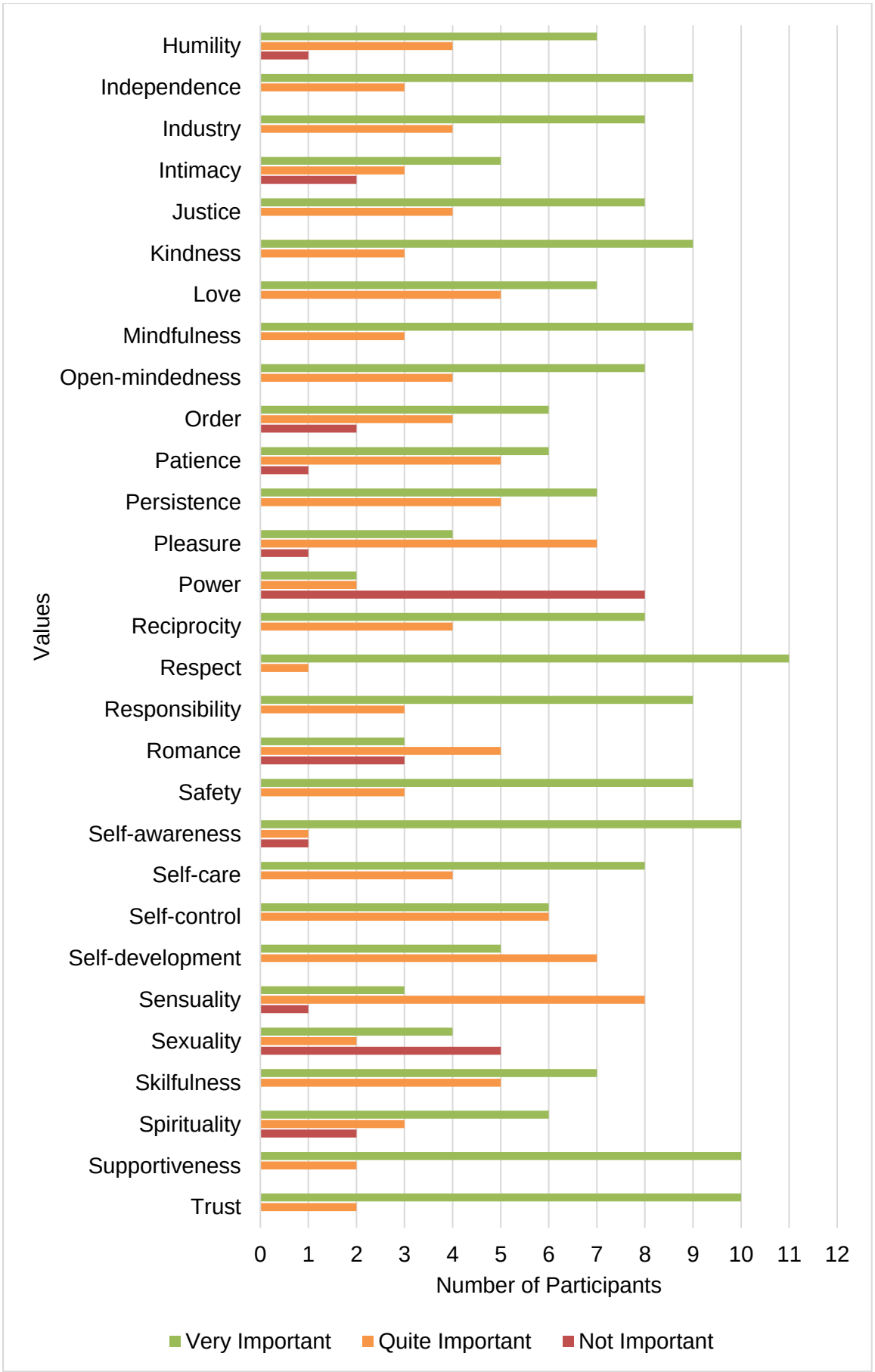


Figure 6b: Values Checklist Ratings Continue

Every participant, in at least one instance, pulled in a variety of other values when talking about one. Jack, for instance, linked adventure to having purpose and curiosity:

> *It's having more purpose I think, finding that purposefulness again… you're not doing the same thing and expecting to get different results…There's curiosity in there as well, that's important. So, there's a few that cross over aren't there?*

Other examples include Megan, who considered mindfulness to embody *"gratitude"*; Harry, who described *"self-awareness is my wellbeing… my independence as well"*; Chloe, who connects spirituality to *"self-love and kindness"*; and finally, Helen, for whom fun encompasses *"having a laugh with people, socialising and that, trusting people"*.

Inconsistency in Value Stability. In line with the general population, it appears that many participants' values remain consistent across their lifetime. Many referred to values as having *"always"* been important (Chris, Megan), others described their values and valued action as being *"natural"* (Paula, Helen, Harry). Helen explained how she has always valued generosity, even to a fault: *"I leave myself with nothing and give to others. I always do. I can't help it; I know I shouldn't do it… but I just keep doing it"*.

For many, values shifted as their context did, for instance, a decrease in their physical health led Megan to re-evaluate how important fitness and self-care were, *"It's been more important to me over the last six months, you know, and it's made me appreciate my physical fitness"*. Others found their values shifted as they progressed throughout recovery, such as Kate and her value of assertiveness, *"It's important that I stand up for my rights… my voice has to be heard. I've only felt like that a few years"*. Harry, on the other hand, found that his experiences of adversity had led him to re-prioritise, and increase enactment of certain values such as supportiveness and compassion:

> *I was unable to have that kind of contact (with family) that I wanted. So now when I'm faced with a situation, and somebody needs help, I will literally go that extra mile and do my upmost to do what I can do.*
> Harry

The Benefits of Value Identification and Enactment

Regarding identification on values, some participants found that completing the PVC allowed them to name values they were living in line with, but not necessarily aware of:

> *(Courage) I don't even think I thought that that was a value of mine until we talked through it and I've kind of gone oh this might be. And I don't think I've realised that it's what I've been building over the last couple of years.*
> Hannah

For others, completing the PVC allowed them to become more aware of themselves; Chris, for instance, wondered whether this could help other people:

> *Do you know what, half of (the values) you're reading out, people have got them, but they don't realise that they've got them… some people don't see it, it would be nice if you could point them out for people like look this is a value for you, it's a positive for you.*

Participants all offered a wide range of examples with ways in which they enact their values in their day-to-day life. For some this involved personal hobbies such as Harry teaching others to *"play a bit of guitar"* to enact creativity and fun; *"going out into nature"* (Megan) for mindfulness; and Emily planning to *"bring my own veg"* to upcoming events in regard to her values of connection and collaboration. Others described how enacting one value, such as adventure, can support their ability to enact another, creativity:

> *I walk everywhere… I can do up to ten miles a day… I like finding things, going through skips, and mooching stuff. So, most of the things I'm using to (create art) again are found objects so there's a bit of adventure in that, it's like finding treasure.*
> Jack

Others gave more specific examples of times in which they enact their values and why, for instance, enacting caring and compassion, *"I talk to random strangers in the street… you never know when the last time that they had a conversation or the next time they're going to get one"* (Jess). Kate discussed her value of caring, how she was

"robbed" after prioritising looking after her friend but for her, *"keeping them safe was more important"*. In the following example Paula explained how she was recently assertive:

> *I had a neighbour… I was a bit passive but also assertive. Her behaviour towards me was unacceptable. But instead of me getting aggressive or talking behind her back, I just did that sort of sensible thing and walked off and said this ain't for me.*

Several people highlighted ways in which they enact values within services, for instance Chris described using his values in therapy, such as working on forgiveness, *"my counsellor… (that's what) we're working on now… forgiving and forgetting"*. Others highlighted that contributing to service provision was a way in which to live by their values *"I'm on a panel at the moment… to improve the way they treat people"* (Paula, talking about assertiveness). Another example comes from Chloe who recently volunteered to support at-risk children, enacting her value of contribution:

> *This week, I've sorted out… a meeting for the job that I used to work for and I'm going to ask to volunteer so that I've got purpose. Because I loved the job.*

For many, enacting valued behaviour supported them in looking after themselves and improving their wellbeing, Chloe talked about her values of spirituality and self-care, *"now if I'm having a bad day, I'll try and deal with it and get to the bottom of it… I'll stay in bed and self-care, watch the videos, I've got loads of self-help books as well".* Participants outlined instances in which valued behaviour increased their motivation to continue living in line with their values. For instance, Tom spoke about enacting his value of mindfulness:

> *When you reach a certain age, you start looking at things properly, like I noticed the little plants in the corner one day and I went up to it and was like it's lovely and usually I'd have just walked past them. Well, I know I've not got long left on the planet, maybe 20 years if I'm lucky, so I want to get the most out of it.*

Another example comes from Emily, who discussed encouragement in regard to pushing herself to go on the bus to the shops:

> *I encouraged myself to go on the bus on my own… it kind of s**t me up a bit… but I did it. I didn't get all the stuff I needed, but I did it; and hopefully I can encourage myself to go back out.*

Jess described the benefits of being respectful to staff and having that valued behaviour reciprocated:

> *It shows that I actually mean something to them … I've actually touched them in some way, and they can see that I feel that (respect) for myself and yeah, they care and they're real.*

Chloe reflects on how spirituality has given her a new outlook on life, *"it's a lesson… what these books are teaching me… you don't get given something unless you can actually take it on. So, the more challenges you get, the stronger you become".* Emily displayed a sense of pride whilst recalling a time when despite her own suffering, she enacted her values of honesty and trust. Emily's support worker had accidentally left their purse at her home and even recalling this event left Emily visibly emotional:

> *At that time … I didn't have no electric or nothing… I didn't touch it; I wouldn't touch it... Look I've even got goose pimples thinking about that time … It's brought tears to my eyes.*

Another example describes how Chloe supported the recruitment of foster carers with a service that used to support her as a child. She reflects upon how her wellbeing was impacted not only by the experience, but by the impact of her valued action on others and their subsequent response to her:

> *I noticed when we would do interviews… they wouldn't ask all the professionals who have been to university… they'd ask for my life experience… it just light up as a flame inside of me and like my experience really does make a difference to what people want to do.*

Harry summarised how connecting with his values of self-awareness and acceptance, *"helps me to reflect back on situations… on how I'd like to see my day go… think about how I can make the next day subsequently a little bit better"*. Several participants

highlighted that identifying and discussing their values had motivated them to engage in more valued behaviour. Tom, for example, had planned to *"take a packed lunch up to the park, have a walk"* the morning of our interview. He later described feeling increasingly motivated to follow through with his plan, after we had been able to identify and explore his value of adventure:

> *Well, this morning… when I had the thought in my head and let's say you didn't turn up the chances of me thinking about doing it at this time would be slim. With you bringing it up and that checklist, it made me think if I don't do it today, I'm going to do it tomorrow. And if I don't do it tomorrow, I'm definitely going to do it the day after. I'm definitely going to do it.*

The Risks and Challenges of Value Identification and Enactment

Challenges Faced by the Individual. As stated by Emily, *"everything in life can get in the way"* of valued living. Megan highlighted that a person's *"finances could be a barrier, (not) having the opportunity"*, elaborating that *"it could be as simple as not treating myself to some felt tips or a quizzing book"* to enact creativity. Some people described an internal struggle between managing their wellbeing, utilising support, taking professionals' advice, and living in line with their values. For instance, Chloe highlighted her struggle between enacting spirituality and prioritising her mental wellbeing:

> *I take into account what the (spirituality) book says (about not taking medication in order to avoid clouding the mind), but I also think that I need it for the moment because I'm not strong enough and I can't do these things on my own. But I know in the future I can be strong enough to come off the medication.*

Every person referred to how their experiences of trauma and subsequent mental health difficulties challenge their ability to enact valued behaviour, *"how can you properly recover from all those years of abuse anyway"* (Paula). As Chris reflected on forgiveness, he stated *"it can be tricky… I've got one of those minds that tick a lot and sometimes I can just sit there going over all the bad stuff"*. Similarly, Harry described how his negative thinking can be a barrier to self-awareness:

> *It can be tough… I can become very frustrated within myself, especially if there's a situation and I don't understand it… I just become very frustrated and wound up within my own emotions and my thinking and it will have an impact on how others then see me.*

One person indicated that feelings of shame, regarding their need for support to enact valued behaviour, can be a barrier: *"they ring me up... they ask how I'm doing; they offer encouragement… you shouldn't be, but I do feel ashamed of it… I should be doing it myself"* (Paula). Everybody outlined a wide range of related barriers to enacting valued behaviour or change, including at times, themselves. When asked what gets in the way of living in line with her value of courage, Hannah replied:

> *My own head. Negative thinking. Patterns of behaviour. Habits. Other people. Their input. (laughs) Their expectations. My expectations. A lot of things. Circumstances. But I can't really blame that because at the moment it's still my you know choices and stuff.*

Multiple people described feelings of guilt in regard to not living in line with their values, *"I was guilty of cancelling appointments… I didn't have the confidence or will to keep going to these things"* (Jack). This appears to have a negative impact on people's emotional wellbeing: "*I am really bad for letting people down… that sometimes gets in the way… so that will darken my spirit a little bit"* (Chloe, discussing spirituality). Chloe further outlined how she needs the internal motivation to engage in recovery:

> *I know the resources and I know what to do… I guess it's just being human, but I am the problem if that makes sense. I'm the problem. So even if you can tell me everything that I need to know, it's me.*

Tom described his perception of both his own, and services' role in hindering his progress: *"I've messed most of my life up, that's my fault, nobody else's. I could cry and say it's the systems fault and, in some ways, maybe it is"*.

Challenges Embedded in the System. Many people referenced the lack of funding and service provision limit how helpful support can be, *"they're putting too many clients on one member of staff to deal with, then they can't deal with them"* (Tom). Several participants described how cutbacks have led to reduced opportunities

to engage in valued behaviours or change and creates conflict amongst service users and staff:

> *A lot (of hostels) for instance won't have residents' meetings so there's no feedback to the staff how residents feel. So, it gets like staff against residents and residents against staff, and it just boils over to the point where people have to vacate… for a better term… if there's nothing like activities, there's nothing there to stimulate an individual, then it just seems a complete waste of time. Because all you're really offering is a bed and a room… with no purpose whatsoever.*
>
> Harry

Many participants noted the challenges of enacting valued change, whilst placed in supported accommodation, *"people have made themselves homeless again because they can't hack it here"* (Kate). This left Jess finding maintenance of valued behaviour (i.e., sobriety) more challenging, *"I could still slip at any time with the environment that they put me in".* Some felt that staff were not interested in supported them in valued living, *"they don't want to know you. It's just fill out these forms. It's all about protocol"* (Jess). Furthermore, Hannah highlighted the various restraints in place in terms of her ability to live in line with her value:

> *I'm living within certain restrictions so there is a limit to what I can be courageous about. Even in the sense of, I don't have complete, well does anybody have complete freedom, but I don't have a high degree of freedom in terms of how I'm living at the moment.*

Challenges within participants immediate systems was a common thread, *"just having that wrong person around you for instance (can get in the way of forgiveness)"* (Chris). In some instances, being in a particular context, such as under a section of the Mental Health Act, leads people having to sacrifice one value, such as fitness, in order to enact another, *"that's when I started smoking fags as well. The only freedom I had would be to go outside and have a fag"* (Chloe). One person reflected upon how their perception of their own ability is associated with their various identities within a service, leaving them questioning their valued-behaviour and progress:

> *It's like I've got a kind of fear. Because with (expert by experience group) I'm used to going to (location) to do some of our meetings, one minute I'm going there with a visitor's lanyard on as an (expert) and then the next minute I'm going there as a service user. I don't know it feels a bit hypocritical to me… I think… how can I be doing well as well as using? I don't know. I really don't.*
> Emily

One person highlighted that when you are able to access services that allow you to enact valued behaviour, such as a local theatre group to enact creativity and adventure, it can create conflict with their surrounding system:

> *I get constantly asked 'why can't we get referred to the service?' and it almost causes like, 'well it's alright for you, what's different about us?' it's almost conflict building.*
> Harry

The impact of stigma was raised by numerous people, *"we're all brushed with the same tar"* (Jess), explaining how this leaves them without much needed support, being *"put down to the bottom of a heap (to) be forgotten about"* (Paula). An inability to escape one's reputation was raised by a few participants as a barrier to enacting valued behaviour, *"I'm on the edge, but I'll never get out of that circle. My reputation, my name… I'm not that person anymore"* (Tom). It appears that this can leave people feeling they have to withdraw from relationships:

> *They want to see you as you used to be, but you're not that person anymore… its unfair that people do that, it gets in the way sometimes… I've had to move away from old friends and stuff, I still get it from my family.*
> Paula

Finally, those no longer currently experiencing SMD highlighted that the challenges in accessing support continue, *"aftercare… I would say is missing"* (Jack) and the impact on their wellbeing: *"I shouldn't have to be trying to kill myself for you to listen to my problems"* (Chloe). Paula spoke about how engaging in valued behaviour, such as attending expert experience groups and panels, can be used as evidence for services to not provide much needed support:

> *They're saying that I'm perfectly alright, and I mean wow… I wish I was perfectly alright… that I didn't have all these problems… it was really unfair… I totally was just so nervous over the phone to the assessment worker that you know, all these questions that she was asking me… I was just trying to skim through them.*

Needing to Protect Oneself. Every participant reflected upon the various risks they face in regard to value identification or enactment; furthermore, exploring how the necessity of protecting themselves can take priority over valued living. For instance, Kate described when attempting to enact connection has backfired, "*every time someone gets close to me, they just take advantage".* Hannah outlined the very real threats she faces when enacting her value of courage:

> *Where there's like a physical threat or quite a significant emotional threat or whatever… a power imbalance… I'd say the biggest one for me on (what gets in the way of living in line with my values) is the threat of physical, physically not being safe.*

Participants highlight that the need to protect themselves often connects to re-prioritising values or enacting different behaviours. Kate reflected upon her changing values in relation to forgiveness and maintaining boundaries, *"it used to be very important that I forgive people… but you have to have a line, people will always push their luck"*. Similarly, Helen states *"I'm too friendly, it gets me into trouble"*. When elaborating on her value of generosity, she further explains how it can leave her vulnerable:

> *I always say I won't do it again, but then again; I do… people have just trod on me … and caused me trouble and grief over it.*
> Helen

Furthermore, people indicated that they needed to protect themselves from staff and services, *"nobody can trust anybody, even the ones who are there to help you, they throw it back in your face and blame it all on you"* (Jess, discussing trust). Alternatively, Chloe discusses how trying to enact values by supporting others can be exhausting if that person is unable to accept the support being offered, potentially reflecting similar experiences for staff members:

> *I won't go out of my way to help someone that doesn't want help. Because then you're draining your energy and draining their energy. I've been there, I know what it feels like.*
> Chloe

Participant's perception of their ability or inability to live in line with their values was commonly cited:

> *It's helpful for me to know what my values are… have that as a vision for what I'm moving towards, but… I need to get those foundations first before I start moving towards that other stuff. Because if I haven't got somewhere relatively safe and stuff, I know I can still live by my values don't get me wrong, but that's part of the limitations, I guess… I can do it, but within certain restrictions.*
> Hannah

The Relationship Between Values and Support

What Helps, also Hinders. Further examples of helpful support are outlined by participants, *"they do care about me…they've had my best interests at heart… the main focus (has been) getting me better"* (Chris, discussing trust). Although Tom commented on the limitations of cutbacks, he also acknowledged that their support has allowed him to live in line with his values: *"(Service) have done a lot for me. They could have done a lot more but unfortunately; they ran out of funds"*. For others, the 'normality' of support offered, allowed them to feel more able to engage in valued behaviour, such as creativity:

> *The practical stuff they've given me, even if it's just meeting for coffees and stuff, it's been a way of kind of getting back into life. Doing the normal things again… like they've purchased things for me and helped me to get the creativity going again.*
> Jack

Jack, reflecting upon what helps encouragement, indicated that *"seeing how people have achieved and succeeded in their lives with similar life experience…that's all been very very enlightening… to have that around me is very encouraging as well"*. Emily highlighted that anyone can help her with valued action, in this instance

encouragement, *"they have helped loads… my workers, even my family and friends… my neighbours, my… associates"*. Connecting to previous themes, she further elaborated on the positive impact this has on her wellbeing:

> *Everyone has given me some kind of… feedback and encouragement… To receive encouragement, you think it's just words, but when someone does encourage you to do something… you've achieved that. It makes you feel so good, well it does me.*
> Emily

Having good relationships with staff was a helping factor for many, *"it's about that bond, isn't it?"* (Megan). Paula described how when services focus on inclusion, it helps her to remain engaged in valued activity, *"(they) keep me up to date on minutes (from missed meetings) … so it doesn't make me feel like I missed out or I'm being treated unfairly because I didn't go"*. Hannah reflected that at times, staff have been helpful in supporting her to be mindful without her realising:

> *For example, [picks up a sensory dog toy] when I've been making difficult phone calls… they've given me the dog… because of that like sensory experience which you know is that kind of mindfulness. So, I think actually, maybe there's ways that this has been used but I've not recognised it at the time.*

Most outlined the complex impact negative support can have on their ability to engage meaningfully with values:

> *Now I'm working with someone else, the best is coming out of me. It just shows if you're working with the wrong people as well, it can f**k you up.*
> Jess

Whilst support can be instrumental in valued living, participants also highlighted how poor support can be a significant barrier. Simply put, *"you get some passionate staff and then you get some unpassionate staff"* (Kate). Hannah suggests that even if staff want to help, the demands and restraints placed upon them can get in the way of them supporting her to enact mindfulness:

> *I don't think there is that awareness that it's something that works for me… It's not that they're not being interested, but it's that time and stuff. They might not see you often enough and get to know you enough to know (your values). Sometimes there's just people you immediately match with, and it makes sense and you're both on the same page about it.*

Many participants indicated that the helpfulness, or not, of support can depend on the individual member of staff allocated to them, *"once again, it depends on who's supporting you… I've come across workers who were fair, and I've come across those who were unfair… you know, tried to put stuff into your head"* (Paula, discussing fairness). Kate reflects upon what could have been if staff had taken the time to understand what is important to her, in this instance, trust: *"I wouldn't be so dubious with staff… it might have helped me, it might not have done. But they didn't take that time back then, and they really haven't this time".* Finally, some people referred to the specific qualities in staff members that they find hinder their ability to enact valued behaviour or change:

> *Now I've been given another worker who, in fairness she's doing the best she can but, it's almost like reinventing the wheel… I found that quite frustrating. She lectures … she's not mentioned to me that she's been in touch with my doctor. She just feels a bit tired, and she's missed appointments… the other week she got the day wrong … it's like I shouldn't be compensating for your inadequacy.*
> Jack

The Potential of Value-Focused Support. Multiple participants shared their opinion on ways in which services could further encourage people to live in line with their values. On the whole, participants responded positively to the thought of services more actively considering their values and using this understanding to tailor a strengths-focused, person-centred approach, *"I think it's a useful way of going about decision making and making plans"* (Hannah). Emily reflected *"that does sound a good idea because it will also encourage the person to start living"*, whilst Chris commented *"I reckon having more support doing that would definitely help me"*. Harry outlined his belief there is an appetite for such support:

You might want to sit down and just say what are your interests, what are your hobbies, is there somewhere we can get you into, where you might get interested… people want to learn.

Others reflected on the emotional difficulty in acknowledging what could have been, *"I'm happy with the way I am now, but I think I would have got to my full potential. Just thinking about it is very emotional"* (Megan). Chloe reflected upon how such support earlier, could have been lifesaving:

It makes me angry… that could have saved my life… if you told me to read a (spirituality) book years ago, and start my journey, and know that I could help myself instead of relying on services, maybe I wouldn't have a damaged liver now.

Participants discussed the impact such support could have on their motivation and engagement, *"I might feel more motivated… and take more responsibility myself"* (Hannah). Elaborating on this, Jack identifies how such encouragement is rewarding and meaningful:

I'd be more willing. I think I'd definitely engage more… it's the acknowledgement that you're doing it… it's like a reward… where you're being acknowledged and encouraged with what your decision is… it's bottom-line stuff.

Hannah questions the applicability of such an approach in all services, *"I'm seeing some of this stuff come further down the line, so maybe not at this specific service (hostel)"*, as well as the potential risks associated:

That seems quite an intimate thing, again I think it would help me myself, but I don't know about the relationship between a worker and me doing that, but maybe that's me, I'm quite private.
Hannah

She further elaborates on feeling that such an approach is unobtainable within the systemic constraints:

I don't think they have the time; I don't think they have the resources… I don't mean that in an ungrateful way for what we have available, but I can't imagine

> *how services could bring it in in that way… I'm sure it would be great, but I cannot imagine if financially and stuff if that would ever be possible.*
> Hannah

An interesting point, although not included in the main results as only highlighted by one participant, considers the applicability of particular values to service provision. When discussing humour, Hannah suggested that some values are not applicable to service provision: "e*ven though it's a value, it's… not as important for staff to focus on"* (Hannah). When asked further questions however, she contradicted herself in acknowledging where humour could in fact be integrated in a helpful way:

> *It's something you already have in common and there's that familiarity… I think… it puts me at ease, so even though there's difficult things that need to get done, it's knowing that it's not always going to be really heavy.*
> Hannah

4. Extended Discussion

The results from the PVC alongside the first theme evidence that, regardless of their experience of SMD, people have a wide range of individual, personally meaningful values. The PVC was developed with 58 values that are commonly found in the general population (Harris, 2010); as evidenced by the ethical application[24], assumptions are often made that people facing SMD could not (or perhaps should not) value such things. As every single value was rated important by at least one person, the results of this study evidence that the type of values of people facing SMD are not dissimilar to those of the general public. Whilst values have been widely studies in other populations (Coppola et al., 2017; Jayawardhena, 2004; Chase et al., 2013), it was difficult to generalise such findings to a population whose experience is very different to that of students or the general public. The present findings suggest that whilst there are some key differences, the experience of having a set of personally meaningful, individual, verbally constructed, and dynamic values (Wilson & Dufrene, 2009; LeJeune & Luoma, 2019) is transferable and occurs regardless of being in a context of significant exclusion and disadvantage.

In regard to the interconnectedness of values, it could be argued that given the paucity of previous literature, and the structure of the interview, that this finding was primarily due to participants being primed to mention other values discussed during the PVC. Regardless, this finding is still of interest. Given the variation in participants' awareness of their values upon starting the interview, it is notable that after completing the PVC, every person had created at least one 'web' of connected values. Furthermore, as the interview was completed on average in 90 minutes, and all but two people were able to complete the interview in one sitting, it appears that a short values exercise alongside a discussion is a tolerable activity for some, if not all, people experiencing SMD. Furthermore, a much shorter exploration of values could be completed to make the process more accessible for those individuals who may struggle to complete a 90-minute session.

Another novel finding of the present study refers to the stability of values when experiencing SMD. The present findings indicate that value stability is not guaranteed in this population, likely due to the risk of value enactment and the impact of

[24] See Extended Reflection 5.3

experiencing compound trauma (Cockersell, 2018) and cumulative disadvantage (Dannefer, 2003; D'Andrea et al., 2011). Such results support extant theory that values can change in response to trauma (Tedeschi & Calhoun, 2004) or major life transitions (Johnson, 2001).

Participants varied in regard to their awareness of their values upon commencing the interview; during the open exploration of values, many discussed value domains, the arena in which values are enacted (LeJeune & Luoma, 2019), rather than specific values. Although the PVC is a structured exercise, most people would engage in reflection and discussion when trying to rate a value's importance; supporting suggestions that identifying values relies on dreaming, creating, choosing, and assuming more so than weighing out a list of pros and cons (Luoma et al., 2017).

Previous theory regarding enactment of values does not often consider people's ability to enact values, or the risk of bringing attention to values and valued living. ACT literature often seems based on assumptions that people are generally able to enact valued behaviour; crucially however, highlighting that context should always be considered (Hayes et al., 2012a; 2012b; Wilson & Dufrene, 2009). The present findings indicate the importance of considering not only the context of experiencing SMD, including the real and/or perceived ability to live in line with values, but the potential emotional distress of identifying and exploring values. People may identify that they have not been living in line with their values, or that they have, at times, been restricted from doing so.

Results indicate that values are still key motivators for people experiencing SMD, in line with theory (Dahl et al., 2005; Hitlin & Piliavin, 2004; LeJeune & Luoma, 2019); although importantly, motivation can be diminished in relation to ongoing risks or threats. Results also support theory suggesting that values act as distal reinforcers of congruent behaviours (Hayes et al., 2012a; Wilson & Dufrene, 2009), with many people evidencing how one valued behaviour can reinforce their motivation to continue with concurrent behaviours.

Interestingly, many participants referred to the fact that taking part in the interview had motivated them to engage in more valued behaviour, offering tentative support for theories suggesting values exploration leads to increased motivation to enact behavioural change (Fitzpatrick et al., 2016). As no evidence was gathered to confirm

whether participants did in fact engage in such behaviours following the interview, it is impossible to fully support the theory that bringing focused attention to values increases enactment or sustainment of valued behaviour (Fitzpatrick et al., 2016; Gregg et al., 2007). However, the results do indicate that bringing focused attention to values increases participants' awareness of how to enact valued behaviour, and at the very least, increases in-the-moment motivation to enact such behaviours or changes.

In line with the theory that valued living is likely to improve one's life, whereas simply identifying values typically does not (Bramwell & Richardson, 2018); results indicate that participants are more likely to report improved wellbeing and connection to meaning when describing instances in which they enacted their values, or through the realisation that they have been engaging in valued action. Even within the context of significant disadvantage and suffering, in line with theory, participants were still able to connect with meaning (LeJeune & Luoma, 2019), subsequently reaping the rewards of improved psychological well-being (Murthy et al., 2021; Creswell et al., 2005; McCracken & Yang, 2006).

Interestingly, participants who engaged in more experiential avoidance (i.e., skipping questions, choosing to move on from answers when connecting to feelings), were less likely to offer examples of times in which valued living had supported them to connect for meaning. For instance, Helen, who struggled to identify the benefits of valued action, refers to drinking as a way to enact her value of excitement; however, when discussing the outcomes of this behaviour, she offered short answers, often placing the responsibility for challenges, barriers, or her negative experiences, on services and staff. These findings tentatively support theories indicating reduced psychological flexibility (included lack of valued action) is associated with poorer wellbeing (Masuda 2014; Skinta & Curtin, 2016; Gloster et al., 2017), including in a homelessness population (Murthy et al., 2020).

Although the individual and systemic challenges were separated into different subthemes, in line with a socio-ecological understanding of trauma (Bronfenbrenner, 1979) and the push to provide holistic person-centred support (Everitt & Kaur, 2019), findings show the importance of recognising how different levels of the system contribute to trauma, exclusion, disadvantage, and conversely, recovery.

Most participants readily acknowledged where they themselves hindered their own ability to live in line with their values, as well as the complex intersection between their own actions, and the actions of services and the wider system. This could be an indication of some participants' psychological flexibility, specifically their openness to their experience and behavioural awareness (Harris, 2009). The emergent evidence for using ACT in homelessness settings (Murthy et al., 2020) and present results indicate that when participants are able to engage in valued action, they are likely to experience increased wellbeing. Perhaps those people who are more psychologically flexible and engaging in valued living are more likely to benefit from increased wellbeing and a deeper connection to meaning.

It could be suggested that those instances when participants' values clashed with staff or service values led people to perceive a threat to their autonomy; feeling that they are unable to choose or enact their values freely and without judgement. This corresponds with previous literature highlighted the importance of allowing people to choose values freely as an instrumental factor in increasing valued-behaviour and psychological flexibility (Engle, 2017).

Notably, those participants whose experience of SMD was historical, found that whilst they had experienced an overall decrease in suffering, they did not necessarily evidence an increase in their enactment of valued behaviour, supporting previous theory (Gloster et al., 2017). Participants found that the barriers to valued action did not disappear but changed as they progressed on their journey of recovery. Given the previously discussed likelihood of values changing due to the experience of SMD, it could be that people have not had the opportunity or encouragement to re-identify their values and consider ways in which to enact them that suit their current context and ability.

Given that previous research has tended to focus more on the importance people attribute to values and less on how people live in line with them (Sheldon & Krieger, 2014), the present findings offer a unique insight into how people facing SMD find ways to enact valued behaviour; furthermore, then choosing to enact them, even within their context of significant disadvantage and with the potential risks involved.

Participants offer their perceptions that they would appreciate support that focused on what is important to them, and how they can engage meaningfully with these values, which in turn could potentially increase their motivation to do something challenging, but essentially important like attending assessment for a new service; supporting literature that suggests values help people persist with difficult or painful tasks (Grumet & Fitzpatrick, 2016; Paez-Blarrina et al., 2008).

Alternatively, the results indicate that when participants feel that a service's or staff member's values are misaligned with their own, this can create complex and significant challenges to valued living. Multiple participants, for instance, confirmed previous findings that homelessness services often cause trauma themselves, with individuals finding the experience of being in a homeless service could at times be traumatising in itself (Coates & McKenzie-Mohr, 2010; Hopper et al., 2010; Yatchmenoff et al., 2017; Bloom & Farragher, 2010); additionally suggesting that they are not an inducive environment in which to enact valued behaviour, due to the limitations and risks involved. Results tentatively indicate that there is relationship between challenging or traumatic experiences within a service and time when values-clashes occur; with participants describing particularly hindering events as those that showed them that the service or person did not value the same things they did such as compassion or honesty. Often, this led people to question service providers' ability to understand, and therefore, help them.

Participants indicated positive perceptions of value-focused support, offering further, albeit tentative, support for the use of ACT-informed interventions in homelessness settings (Murthy et al., 2020; 2021). Participants felt that service provision supporting them to identify their values would help orient them towards making positive behavioural changes connected to what is most meaningful for them, even within their context of suffering (Yadavia & Hayes, 2009). Furthermore, the results support evidence that value-focused support could increase people's motivation and engagement with services, supporting treatment adherence (Forman et al., 2009; Woods et al., 2006). However, this would warrant further investigation to see if it translates to different outcomes in practice.

4.1. Extended Limitations

Recruitment Bias. There is a high likelihood that the research recruited participants who were already interested in values and/or more comfortable/able to discuss what it important to them in the context of an interview. This self-selection bias, alongside that fact that all participants were recruited from one city, alongside the fact that twice as many women completed the interview; one could argue that the findings limit transferability. Although a fair argument, the benefit gained from gathering an in-depth exploration of the values of people facing SMD, far outweighs the potential limitations to transferability. The challenges of completing research with individuals facing SMD, alongside the scarce literature directly recruiting people with lived experience (as opposed to gathering information through staff or service-level data) has led to a significant gap in the literature base. Given this, high-quality research is of great importance, to increase understanding and subsequently improve service provision. Although the present project has limitations, it still offers a unique, robust addition to a much-needed literature base.

Given the higher prevalence of males experiencing SMD (Bramley et al., 2015; Sosenko et al., 2020), it is interesting to consider why this project recruited more women than men. The most likely reason is that one of the services recruited from was a female-only service, in which there were a number of highly motivated staff supporting recruitment. Due to this, many service users indicated interest and were able to use support from staff to engage in the interview (e.g., reminders, prompts, support following the interview). In comparison, others who took part in the interview were no longer in supported accommodation or did not want information shared and/or support from staff in regard to the interview. As such, these participants were much more likely to reschedule interviews or not attend. Although a male-only accommodation service was contacted, no participants were forthcoming.

It could be possible that the gender differences found in recruitment were that the research aims were more likely to interest women than men, although a roughly equal number of males and females expressed initial interest in the project. Perhaps there are gender differences in regard to awareness of values or openness to discussing potentially sensitive or personal information. There is a clear lack of literature exploring such topics, indicating a limitation in the value-literature base. It could also have been possible that the inclusion of domestic violence in the definition of SMD led to

increased women meeting the inclusion criteria; however, after reviewing the data, every person included in the study would still meet the inclusion criteria, even if domestic violence were to be removed.

Response Bias. The aforementioned findings, although novel and valuable, must be considered within the limitations of the research. The primary, and most significant limitation of the research is the likelihood of response bias. Participants may have responded with social-desirability bias, trying to answer questions in a way that the researcher would find favourable. Whilst such bias can never be fully removed, especially when discussing sensitive topics such as offending or substance use, the researcher utilised their experience and skill in completing research interview, taking evidenced steps to reduce the possibility of eliciting such bias (Bergen & Labonté, 2020).

The existence of such bias in no way eliminates the utility of the findings, it should however be acknowledged, that the results of this study do not evidence the effectiveness of value-focused support for individuals facing SMD, nor did they intend to. The results, instead, offer a unique insight into the values and valued behaviours of people facing SMD. The findings offer participants' perceptions of the helpfulness of services, and well as offering evidence that people facing SMD feel favourably towards the possibility of value-focused support. Crucially, more research is needed to explore and evaluate the efficacy of value-focused support in homelessness services.

Additional Areas of Disadvantage. The final limitation represents a reflection on the development of the study and where improvements could have been made. Initially, the rationale for gathering only basic demographic data was to try and reduce the load on participants, remaining mindful that long interviews would likely be challenging for most. Also, so as not to make people in a relatively small population, known to many professionals in a relatively small city, identifiable by including too many details. In hindsight, gathering additional information on potential sources of disadvantage may have supported further contextualisation of the results, without losing the need to define SMD to create a sufficient inclusion/exclusion criterion. However, future research doing so should consider how to use this information without risking participants anonymity.

4.2. Extended Clinical Implications

As previously summarised, the present study is the first step towards evidencing the role values could play in supporting people facing SMD. Arguably, values could be integrated to provision of support at a variety of individual and systemic levels as outlined below. Given the local (Everitt & Kaur, 2019), national (Bramley et al., 2015), and global (Wright, 2000) need to improve service provision for homelessness, the following suggestions are made based upon the available literature and present findings.

Wider System. Participants discussed how the attitudes of the general public and individuals within the wider system, as well the stigma associated with experiencing the various facets of SMD, can lead to decreased wellbeing and hinder their ability to enact valued behaviour or change. Evidence of such attitudes and stigma are widely available in the literature (Phelan et al., 1997; Toro et al., 2007), popular media (Devereux, 2015), and in responses to the present study (See Extended Reflection 5.3). Research suggests that increasing the general public's exposure to a highly stigmatised group, such as those facing SMD, leads to an increase in positive attitudes regarding that group (Lee et al., 2004). Arguably, if people were to become more aware of the intricate, individual, and most importantly relatable values and valued actions of people facing SMD, would this help to humanise a highly stigmatised group, potentially reducing the wider stigma and negative attitudes towards people experiencing SMD?

Services. There is growing recognition of the limitations of the provision of support for people facing homelessness and SMD, alongside a greater understanding of the need to treat service users holistically and as a whole person; supporting them to achieve their aspirations, build on their strengths, and live a fulfilling life (Everitt & Kaur, 2019 p.32). Values are a well evidenced, theoretically sound tool that can be integrated in a variety of approaches that could potentially do just that.

Given the complex nuances of value stability, identification, and enactment revealed in the present study, alongside the supporting evidence for increased enactment of valued action and wellbeing; service providers may benefit from considering how to integrate values identification, exploration, and encouragement into their already existing services and interventions available (e.g., include values identification exercise in assessment process; incorporate into pre-existing activities or groups).

The relationship between service user and service provider values was highlighted throughout the results as a significantly helpful or hindering factor in engaging in valued living. This suggests that if services were more able to find aligned values to focus on, rather than continuing to experience ongoing value-clashes, service users, and potentially staff, may benefit. It is important, however, to note that the chronic stress and adversity on organisations supporting individuals who have experienced trauma can impact service delivery (Bloom, 2010) and the responsibility for implementing values work across a service cannot fall to individual staff alone.

It is important to note that values-work may present a potential clash with the commissioned remit of services; if a service is set up to find people move-on accommodation, to reduce offending or substance use, or to improve people's mental health, they may not see values work as relevant to the scope of their service. Given that values work is not embedded into the traditional models or approached used in these services, there needs to be further research to demonstrate whether or not connecting people with their values offers a mechanism through which to achieve the outcomes expected by commissioners.

Given that any service or team's values will be influenced by broader policy and commissioning contexts, there may be a clash between staff members' values and the remit of the service. Some staff, teams, or services may not have ever considered or identified their values, with a high likelihood that some services might not have easily accessible shared values. It may be beneficial for a service or team to identify or re-evaluate their values and make this more explicit to service users. Thus, embedding values into the core of the service and support offered, rather than expecting service users to benefit from a one-off values intervention, especially if that person is unaware of what the service itself values, or feels unsupported in continually enacting valued action.

Staff members experiencing work-place stress and burnout is prevalent amongst services providing support for traumatised individuals (Bloom, 2010), within a challenging system (Buckley et al., 2021). Emergent research is evidencing the use of ACT for frontline homelessness staff in reducing burnout and work-related stress (Reeve et al., 2021). As valued action is a key focus of ACT (Harris, 2009), it could be hypothesised that implementation of values identification and exploration within staff

teams could be a helpful tool to reduce stress, promote wellbeing, and potentially support them to reconnect with ways in which they are enacting their values through their work. Such support could be offered as training, whether in-person or online (for instance the freely available 'ACT on Wellbeing' resource: www.pdunottingham.org based upon the work of Reeve et al., 2021), or as a direct intervention offered to an individual member of staff or a team. There is of course a need to balance the availability of individual staff-support with an ongoing recognition of the need to organisational resilience (NHS, 2019); as such, not putting the onus of change onto individual staff members or teams.

Many homelessness services are moving towards the implementation of PIE or adoption of TIC (Burge et al., 2021; Hopper et al., 2010). Arguably, values could be integrated into either approach, regardless of the primary psychological theory being utilised (Engle, 2017; LeJeune & Luoma, 2019). Services currently considering the implementation of such approaches may wish to consider whether values identification and exploration (whether for service users and/or staff) could be appropriately integrated into their approach.

Staff. Although the evidence base is limited (Murthy et al., 2020; 2021), psychologists working with people experiencing SMD should consider the use of ACT, if appropriately trained, as a contextually appropriate psychological intervention for this population. Professionals providing mental health support, who are not competent in ACT, should consider the implementation of values into their psychological intervention; arguably, vales can be integrated into any intervention, supporting therapists to connect clients to what is most meaningful to them, even within their context of significant suffering (LeJeune & Luoma, 2019). Evidence suggests that values are more effective in sustaining behavioural change than education (Gregg et al., 2007) or creation of a therapeutic space (Lundgren et al., 2006) alone. Such an approach may help therapists to "create a sense that therapy, and life in general, could be focused on something bigger than their struggles" (LeJeune & Luoma, p.55).

Staff working with people facing SMD may also benefit from integrating value-focused support into their role. Given the universally evidenced benefits of values identification and exploration, staff may wish to reflect upon their own values and the ways in which they already enact and could potentially increase enactment of valued behaviour

within their role. Staff may also wish to incorporate values directly into their work with service users to coach people in enacting behavioural changes. The present study highlights that it is possible to complete a value identification exercise and reflective discussion in, on average, 90 minutes. There are numerous easy-to-use, accessible, and creative values identification exercises freely available online, (for instance: https://contextualscience.org/values_exercises). Staff who are interested in supporting a service user to identify their values may wish to use a variety of methods; initially open-ended questions are helpful (i.e., what is important to you? what do you want your life to stand for?), but staff may find that using a structured activity yields more in-depth, reflective responses. Staff may wish to support people in creating a values action plan to help people in enacting and sustaining their chosen valued behaviour (i.e., a step by step guide the person can follow to move towards their values, in-line with their current context and ability, trying, when possible, to mitigate any potential risks). It is important that staff ensure such plans are achievable within the individual's current context, openly discussing where barriers may arise and what could be done to overcome them. Of course, any staff intending on using such an approach should remain mindful of the potential risk of values identification and exploration, using their knowledge and skill to determine the appropriateness of the intervention at any given time. As such, staff should be prepared to understand and think with individuals about ways to enact specific values that feel safe enough within their current context, as well as considering the potential consequences of any planned value action.

4.3. Extended Future Research

Provided that research has focused primarily on the importance of values rather than how they connect to behavioural outcomes (Sheldon & Krieger, 2014), it seems pertinent for research to further explore the connection between values and behaviour, including the efficacy of value interventions of encouraging behavioural change.

Given the complexities of homelessness service provision, it is difficult to elicit results that align with the strict parameters of research. Expecting to start with a problem (e.g., substance use), provide a service (e.g., detox), and then achieve clear results (e.g., sobriety), narrows one's ability to focus on real outcomes for real people (Knight et al., 2017). It has been argued that practice-based evidence linked to theory and tested

against hypotheses is more of a “gold standard” compared to randomised control trials (Cartwright, 2007), particularly applicable regarding research on people experiencing SMD.

Services that are considering implementing value-focused work, should, if possible, try to gather evaluative data on the efficacy of such interventions and disseminate as appropriate. It would be interesting to explore the impact of values support (e.g., values training; reflective practice sessions; ACT-informed interventions) for staff (e.g., work-related stress; burnout; wellbeing; insight; attitudes).

Additionally, professionals embedding values work into their implementation of PIE or TIC into a service, should consider evaluating and publishing these interventions; examples of such service level interventions in homelessness and SMD settings are available (Cockersell, 2016; Burge et al., 2021).

Regarding direct interventions, there are numerous possibilities in terms of evaluating the efficacy, impact, or perception of value-focused support for people experiencing SMD. Professionals completing value-focused group or individual interventions may wish to consider appropriate ways in which to evaluate these, and disseminate, adding much needed evidence to the limited literature base.

Research exploring the collective values of homelessness services, staff teams, and/or staff members may be of interest. Considering where values intersect and/or clash between the various levels of the system may support better understanding of the relationship between values in service users and service providers.

Although preliminary evidence supports the use of ACT in homelessness settings, it is clear that there is a need for more research. Psychologists completing ACT-informed interventions with people who have faced or are facing SMD should consider evaluating, and if possible, publishing such findings in aid of building a better understanding of how to best support people who are experiencing SMD.

5. Extended Reflection

For the purposes of offering a personal, meaningful, and engaging reflection on the research, from here on the primary researcher will refer to themselves in the first person.

5.1. Researcher's stance

To begin, I would like to offer readers an opportunity to understand how I came to this particular research project. I identify as having faced numerous disadvantages throughout my life, some historical (e.g., ACEs) and some current (e.g., physical disabilities). As such, whilst I have no first-hand experience of SMD, I can empathise with the experience of exclusion and disadvantage, having experienced only some of the complex and often invisible barriers in place to receiving much needed support.

On the contrary, I must also acknowledge my significant advantages and power; born a white female in Britain, I had privileged access to free healthcare and education, and any current sources of disadvantage (e.g., physical disability) are invisible, giving me full control of if and when to disclose. In contrast with my early life, I am currently in a position of significant privilege, embarking on a professional career with relative financial security and a level of societal privilege (e.g., a doctoral title).

Prior to beginning training, I completed an MSc placement working with individuals facing SMD and the staff supporting them. This placement and research project fell in nicely with my personal values and general psychological interests upon beginning my career journey. Naturally, having had a successful placement in this area, upon beginning training, I was keen to further study this under-researched population and area of service provision.

It felt appropriate, given the research aims, to spend some time identifying my own values to remain mindful of which values are perhaps less important to me, and as such, ones I may unintentionally pay less attention to (or vice versa). As such, I completed my own PVC (Appendix M) and regularly reviewed this, especially throughout the data analysis stage.

Others have often described me using words such as 'eager', 'bouncy', and 'keen'; I do not hide the fact that I am passionate about helping people, it is after all the primary

reason I chose the career I did. This does however pose difficulties when it comes to viewing the findings through a rose-tinted lens, something I held in mind throughout the project. Given these factors, I readily acknowledge that from the very conception of this project, I had an internal bias towards positive findings – in other words I wanted to *do* and *find* something helpful. Whilst this is a key intrinsic motivator and by no means can be removed from the process, it did mean that I was keen to continually check my biases and transparently reflect upon these to ensure the research was of a high quality.

Disclosure of such experiences hopefully allow the reader to infer not only how I was pulled towards researching and supporting individuals who experience significant exclusion and disadvantage, but also to offer more context within which to place the following reflections.

5.2. Impact of the COVID-19 Pandemic

Initial planning of the study began in September 2019, and on March 16th of 2020, the initial research protocol was submitted and subsequently passed by the course. One week later on the 23rd of March 2020 lockdown measures in the UK legally came into force following the growing concern of the COVID-19 virus (Institute for Government, 2021). Following this announcement, I was forced to make some changes to the study protocol to both increase the likelihood of successfully recruiting participants, and to ensure the safety of all involved, obeying both national and UoN guidance and policies during every stage of the research.

Values Card Sort to Checklist. Originally, the Personal Values Card Sort (PVCS; Miller et al., 2001) was chosen as the structured exercise to identify and explore values with participants. The PVCS has been utilised in a variety of research (Parsons et al., 2013) and was deemed an appropriate exercise for the interview. However, the ethical implications of conducting an exercise that would include sharing of materials in close proximity , given the risk of transmitting the virus, as well as the need to conduct virtual interviews throughout national lockdowns, meant a change in exercise was necessary. The PVC (Harris, 2010) was deemed an appropriate alternative that could be completed easily whether interviews were completed over the phone, video platforms, or face-to-face.

This change was made at the time for purely practical reasons, however in hindsight, I've reflected on how this had unforeseen benefits. At the time of study development, I had not yet completed a PVCS clinically; having since used the tool multiple times, I cannot help but reflect that the card sort may have been too long for the present study. As participant comfort was an important part of the research, by completing the shorter PVC over the PVCS (58 and 83 values respectively), the interviews were better suited to the participants, offering more opportunity to discuss 1 or more value(s) in more detail.

Recruitment. To abide by national lockdown guidance, the recruitment strategy was separated into two primary phases. The first phase focused on recruiting participants from a charity funded SMD outreach service of which every service user would meet the inclusion criteria. Initial recruitment, which began during a national lockdown, focused on individuals who were part of an Expert by Experience group. The rationale for this was twofold: firstly, all group members had been given access to smartphones and training on using video platforms during the first lockdown, and secondly, individuals in this group are familiar with taking part in research as part of their group membership. Following the lifting of lockdown, recruitment then opened to the whole charity-funded outreach service, and I began phase two: outreach to local temporary-accommodation services.

It is undeniable that the impact of the COVID-19 pandemic had a negative impact on my ability to recruit this already challenging-to-reach population. Given the higher risk of contracting COVID if homeless or living in temporary accommodation, services were understandably focused on reducing risk and the need to prioritise safety over all else. As such, at various points during recruitment, services would be locked down and visitors barred from entry. Given the increase of demands on staff, it could be hypothesised that they felt less able/willing to engage with research recruitment when faced with a variety of more pressing demands. Furthermore, it could be assumed that a large proportion of individuals experiencing SMD have limited, if any, access to the technology (e.g., smartphone, computer) required to complete virtual interviews over video platforms such as Zoom or MS Teams. Even if potential participants had access to suitable technology, they may have had limited access to the internet and/or a confidential space with access to charging ports in which to complete the interview.

5.3. Ethical Application

Interestingly, from the onset of developing the project, I noted that the ability to gain ethical approval was questioned by various parties (including supervisors and other staff on the program during academic exercises such as research presentations); these worries often centred around recruitment and data collection. One example arose when, during a feedback session, someone questioned the appropriateness of offering reimbursements to individuals currently using substances. It was argued that excluding such people would be counter to the aims and underlying ethos of the study; as long as the person was able to provide informed consent, did not pose any significant risk to self or others whilst under the influence, and was able to take part in the interview, they should be allowed to partake.

Another example occurred whilst applying for ethical approval, two reviewers commented upon the use of the PVC, highlighting some hesitancies that this was not appropriate to use with the population:

> *"This is a reflective comment: This checklist doesn't feel particularly appropriate for people who have multiple disadvantages. It is hard to read and very long. Many of the values seem like a luxuries for people who are homeless or unemployed. Could the list be rationalised a little?"*

> *"As mentioned by the other reviewer. The use of the personal values checklist may need re-thinking. The list is very long and it may not be feasible for the participants to read through them all. Some also cover more sensitive topics and are not relatable for people experiencing multiple disadvantage. Is there a way for you to select a handful of values and for participants to select from a smaller (less contentious) number? This part of the project needs consideration."*

In response to such hesitancies from the ethical review board, I argued that the act of reducing the values checklist based upon assumptions of what people experiencing SMD may value (or be unable to value as suggested?) would limit the importance of the research. Part of the rationale is that professionals or services, even with good intentions, are likely to be assuming what people facing SMD need/want/find important (e.g., employment, sobriety, housing). This may be acting as a barrier to services being able to offer truly tailored, person-centred support. To ensure that the present

research does not fall into such a trap, I believe it is imperative that participants are given the opportunity to speak to any value they wish to (and of course skip any that are too sensitive or contentious). As such, each participant will be given full control over choosing what values they think are important and which ones they are happy to discuss.

I believe it is appropriate to include this example as it offers a real-life, very live example of the stigma and bias surrounding individuals experiencing SMD, as well as showing how, if I were to have taken their comments on board, my research would have missed the depth and attention deserved by this population. Of course, this is in no way intended to shame the reviewers (as such, they have been completely anonymised including in the appendices); they are in fact offering insight into some of the individual anxieties and wider structural barriers in place that are impeding researchers' ability to study this population. Further highlighting my personal beliefs that this population are not understood at an individual or systemic level, and as such strengthening my rationale for the importance of completing a robust, transparent, and high-quality piece of research.

5.4. Data Collection

Recruitment. The recruitment period began on 23rd April 2021 and ended on 3rd December 2021, resulting in a total of just over 7 months. Given the aim to recruit a notably hard-to-reach population, I had to consider recruitment carefully and utilise a variety of outreach methods. I had to quickly develop good relationships with staff members from a range of services to get their support in recruiting participants. This included attending numerous team meetings to meet staff teams, explain the research and rationale, and asking for support in recruiting. Although staff were under increasing pressures due to the ongoing pandemic, I was incredibly honoured to meet many staff members who responded positively to the project and were keen to support me.

To try and build rapport with potentially interested participants, I arranged a number of drop-in sessions in the services being recruited from. I wanted to make this a casual opportunity to meet potential participants, share the rationale for the research, ask questions, and decide if they would be happy to speak further with me. In terms of the

sessions themselves, the researcher ensured to adopt a casual and friendly approach, utilising their interpersonal skills such as humour and empathy to put participants at ease and build rapport. These sessions were well-attended, and many people expressed an interest in the research, even though many of them were unable or chose not to complete an interview.

Arranging Interviews. Regarding arranging the interviews, I expected a relatively high level of cancellations, missed interviews, and/or requests to rearrange given the complex lives of the individuals being reached out to. As such the only appropriate approach to recruitment was a flexible outreach one: offering to rearrange with participants as many times as needed; conducting interviews over a number of sessions; giving each participant choice in when, where, and how to complete the interview; and liaising regularly with staff and gatekeepers as to when may be an appropriate time to approach an individual. Given this outreach stance, I wanted to remain mindful of being consistent and clear in approaching people, but not overly persistent or in any way coercive. Whilst I would contact individual's numerous times, using various methods (e.g., text, phone, email) this was discussed regularly with staff/gatekeepers as well as in supervision to decide whether to continue to reach out, or whether to assume that the individual was no longer interested in taking part.

Informally, I would estimate that for every interview completed, upwards of 5-10 were cancelled, missed, or the person rescheduled. Although I expected challenges in finding individuals who were interested in taking part, I did not fully anticipate the difficulty of pinning down an interview once someone had indicated their interest. For example, one participant indicated interest within the first week of recruitment, after many interviews were arranged and missed, they completed their interview one month before recruitment ended. Understandably at times this led to frustration and anxiety on my part, given the implications of completing this project and receiving my doctoral qualification. Although small doses of anxiety help to maintain my motivation, I ensured to manage my own wellbeing, utilising reflection, and supervision to place such frustrations within the context of completing the research alongside placement and other course demands, within the wider context of doing so in a global pandemic, with numerous chronic health conditions.

During the Interviews, I ensured to be mindful of managing the session appropriately to ensure the participant did not experience any unnecessary discomfort or distress. This included simple steps such as taking account of the individual's wishes regarding the length of the interview, checking in regularly throughout the interview, and suggesting short breaks when appropriate. Furthermore, I had to use my judgement and skill in managing the interview lengths, accounting for participants engagement and/or ability to continue. This meant carefully considered finding the balance between ensuring enough rich data has been collected from an interview, without pushing the participant to talk for longer than they feel able/wish to. Although I had originally intended to discuss three values in detail with every participant, as I completed my initial interviews, I realised that this was an inappropriate choice. Some participants would speak in so much detail about one value, that the interview would last 90+ minutes, whilst other people would spend the equal amount of time discussing three values in less detail. Given this, I made the decision to use my clinical judgement during the interviews to determine how many values to discuss in more depth. This decision was based upon participants' engagement, the length of the interviews and participants' comfort level, and the quality and sufficiency of the data collected so far. Interestingly, no interview, regardless of the number of values discussed, was shorter than an hour. As such I feel that the choice to be flexible with the number of values discussed in-depth was the correct decision for this study and did not decrease the quality or sufficiency of the data collected.

Of interest during the interviews, I noticed that participants generally had a relatively strong reaction to the use of the miracle question in the open-ended exploration of values. A number of participants struggled to answer the question and a few of those mentioned in passing the limitations of such a question, one person stating that it 'wasn't their cup of tea'. In my clinical experience with various populations, people do tend to either 'gel' with this question or feel quite negatively towards it. Perhaps use of such a question with individuals experiencing SMD can feel too unrealistic, or too far removed from their current context, leading to variable usefulness of the question throughout the interviews. Perhaps if I were to complete further research in the area, I would think more critically about the open-ended questions and perhaps choose those that are more accessible, and less far removed, to this population.

5.5. Data Analysis

In line with the reflexive TA approach, I acknowledged that analysis does not always necessarily follow the linear structure of the original TA model (Braun & Clarke, 2006). Given the context of me completing this research alongside DClinPsy training, it would have been unrealistic to expect to gather all data prior to beginning transcription or analysis. My analysis was much more fluid, completing different stages of analysis for different participants at any given time. I would begin analysis as soon as an interview was completed, maintaining the same linear structure throughout:

1. Transcribe the interview via automated transcription service
2. Check the transcription is accurate by re-listening and re-reading, editing as appropriate
3. Systematically inductively code the transcript
4. Systematically deductively code the transcript
5. Input codes into excel workbook with corresponding pseudonym and line numbers

Completing different stages for different participants at any given time whilst ensuring that each participant's dataset was completed in sequential order, felt like an appropriate balance between practicality (i.e., ensuring I had sufficient time to analyse the data, managing other course demands) and robustness (i.e., systematically coding each dataset, maintaining clarity about the process of analysis especially regarding inductive versus deductive coding). Once every interview was coded, I began to group codes into initial themes; for examples of this process see Appendix J.

Deductive Coding. Initially, five deductive codes were developed, however as I made my way through the deductive coding, I found that I was really struggling to apply the 'attitude' code as outlined in Table 13. In contrast, the four other themes I had developed felt much easier to apply. After perhaps the third interview, I reflected upon why I was struggling so much with this code. I quickly realised that I was getting tied up within the meaning and definition of attitudes within the context of this research. Furthermore, it was challenging to confidently interpret that an attitude had been influenced by a value or vice vera. Through reflection and supervision, I decided that the most appropriate option was to scrap this deductive code. As the aim of my project was not to explore the impact of values on attitudes, the inability to code this dataset

using this deductive framework does not necessarily support the theory that this framework or theory is incorrect.

Table 13. Scrapped Deductive Code

Coding Framework	**Link to Literature**
Does the data show evidence for or against…	*Research suggests that…*
Values impacting attitudes	The process by which values link to behaviour is that values impact attitudes, which in turn influences behaviour (Homer & Kahle, 1988; Maio & Olson, 1994).

Taking a critical stance was a crucial aspect of the entire project, but particularly throughout data analysis. Given the earlier mentioned assumptions and biases I bring to the research it felt important to maintain a critical eye on the data. One such way of doing this involved consciously stepping into an alternative position; re-reading the data/results from the position of a person who holds negative beliefs regarding the SMD population e.g. asking myself questions such as 'what if all the participants are saying what you want to hear just to get the voucher at the end?', 'can we trust participants' perspectives on services as they probably just want someone/something to blame for their own poor choices?'. Whilst this was an uncomfortable position to place myself within, contrasting not only with my values but stance as a clinician and researcher, it supported me in challenging my assumptions and seeing the data through another lens.

One instance of critical thinking occurred in regard to a contradictory theme provided by Helen. Many participants had referred to reduction or abstinence from substances as a key facet in living valued lives. However, Helen had disagreed with this, suggesting that substances were how she lived a valued life (in relation to excitement). It should be noted at this point that I already felt Helen's interview was one of the poorer quality interviews I completed; it was the shortest of the twelve, she often struggled to stay on topic, instead engaging in long complaints about services and how they are at fault for her current context and distress. Although I often felt compassion towards her and empathised with her distress, there were also times I felt less sympathetic towards her, perceiving her as someone who seemed prone to blaming others for her distress. Furthermore, although not confirmed, nor a

requirement to taking part in the interview, I did make a note during Helen's interview that she may have not been completely sober at the time. With these factors in mind, I can understand why my initial response to Helen's rogue theme was to dismiss it. However, as my coding process involved never deleting codes, only moving them between themes, I left Helen's code with the theme and continued analysis.

At a later date, I returned to this theme with a more critical eye. I reflected upon the aforementioned reasons as to why I may feel more inclined to ignore this theme, which allowed me to consider an alternative viewpoint: perhaps Helen's psychological inflexibility or the significant risk of considering her own role in hindering valued living was too emotionally un-containing for her. In other words, if you are doing little to help yourself in regard to the majority of your values, attributing something that you are already doing such as drinking, to a value and focusing in on this, may help to reduce cognitive dissonance and subsequent distress. This led me to think more deeply about the role individuals play in their own suffering, as such I was able to add more nuance to the subtheme *'Challenges Faced by the Individual'*, considering not only how their experiences of SMD challenges their valued behaviour, but also their beliefs, attitudes, and actions. Furthermore, this experience supported me in writing the discussion, finding it easy to connect my research to previous literature having already at point considered it.

Another example occurred as I was pulling quotes from the transcripts to include in the project, I was very mindful of which participants, at that time, I was feeling more positively towards. For instance, I had been notably impressed by Chloe and Hannah's reflective ability and eloquence in articulating themselves during their interviews. As I transcribed and coded the data, this positive feeling towards them was reinforced, they were interesting to transcribe and code. Unlike some other participants, they spent little time talking about unrelated things, meaning that the process of transcribing and checking their interview was slightly less laborious than for others. Given these factors, I was mindful that I would likely be biased towards choosing their quotes to illustrate themes. To combat this, prior to writing up my results section, I systematically went through each theme (utilising my very thorough, and at this stage incredibly helpful, coding workbooks) and pulled quotes from every participant who had contributed to the theme. This document was a helpful tool to use throughout writing the results section; if I reflected that one section had too many quotes from a single participant, I

could return to this document and choose another example to use in the journal paper. Of course, as in all research, those participants who gave more detailed, insightful answers, are much more likely to be quoted more often. However, I felt it was important to ensure that all of the participants were reflected throughout the results section and feel that I balanced this appropriately.

A moment of confidence. A notable moment whilst I was in the depths of analysis occurred as I was attempting to draft my results section outlining the themes using quotes. As I wrote, I ensured to continually question whether my statements were supported by the data, thinking back to the pages of interviews and codes I had been pouring over. Amongst the chaos, I found a moment of joy and confidence in not only myself, but the project as a whole. The moment itself was small, I was writing about how values are individualistic, and to really bring the point home, I wanted to pull in numerous participants' sense-making of a single value. Without thought, I immediately pulled up two transcripts and used the finder tool to quickly find the quote I was looking for. It was not until shortly after that I realised what I had done, I was so immersed in the data, so familiar with each interview and participant, and so invested in the project, that I already knew where to find the data I needed without checking my (incredibly thorough and often helpful) coding/theme workbook. I reflected that this to me, represented my feeling of growing confidence, having found a number of interesting, and in my opinion, significant results.

5.6. Concluding Thoughts

As this project comes towards a close after three years in the making, I believe and hope, it will offer a novel, valuable addition to the literature. I feel confident that I have developed and completed a rigorous, well-evidenced reflexive thematic analysis that offers a truly unique and much-needed insight into the experiences of people facing SMD. Regardless of the challenges, I would encourage anyone with an interest in using psychology to support disadvantaged populations to consider using and researching ACT- or value-informed interventions for services supporting and individuals experiencing SMD. In my experience, the benefits of producing such work far outweigh any costs. I hope that anybody who has got this far has enjoyed reading about this project as much as I enjoyed completing it.

Extended References

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: Development and refinement of a codebook. *Comprehensive Psychology*, *3*(4), 1-7. https://doi.org/10.2466%2F03.CP.3.4

Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners.* John Willey & Sons, Ltd.

Barnes-Holmes, Y., Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). Relational frame theory: A post-Skinnerian account of human language and cognition. *Advances in Child Development and Behaviour, 28,* 101-138, https://doi.org/10.1016/S0065-2407(02)80063-5

Bassuk, E. L., Perloff, J. N., & Dawson, R. (2001). Multiply homeless families: The insidious impact of violence. *Housing Policy Debate*, *12*(2), 299-320. https://doi.org/10.1080/10511482.2001.9521407

Bennett, R., & Oliver, J. E. (2019). *Acceptance and commitment therapy: 100 key points and techniques*. Routledge.

Benton, T., & Craib, I. (2010). *Philosophy of social science: The philosophical foundations of social thought*. Macmillan International Higher Education.

Bergen, N., & Labonté, R. (2020). "Everything Is Perfect, and We Have No Problems": Detecting and Limiting Social Desirability Bias in Qualitative Research. *Qualitative Health Research, 30*(5), 783-792. https://doi.org/10.1177%2F1049732319889354

Bhaskar, R. (1979). *The possibility of naturalism: A philosophical critique of the contemporary human sciences.* Humanities Press.

Bloom, S. L. (2010). Organizational stress and trauma-informed services. *A Public Health Perspective of Women's Mental Health*, 295-311. Springer. https://connectingparadigms.org/wp-content/uploads/2019/05/21360-Organizational_Stress_as_a_Barrier_to_Trauma-Informed-Bloom.pdf

Bloom, S. L., & Farragher, B. (2010). *Destroying sanctuary: The crisis in human service delivery systems*. Oxford University Press.

Boobis, S., & Albanese, F. (2020). *The impact of COVID-19 on people facing homelessness and service provision across Great Britain.* Crisis. https://www.crisis.org.uk/media/244285/the_impact_of_covid19_on_people_facing_homelessness_and_service_provision_across_gb_2020.pdf

Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard Edges: Mapping severe and multiple disadvantage in England.* Lankelly Chase Foundation. https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). *Hard Edges: Mapping Severe and Multiple Disadvantage.* https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

Bramwell, K., & Richardson, T. (2018). Improvements in depression and mental health after acceptance and commitment therapy are related to changes in defusion and values-based action. *Journal of Contemporary Psychotherapy*, *48*(1), 9-14. https://doi.org/10.1007/s10879-017-9367-6

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Braun, V., & Clarke, V. (2014). What can “thematic analysis” offer health and wellbeing researchers?. *International journal of qualitative studies on health and well-being*, *9*(1), 26152. https://dx.doi.org/10.3402%2Fqhw.v9.26152

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality in practice in (reflexive) thematic analysis?, *Qualitative Research in Psychology, 18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Breedvelt, J.F. (2016). *Psychologically informed environments: a literature review.* https://www.mentalhealth.org.uk/sites/default/files/pies-literature-review.pdf

Bronfenbrenner, U. (1979). *The ecology of human development.* Harvard University Press.

Buckley, S., Tickle, A., & McDonald, S. (2021). Implementing psychological formulation into complex needs homeless hostels to develop a psychologically informed environment. *Journal of Social Distress and Homelessness, 30*(2), 164-173. https://doi.org/10.1080/10530789.2020.1786922

Burge, R., Tickle, A. & Moghaddam, N. (2021). Evaluating trauma informed care training for services supporting individuals experiencing homelessness and multiple disadvantage. *Housing, Care and Support.* Advance online publication. https://doi.org/10.1108/HCS-01-2021-0002

Byrne, D. (2021). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity.* Advance online publication. https://doi.org/10.1007/s11135-021-01182-y

Cartwright, N. (2007). Are RCTs the gold standard?. *BioSocieties*, *2*, 11-20. https://doi.org/10.1017/S1745855207005029

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Charmaz, K., & Henwood, K. (2008). Grounded theory. In C. Willig & W. Stainton Rogers (Eds), *The sage handbook of qualitative research in psychology* (pp. 240-259). Sage.

Chase, J. A., Houmanfar, R., Hayes, S. C., Ward, T. A., Vilardaga, J. P., & Follette, V. (2013). Values are not just goals: Online ACT-based values training adds to goal setting in improving undergraduate college student performance. *Journal of Contextual Behavioral Science*, *2*(3-4), 79-84. https://psycnet.apa.org/doi/10.1016/j.jcbs.2013.08.002

Coates, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: Trauma in the lives of homeless youth prior to and during homelessness. *The Journal of Sociology & Social Welfare, 37*(4), 65 -96. https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=3561&context=jssw

Cockersell, P. (2016). PIEs five years on. *Mental Health and Social Inclusion*, *20*(4), 221-230. https://doi.org/10.1108/MHSI-08-2016-0022

Cockersell, P. (2018). *Social Exclusion, Compound Trauma and Recover: Applying Psychology, Psychotherapy and PIE to Homelessness and Complex Needs.* Jessica Kingsley Publishers.

Cook, T., & Campbell, D. (1979). *Quasi-experimentation: Design & analysis issues for field settings.* Houghton Mifflin.

Coppola, A., Verneau, F., Caracciolo, F., & Panico, T. (2017). Personal values and pro-social behaviour. *British Food Journal*, *119*(9), 1969-1982. https://doi.org/10.1108/BFJ-10-2016-0474

Creswell, J. D., Welch, W. T., Taylor, S. E., Sherman, D. K., Gruenewald, T. L., & Mann, T. (2005). Affirmation of personal values buffers neuroendocrine and psychological stress responses. *Psychological Science*, *16*(11), 846-851. https://doi.org/10.1111/j.1467-9280.2005.01624.x

Crisis. (2020). *Government Response to homelessness and COVID-19.* https://www.crisis.org.uk/media/241941/crisis_covid-19_briefing_2020.pdf

Crisis. (2021). *About Homelessness.* https://www.crisis.org.uk/ending-homelessness/about-homelessness/

Critical Appraisal Skills Programme. (2018). CASP Qualitative Checklist. https://casp-uk.b-cdn.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

D'Andrea, W., Sharma, R., Zelechoski, A. D., & Spinazzola, J. (2011). Physical health problems after single trauma exposure: When stress takes root in the body. *Journal of the American Psychiatric Nurses Association*, *17*(6), 378-392. https://doi.org/10.1177/1078390311425187

Dahl, J., Wilson, K. G., Luciano, C., & Hayes, S. C. (2005). *Acceptance and Commitment Therapy for Chronic Pain.* Context Press.

Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *The Journals of Gerontology Series*

B: Psychological Sciences and Social Sciences, *58*(6), 327-337. https://doi.org/10.1093/geronb/58.6.S327

De Bellis, M. D., & Zisk, A. (2014). The biological effects of childhood trauma. *Child and Adolescent Psychiatric Clinics*, *23*(2), 185-222. https://doi.org/10.1016/j.chc.2014.01.002

Department of Health and Social Care. (2017). *UK policy framework for health and social care research.* https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/.

Devereux, E. (2015). *Thinking Outside The Charity Box: Media Coverage of Homelessness.* https://www.feantsa.org/download/devereuxejh2-2015article11259989678303316558.pdf

Devers, K. J., & Frankel, R. M. (2000). Study design in qualitative research--2: Sampling and data collection strategies. *Education for health*, *13*(2), 263-271. https://doi.org/10.1080/13576280050074543

Engle, J. L. (2017). *A Comparison of ACT Values Procedures to Increase Values Behaviours* (Unpublished doctoral dissertation). University of Nevada.

Everitt, G., & Kaur, K. (2019). *Severe Multiple Disadvantage (Multiple Needs) 2019.* https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/joint-strategic-needs-assessment/children-and-young-people/severe-multiple-disadvantage-multiple-needs-2019/

Felitti, V. J. (2004). The origins of addiction: evidence from the Adverse Childhood Experiences Study. https://nijc.org/pdfs/Subject%20Matter%20Articles/Drugs%20and%20Alc/ACE%20Study%20-%20OriginsofAddiction.pdf

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258. https://doi.org/10.1016/s0749-3797(98)00017-8

Fitzpatrick, M., Henson, A., Grumet, R., Poolokasingham, G., Foa, C., Comeau, T., & Prendergast, C. (2016). Challenge, focus, inspiration and support: processes of values clarification and congruence. *Journal of Contextual Behavioral Science*, *5*(1), 7-15. https://psycnet.apa.org/doi/10.1016/j.jcbs.2016.02.001

Fledderus, M., Bohlmeijer, E. T., Fox, J. P., Schreurs, K. M., & Spinhoven, P. (2013). The role of psychological flexibility in a self-help acceptance and commitment therapy intervention for psychological distress in a randomized controlled trial. *Behaviour Research and Therapy*, *51*(3), 142-151. https://doi.org/10.1016/j.brat.2012.11.007

Forman, E. M., Butryn, M. L., Hoffman, K. L., & Herbert, J. D. (2009). An open trial of an acceptance-based behavioral intervention for weight loss. *Cognitive and Behavioral Practice*, *16*(2), 223-235. https://psycnet.apa.org/doi/10.1016/j.cbpra.2008.09.005

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(117), 1-8. https://doi.org/10.1186/1471-2288-13-117

Georgaca, E., & Avdi, E. (2012). Discourse analysis. In D. Harper & A. R. Thompson (Eds). *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 147-162). Wiley.

Gloster, A. T., Klotsche, J., Ciarrochi, J., Eifert, G., Sonntag, R., Wittchen, H. U., & Hoyer, J. (2017). Increasing valued behaviors precedes reduction in suffering: Findings from a randomized controlled trial using ACT. *Behaviour Research and Therapy*, *91*, 64-71. https://doi.org/10.1016/j.brat.2017.01.013

Gloster, A. T., Walder, N., Levin, M. E., Twohig, M. P., & Karekla, M. (2020). The empirical status of acceptance and commitment therapy: A review of meta-analyses. *Journal of Contextual Behavioral Science, 18,* 181-192. https://doi.org/10.1016/j.jcbs.2020.09.009

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist*, *46(*11), 1219-1225. https://psycnet.apa.org/doi/10.1037/0003-066X.46.11.1219

Gregg, J. A., Callaghan, G. M., Hayes, S. C., & Glenn-Lawson, J. L. (2007). Improving diabetes self-management through acceptance, mindfulness, and values: a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *75*(2), 336-343. https://doi.org/10.1037/0022-006x.75.2.336

Grumet, R., & Fitzpatrick, M. (2016). A case for integrating values clarification work into cognitive behavioral therapy for social anxiety disorder. *Journal of Psychotherapy Integration*, *26*(1), 11-21. https://psycnet.apa.org/doi/10.1037/a0039633

Haigh, R., Harrison, T., Johnson, R., Paget, S. and Williams, S., (2012). Psychologically informed environments and the “Enabling Environments” initiative. *Housing, Care and Support*, *15*, 34-42. http://dx.doi.org/10.1108/14608791211238412

Harper, D. (2011). Choosing a qualitative research method. In D. Harper & A. R. Thompson (Eds). *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 83-98). Wiley.

Harris, R. (2006). Embracing Your Demons: an Overview of Acceptance and Commitment Therapy. *Psychotherapy in Australia, 12*(4), 2-8. http://dx.doi.org/10.4236/jssm.2014.73019

Harris, R. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. New Harbinger Publications.

Harris, R. (2010). *Values Checklist: 60-item List.* https://www.actmindfully.com.au/free-stuff/worksheets-handouts-book-chapters/

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (Eds.). (2001). *Relational frame theory: A Post-Skinnerian account of human language and cognition.* Plenum Press.

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012a). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, 40*(7), 976-1002. https://doi.org/10.1177%2F0011000012460836

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012b). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change* (2nd ed.). Guilford Press.

Hayes, S. C., Zettle, R. D., & Rosenfard, I. (2004). Rule-following. In S. C. Hayes (Ed.). *Rule-governed behaviour: Cognition, contingencies, and instructional control* (pp. 191-218). Context Press.

Health Research Authority. (2014). *Payments and Incentive in Research*. https://warwick.ac.uk/services/ris/research_integrity/researchethicscommittees/biomed/faqs/hra-guidance-payments-incentives-research.pdf

Hitlin, S., & Piliavin, J. A. (2004). Values: Reviving a dormant concept. *Annual Review of Sociology*, *30*(1), 359-393. http://dx.doi.org/10.1146/annurev.soc.30.012703.110640

Homeless Link. (2017). *An introduction to psychologically informed environments and trauma informed care.* https://www.homeless.org.uk/sites/default/files/siteattachments/TIC%20PIE%20briefing%20March%202017_0.pdf

Homeless Link. (2018). *The Future Hostel.* https://www.homeless.org.uk/sites/default/files/site-attachments/The%20Future%20Hostel_June%202018.pdf

Homer, P. M., & Kahle, L. R. (1988). A structural equation test of the value-attitude-behavior hierarchy. *Journal of Personality and Social Psychology*, *54*(4), 638-646. https://psycnet.apa.org/doi/10.1037/0022-3514.54.4.638

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. *The Open Health Services and Policy Journal, 3,* 80-100. http://dx.doi.org/%2010.2174/1874924001003010080

House of Commons. (2019). *Rough sleepers: access to services and support (England).* https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7698

Institute for Government, (2021). *Timeline of UK government coronavirus lockdowns and restrictions.* https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

Jayawardhena, C. (2004). Personal values' influence on e-shopping attitude and behaviour. *Internet Research, 14*(2), 127-138. https://doi.org/10.1108/10662240410530844

Joffe, H. (2012). Thematic analysis. In D. Harper & A. R. Thompson (Eds). *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 210-223). Chichester, UK: Wiley.

Johnson, M. (2001). Change in Job Values During the Transition to Adulthood. *Work and Occupations, 28*(3), 315-345. https://doi.org/10.1177%2F0730888401028003004

Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review, 30*(7), 865-878. https://doi.org/10.1016/j.cpr.2010.03.001

Keats, H., Maguire, N., Johnson, R. and Cockersell, P. (2012). *Psychologically informed services for homeless people.* https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf (accessed 24 June 2021)

Kelly-Irving, M., & Delpierre, C. (2019). A Critique of the Adverse Childhood Experiences Framework in Epidemiology and Public Health: Uses and Misuses. *Social Policy and Society.* https://doi.org/10.1017/S1474746419000101

Knight, A. D., Lowe, T., Brossard, M. and Wilson, J. (2017). *A Whole New World: Funding and Commissioning in Complexity.* https://collaboratecic.com/a-whole-new-world-funding-and-commissioning-in-complexity-12b6bdc2abd8

Kristiansen, C. M., & Zanna, M. P. (1988). Justifying attitudes by appealing to values: A functional perspective. *British Journal of Social Psychology*, *27*(3), 247-256. https://psycnet.apa.org/doi/10.1111/j.2044-8309.1988.tb00826.x

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In D. Harper & A. R. Thompson (Eds). *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 99-116). Wiley.

Lee, B. A., Farrell, C. R., & Link, B. G. (2004). Revisiting the Contact Hypothesis: The Case of Public Exposure to Homelessness. *American Sociological Review, 69*(1), 40-63. https://doi.org/10.1177%2F000312240406900104

LeJeune, J., & Luoma, J. B. (2019). *Values in Therapy: A Clinician's Guide to Helping Clients Explore Values, Increase Psychological Flexibility, and Live a More Meaningful Life*. New Harbinger Publications.

Lundgren, T., Dahl, J., Melin, L., & Kies, B. (2006). Evaluation of Acceptance and Commitment Therapy for Drug Refractory Epilepsy: A Randomized Controlled Trial in South Africa—A Pilot Study. *Epilepsia, 47*(12), 2173-2179. https://doi.org/10.1111/j.1528-1167.2006.00892.x

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An acceptance & commitment therapy skills-training manual for therapists.* (2nd ed.). New Harbinger Publications.

Maio, G. R., & Olson, J. M. (1994). Value—attitude-behaviour relations: The moderating role of attitude functions. *British Journal of Social Psychology*, *33*(3), 301-312. https://psycnet.apa.org/doi/10.1111/j.2044-8309.1994.tb01027.x

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, *26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Manicas, P. T. (2009). Realist metatheory and qualitative methods. *Sociological Analysis, 3*(1), 31-46. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.733.9860&rep=rep1&type=pdf

Masuda, A. (2014). *Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice.* Context Press

McCracken, L. M., & Yang, S. Y. (2006). The role of values in a contextual cognitive-behavioral approach to chronic pain. *Pain*, *123*, 137-145. https://doi.org/10.1016/j.pain.2006.02.021

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, *11*(1), 66-78. https://doi.org/10.1177%2F1744987106060192

MEAM. (2018). *About Multiple Disadvantage*. http://meam.org.uk/multiple-needs-and-exclusions/

MEAM. (2019). *Fulfilling Lives: Changing systems for people facing multiple disadvantage.* http://meam.org.uk/wp-content/uploads/2019/06/MEAMJ7105-Fulfilling-lives-publication-WEB.pdf

Miller, W. R., C'de Baca, J., Matthews, D. B., & Wilbourne, P. L. (2001). *Personal values card sort.* https://motivationalinterviewing.org/sites/default/files/valuescardsort_0.pdf

Murthy, V. E., Hussey, I., & McHugh, L. (2020). A single-session Acceptance and Commitment Therapy intervention targeting shame in people experiencing homelessness: A randomized multiple baseline design. Advance online publication. http://dx.doi.org/10.31234/osf.io/3hpuq

Murthy, V. E., Stapleton, A., & McHugh, L. (2021). Self and rules in a sample of adults experiencing homelessness: Relationships to shame, well-being, and psychological inflexibility. *Journal of Contextual Behavioural Science, 21,* 88-97. https://doi.org/10.1016/j.jcbs.2021.06.003

NHS. (2019). *Workforce Stress and the Supportive Organisation: A framework for improvement through reflection, curiosity and change.* https://tavistockandportman.nhs.uk/training/workforce-development/national-workforce-skills-development-unit/stress-and-resilience-framework/

Paez-Blarrina, M., Luciano, C., Gutiérrez-Martínez, O., Valdivia, S., Ortega, J., & Rodríguez-Valverde, M. (2008). The role of values with personal examples in altering the functions of pain: Comparison between acceptance-based and cognitive-control-based protocols. *Behaviour Research and Therapy*, *46*(1), 84-97. https://doi.org/10.1016/j.brat.2007.10.008

Parkinson, S., Eatough, V., Holmes, J., Stapley, E., & Midgley, N. (2016). Framework analysis: a worked example of a study exploring young people's experiences of depression. *Qualitative Research in Psychology, 13*(2), 109-129. https://doi.org/10.1080/14780887.2015.1119228

Parsons, J. T., Lelutiu-Weinberger, C., Botsko, M., & Golub, S. A. (2013). Predictors of day-level sexual risk for young gay and bisexual men. *AIDS and Behavior, 17*(4), 1465-1477. https://psycnet.apa.org/doi/10.1007/s10461-012-0206-1

Phelan, J., Link, B. G., Moore, R. E., & Stueve, A. (1997). The Stigma of Homelessness: The Impact of the Label "Homeless" on Attitudes Toward Poor Persons. *Social Psychology Quarter, 60*(4), 323-337. https://doi.org/10.2307/2787093

Phipps, C.M.J. (2016). "Living here has changed me": Resident and staff perceptions of Psychologically Informed Environments for homeless people. Doctoral dissertation. University College London. https://discovery.ucl.ac.uk/id/eprint/1519858

PIElink. (2020). *PIEs 2.0 – the basics*. http://pielink.net/pies-2-0-the basics/

Prestidge, J. (2014). Using Trauma-Informed Care to provide therapeutic support to homeless people with complex needs: a transatlantic search for an approach to engage the "non-engaging". *Housing, Care and Support*, *17*(4), 208-214. http://dx.doi.org/10.1108/HCS-09-2014-0024

Räsänen, P., Lappalainen, P., Muotka, J., Tolvanen, A., & Lappalainen, R. (2016). An online guided ACT intervention for enhancing the psychological wellbeing of university students: A randomized controlled clinical trial. *Behaviour Research and Therapy*, *78*, 30-42. https://doi.org/10.1016/j.brat.2016.01.001

Reeve, A., Moghaddam, N., Tickle, A., & Young, D. (2021). A brief acceptance and commitment intervention for work-related stress and burnout amongst

frontline homelessness staff: A single case experimental design series, *Clinical Psychology Psychotherapy, 28*(5), 1001-1019, https://doi.org/10.1002/cpp.2555

Reinharz, S. (1993). Neglected voices and excessive demands in feminist research. *Qualitative Sociology*, *16*(1), 69-76. https://is.muni.cz/el/1423/jaro2007/GEN107/um/reinharz_excessive_demands.pdf

Ritchie, J., & Spencer, L. (1994), Qualitative data analysis for applied policy research. In B. Bryman & R. Burgess (Eds.). *Analyzing qualitative data*. Routledge.

Rogers, C. R. (1959). *A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework*. McGraw-Hill.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179-183. https://doi.org/10.1002/nur.4770180211

Sheldon, K. M., & Krieger, L. S. (2014). Walking the talk: Value importance, value enactment, and well-being. *Motivation and Emotion, 38*(5), 609-619. https://psycnet.apa.org/doi/10.1007/s11031-014-9424-3

Shepherd, K., Pritty, B., Tickle, A., & Moghaddam, N. (2021). “I don’t want to take buprenorphine for the rest of my life”: Acceptance and Commitment Therapy for a Client Struggling to Reduce Low-Dose Buprenorphine (a Hermeneutic Single-Case Efficacy Design). *International Journal of Mental Health and Addiction.* https://doi.org/10.1007/s11469-021-00729-2

Shier, M., Jones, M., & Graham, J. (2012). Employment Difficulties Experienced by Employed Homeless People: Labor Market Factors That Contribute to and Maintain Homelessness. *Journal of Poverty*, *16*(1), 27-47. https://doi.org/10.1080/10875549.2012.640522

Shinn, M., & Toohey, S. M. (2003). Community contexts of human welfare. *Annual Review of Psychology*, *54*(1), 427-459. https://doi.org/10.1146/annurev.psych.54.101601.145052

Skinner, B. F. (1976). *About behaviorism.* New York: Vintage Books

Skinta, M., & Curtin, A. (2016). *Mindfulness and acceptance for gender and sexual minorities: A clinician's guide to fostering compassion, connection, and equality using contextual strategies.* New Harbinger Publications.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A., Flower, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* Sage.

Sosenko, F., Bramley, G., & Johnsen, S. (2020). *Gender Matters.* https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf

Spencer, L., & Ritchie, J. (2012). In pursuit of quality. In D. Harper & A. R. Thompson (Eds.). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* John Wiley & Sons.

St Mungo's (2009). *Rebuilding Shattered Lives: the final report.* https://www.mungos.org/publication/rebuilding-shattered-lives-final-report/

St Mungo's (2016). *Stop the Scandal: an investigation into mental health and rough sleeping.* https://www.mungos.org/publication/stop-scandal-investigation-mental-health-rough-sleeping/

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1-18. https://psycnet.apa.org/doi/10.1207/s15327965pli1501_01

Törneke, N. (2010). *Learning RFT: An introduction to relational frame theory and its clinical application.* New Harbinger Publications.

Toro, P. A., Tompsett, C. J., Lombardo, S., Phillippot, P., Nachtergael, H., Galand, B., Schlienz, N., Stammel, N., Yabar, Y., Blume, M., Mackay, L., & Harvey, K. (2007). Homelessness in Europe and the United States: A Comparison of Prevalence and Public Opinion. *Journal of Social Issues, 65*(3), 505-524. https://doi.org/10.1111/j.1540-4560.2007.00521.x

UK Government. (2018). *Data Protection Act.* https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Vilardaga, R., Hayes, S. C., & Schelin, L. (2007). Philosophical, theoretical and empirical foundations of Acceptance and Commitment Therapy. *Anuario de psicología/The UB Journal of Psychology*, 117-128. https://revistes.ub.edu/index.php/Anuario-psicologia/article/download/8442/10417/0

Watson, C., Nolte, L., & Brown, R. (2018). Building connection against the odds: Project workers relationships with people experiencing homelessness. *Housing, Care and Support, 22*(2), 129–140. https://doi.org/10.1108/HCS-10-2018-0030

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. McGraw-Hill Education.

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education.

Wilson, K. G., & DuFrene, T. (2009). *Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy*. New Harbinger.

Woods, D. W., Wetterneck, C. T., & Flessner, C. A. (2006). A controlled evaluation of acceptance and commitment therapy plus habit reversal for trichotillomania. *Behaviour Research and Therapy*, *44*(5), 639-656. https://doi.org/10.1016/j.brat.2005.05.006

World Health Organisation (2012). *WHO and wellbeing at work.* https://www.hsl.gov.uk/media/202146/5_kim_who.pdf

World Medical Association. (2013). Declaration of Helsinki: ethical principles for medical research involving human subjects. *Jama, 310*(20), 2191-2194. https://doi.org/10.1001/jama.2013.281053

Wright, T. (2000). Resisting homelessness: Global, national, and local solutions. *Contemporary Sociology, 29*(1), 27-43. https://doi.org/10.2307/2654929

Yadavaia, J. E., & Hayes, S. C. (2009). Values in acceptance and commitment therapy: A comparison with four other approaches. *Hellenic Journal of*

Psychology, 6(3), 244-272. https://pseve.org/wp-content/uploads/2018/03/Volume06_Issue3_Yadavaia.pdf

Yatchmenoff, D. K., Sundborg, S. A., & Davis, M. A. (2017). Implementing trauma-informed care: Recommendations on the process. *Advances in Social Work*, *18*(1), 167-185. https://doi.org/10.18060/21311

Zinberg, N. (1967). Psycho-analytic training and psycho-analytic values. *International Journal of Psychoanalysis, 48*, 88-96.

Appendices

Appendix A: Ethical Approval



[redacted]Committee : 03/02/2021
Supervisor: Dr Danielle De Boos
Applicant: Sophie Buckley

Project ID 1659 – Project: Exploring the Personal Values of People Experiencing Multiple Complex Needs

Dear Sophie,

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

[redacted]

[redacted] Ethics Subcommittee

[redacted]

[redacted] Ethics Subcommittee

Note: The names and signatures of the reviewers has been redacted to ensure anonymity in regard to section 5.3. Ethical Application.

Appendix B: Ethical Approval: Amendment

[redacted] Committee

29/04/2021

Supervisor:

Applicant : Sophie Buckley

Project: Project Id Exploring the Personal Values of People Experiencing Multiple Complex Needs

Your amendment ref: [redacted] - 2021 - 1659 - 1 has been approved. Please conduct your study following your approved procedures or you will be operating outside your ethical approval.

yours sincerely

[redacted]

[redacted] Ethics Subcommittee

[redacted]

[redacted] Ethics Subcommittee

/

Note: The names and signatures of the reviewers has been redacted to ensure anonymity in regard to section 5.3. Ethical Application.

Appendix C: Participant Information Sheet



University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Exploring the Personal Values of Individuals Experiencing Multiple Complex Needs.

Chief Investigator: Sophie Buckley, sophie.buckley@nottingham.ac.uk, 07743793297

Supervisors: Anna Tickle, anna.tickle@nottingham.ac.uk
Rob Eagle, robert.eagle@frameworkha.org
Dave Dawson, ddawson@lincoln.ac.uk

Ethics Reference Number: 1659

We would like to invite you to take part in a research study exploring personal values (the things that are important to you in life) in individuals who have experienced multiple complex needs. Before you begin, we would like you to understand why the research is being done and what it would involve for you.

What is the purpose of this study?

The purpose of this study is to understand what matters to people who experience multiple complex needs (also known as your values) and what helps and hinders your ability to live in line with these values in your everyday life.

We cannot promise the study will help you but the information we get from this study may help service providers and professionals (e.g. [redacted] NHS services) better understand how to best support individuals experiencing multiple complex needs.

This study is being done for the purposes of an educational qualification. Sophie Buckley is currently training on the Trent Clinical Psychology Doctorate (DClinPsy) and this research will count towards her gaining this qualification.

What do we mean by multiple complex needs?

'Multiple complex needs' also known as 'multiple disadvantage' refers to an individual who has experience of at least three of the following:

1. Homelessness (you do not/ have not always had a permanent place to stay)
2. Mental illness (you struggle with your mental health e.g. low mood, anxiety)
3. Offending (you have been involved with the criminal justice system)
4. Substance use (you have/are using drugs or alcohol)
5. Domestic violence (you have been in/are in an abusive relationship including physical, sexual, emotional, and financial abuse)

University of Nottingham
UK | CHINA | MALAYSIA

What is a value?

Values are what you find most important in life, they are the things that guide the sort of person you want to be and things that you try to do. Values are not limited to your current situation (e.g. you can value love without being in a relationship, you could value safety even if you do not always feel safe). There are no right or wrong values, we all have different things that are important to us.

Here are a few examples of values to give you a better idea of some of the things that may be discussed during this interview:

- Adventure – to be adventurous, to try new things
- Caring – to be caring towards myself, others, the environment etc.
- Fairness – to be fair to myself and others
- Humour – to see and appreciate the funny side of life

Why have I been invited?

You are being invited to take part because you have experienced or are experiencing multiple complex needs (homelessness, mental illness, substance use, offending, and/or domestic violence) and we are interested to hear your thoughts. You may have been approached because you are currently involved with a service that supports people with multiple complex needs (e.g. [redacted]). We are asking 12-15 people who have experienced multiple complex needs to take part in this study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you change your mind you can stop being involved at any point before or during the interview without giving a reason. If you do decide to take part, you will be given this information sheet to keep and be asked to give consent to take part in this study.

You do not need to take part even if you have been told about the study by someone you know (such as a key worker or professional). Deciding not to take part in the study will in no way affect the care you receive.

Are there any possible disadvantages or risks in taking part?

Values are the things that are most important to us and are therefore often personal, so it can sometimes feel uncomfortable talking about these with others. There is therefore a risk that you may feel some discomfort if you take part. However, if there is anything that you do not wish to discuss, or would like to skip over, that is not a problem – we want you to feel comfortable in talking as much or as little about your values as you want to.

What will I be asked to do?

If you agree to take part you will be asked to complete an interview in which you will be asked about your values (what is important to you), what helps you to live in line with your values in your everyday life, and what may get in the way of this.

The interviews will take around one to two hours, depending on how much you would like to share with the researcher.

The interview has three parts:

1. To explain what values are and ask you a few questions that may help you to identify what is most important to you.
2. The interviewer will talk you through a list of 60 values to see which ones you care about (if any). It is important to note that there are no right or wrong answers, this is about what you feel is important.
3. The last stage of the interview will pick out your top three values (identified in stage 2) that you are willing to discuss in more detail. The researcher will then ask you questions about:
    a. If and how you are able to live in line with this value
    b. What may help or get in the way of living in line with this value
    c. If and how services support you to live in line with this value
    d. What are services doing / could services be doing to support you to live in line with this value (or why that may not be important for you if that is the case)

This interview can be conducted over one session, or if preferred, can be conducted over multiple sessions. Breaks can be taken during the interview at any time.

This interview will be recorded by the primary researcher (only audio will be recorded). This recording will be kept private on a secure device, the recordings will then be written up in a password protected computer document (with all identifiable information removed e.g. names / places). Once this has been completed, the recording will be permanently deleted.

Due to the current COVID-19 restrictions, we hope that these interviews can take place remotely e.g. over the telephone or using a video calling service (e.g. Whatsapp, Zoom, Teams, Skype, Facebook Messenger). If you are interested in taking part but do not have access to a telephone or computer, we will make every effort to arrange a way for you to still take part in this study.

If you are interested in taking part in this study, but cannot complete the interview remotely, the researcher can talk to you about the different options. This will be influenced by the most recent guidance around COVID-19 restrictions, research, and working. Unfortunately, at present we cannot guarantee a face-to-face interview will be possible.

Expenses and payments

In recognition of your time, you will be given a £10 Love2Shop gift card at the end of your interview. If you wish to conduct the interview over multiple sessions, the payment for taking part will remain £10, regardless of the number of sessions needed to complete the interview.

What will happen to the information I provide?

Interviews will be written up by the researcher with help from a University approved transcription service. Your information will be kept strictly confidential and stored on passworded and/or encrypted devices.

University of Nottingham
UK | CHINA | MALAYSIA

Any personal details given during the interview (e.g. names or places) will be removed when the recordings are transcribed. Quotes from interviews will be used in the final report, however these will be fully anonymised so that you will not be able to be identified from the quotes.

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 unless you request we destroy that too 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. To safeguard your rights, we will use the minimum personally-identifiable information possible.

If, following completing the interview, you wish to withdraw your data from the study you may do so within a two-week period. After two-weeks, unfortunately we may not be unable to remove your data from the results as it may be mixed with other people's.

What will happen to the results of the research study?

The results of the study will be shared amongst the services that participants are recruited from: Opportunity Nottingham, Framework, The Friary and Emmanuel House. This will be a brief summary of the findings which will be fully anonymised.

The research will be submitted as the researcher's thesis for their Doctorate in Clinical Psychology. The results will also be submitted for publication in academic journals and may be shared at conferences.

You will not be identified in any publication and if you wish to have a copy of the results this can be arranged.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

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 the University of Nottingham's Research Ethics Committee.

Data Protection

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.

University of Nottingham
UK | CHINA | MALAYSIA

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

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used 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 particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

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 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 or telephone number provided above.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the start of this information sheet.

In the event that something does go wrong and you are harmed during the research and this is due to someone'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.

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.pantry@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Appendix D: Recruitment Poster

HAVE YOU EVER EXPERIENCED MULTIPLE COMPLEX NEEDS?

Are you at least 18 years old? Can you speak English?

HOMELESSNESS



You do not / did not have a permanent place to live

Have you experienced at least **3** of these?

MENTAL ILLNESS



You have struggled with your mental health e.g. low mood, anxiety

OFFENDING



You are / have been involved with the criminal justice system

DOMESTIC VIOLENCE

You have been / are in a mentally, physically, sexually, or financially abusive relationship

SUBSTANCE USE



You have used / are using drugs or alcohol

WOULD YOU LIKE TO TAKE PART IN A STUDY?

This study wants to explore what is most important to you (i.e. your values), if and how you live in line with these values, and finally if and how services have been able to support you to live in line with those values.

Why might I want to take part?

Although the results may not directly affect you, we hope this research will increase understanding of how services can improve support for people experiencing multiple complex needs. Participants will get a £10 Love2Shop voucher as a thank you for their time.

What would I have to do?

Take part in an interview (1-2hours) over phone, video chat, or in person (if COVID rules allow). Interviews will be audio-recorded. Responses will be anonymised. If you are interested please get in touch (details below) or ask someone to get in touch on your behalf. We will then send you some more information.

Researchers: *Sophie Buckley,* Trainee Clinical Psychologist; *Dr Anna Tickle,* Clinical Psychologist; *Rob Eagle,* Beneficiary Ambassador; *Dr Dave Dawson,* Clinical Psychologist

Contact us: 07743793297 or sophie.buckley@nottingham.ac.uk

This research has been approved by the University of Nottingham and is funded by Healthcare Education England

Appendix E: Consent Form



University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

Participant Consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Exploring the Personal Values of Individuals Experiencing Multiple Complex Needs

Researcher: Sophie Buckley, sophie.buckley@nottingham.ac.uk, 07743793297

Supervisors: Anna Tickle, anna.tickle@nottingham.ac.uk
Rob Eagle, robert.eagle@frameworkha.org
Dave Dawson, ddawson@lincon.ac.uk

Ethics Reference Number: 1659

- Have you read and understood the Participant Information and had the opportunity to ask any questions? YES/NO
- Do you agree to take part in an interview that will be recorded about your personal values? 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 been interviewed it may not be technically possible to withdraw your data unless requested within 2 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 will be used in academic research reports or publications? YES/NO
- I confirm that I am 18 years old or over YES/NO
- If you would like a summary of the research findings, please insert your preferred way of contacting you here (e.g. telephone number, email address)

  .....

Signature of Participant ..... Date .....

Name (in capitals) .....

Signature of Researcher ..... Date .....

27 April 2020

Appendix F: Interview Schedule

Semi-Structured Interview Schedule

Starting the interview

Start by welcoming the participant and making sure they are comfortable. Remind them of confidentiality. Tell them that if they would like to take a break during the interview to let you know. Tell them that if they wish to stop the interview they can, and that a second interview can be arranged if they cannot complete it in one sitting.

If a physical copy of the consent form has not been acquired the interviewer to ask the participant if they can get verbal consent to take part in the study and record this separately from the main interview. If participant agreed the interviewer to start recording and read aloud the consent form, asking for the participant to state aloud 'yes or no' and finally to state their name and the date.

If informed consent is gathered: Ask the participant if they are happy for the interviewer to begin the recording.

Before we start can I ask you some questions:

How old are you? .....

Out of the criteria for experiencing multiple complex needs which do you meet?

Homelessness / Mental Illness / Substance Misuse / Offending / Domestic Violence

Is your experience of multiple complex needs current or historical? (i.e. are you experiencing 3 of the above now or in the past?) (If historical roughly when was this e.g. last year, 10 years ago etc.)

Gender? F / M / other

Remind the participant of the aims of the research and use the following script to explain what values are:

> "I want to get a better sense of what might be really important to you if you were totally free to choose. We'll call these your "values". Values are what you are passionate about, what is important to you or in other words, what you want your life to stand for.
> So, you might pretend, just for the moment, that all your suffering has ended and that you have no more problems. What would you still find meaningful and worthwhile? What would you still seek, even if there were no problems and no obstacles? That's what I want you to keep in mind."

Phase A

Explain to the participant that some people find it hard to identify what their values are without some help, so I will start by asking them some open questions and then we will complete a values checklist.

- So, remembering that values are what are important to you regardless of your current life situation, does anything come to mind for you straight away?
- Can you think of some examples of things that have been important to you throughout your whole life?
    - Something you have always felt is very important?

- Do you have any guiding forces that you try to think of when you make decisions? Such as a personal motto?
- Suppose you woke up one morning and by some miracle everything you ever wanted, everything good you could ever imagine for yourself, had actually happened – your life had turned out exactly the way you wanted it. Think about it now…
    - How would your life be different? What would you be doing? What would you notice that would let you know that the miracle had happened?

Interviewer to make a note of any values identified through this phase.

Phase B

Interviewer to complete the values checklist with the participant. Interviewer to explain to participant:

"We are now going to do the values checklist, again there are no right or wrong answers. I will read out a list of values and ask that you respond to each of them by saying either 'yes this is important', 'this is kind of important', or 'no this isn't important' (or some variation of Yes – Quite/Somewhat – and Not at all). If I mention a value that you do not feel comfortable talking to me about in any detail, please just let me know by saying skip (or some variation of skip)".

Interviewer to check that the participant understands the instructions and if so to begin reading out the checklist values with the attached definition. During this, the interviewer will make a note of participants answers.

Following completing the checklist, the interviewer will feedback the values that the participant has identified as important and if there are more than three they will ask the following questions:

- So, looking at all the values you have identified as the most important to you, can we spend some time thinking about which are your top three?
- Do any standout to you?
- Are there any values you feel are most important in your everyday life?

If the participant identifies less than three 'very important' values, the interviewer will suggest that the participant pick a value from their 'somewhat important' values in order to ensure each participant has three values to discuss in Phase C.

Once three values are identified, move on to phase C.

Phase C

The interviewer will ask the participant which value they would like to start with (If the participant does not wish to choose, the interviewer will select one). The following questions will then be asked:

- What exactly does this value mean to you?
- What makes this value so important to you?
- Would you say you live in line with this value in your everyday life?
    - Do you find this easy to do?
    - Is the value something you think about often?
    - Do you actively try to live in ways that fit with this value?
    - Do other things often get in the way?
    - Do services/professionals help you live in line with this value?
- What might get in the way of you living in line with this value?

    - How about things that other people may do?
    - How about things that services may do that stop you from being able to live in ways that fit with this value?
    - Do you feel like service providers take into account what is important to you and why this might influence changes you might want to/not want to make?
    - How about things that you might do?
        - E.g. behaviour, thoughts, feelings, other priorities
- What helps you to live in line with this value?
    - What about things that other people have done in the past?
    - Can you think of anything that other people could do, but haven't?
    - Do you think it would help if service providers took the time to understand what is important for you before they try to support you?
        - Yes/No… why is that? What difference would it make?
    - If services focused their support around what you find important do you think you would be more able/willing to engage?
        - Do you think it would be more helpful? Why? What could they do?
        - *(if participants do not understand what this may look like, interviewer to give an example using the value in discussion e.g. if family is important and services were able to focus their support on helping you to spend more time with your family by supporting with finance management in order to pay for transport / supporting with accessing therapy to manage historical trauma that impacts ability to parent etc.)*
    - Can you think of anything that you could do?

Repeat these questions for all three of the participants values identified at the end of phase B.

Concluding the Interview

Once all the values have been explored, ask the participant if they have anything else they think is important to say that the researcher has not asked them.

Thank the participant for their time and ask if they have any questions.

If conducting the interview face-to-face, give the participant the £10 Love2Shop gift card. If conducting the interview over the telephone / video chat, arrange how the participant would like to receive the gift card e.g. send to hostel, arrange for a trusted member of staff to pass on the gift card in their next meeting.

Remind the participant of their two-week window in which to withdraw their data. Remind them that all the information they have given will remain confidential. If applicable interviewer to remind participants that a trusted member of staff has agreed to give them a call at X time / is available to call.

(If still recruiting) Tell the participant that we are still looking for other people to take part in the study, if they know anybody else who they think might like to take part they are welcome to pass on my contact details. Give contact details again if needed.

Contact Details: Sophie Buckley

sophie.buckley@nottingham.ac.uk

phone number: 07743793297

Appendix G: Personal Values Checklist

A Quick Look at Your Values – page 1

Values are your heart's deepest desires for how you want to behave as a human being. Values are not about what you want to get or achieve; they are about how you want to behave or act on an ongoing basis; how you want to treat yourself, others, the world around you.

There are literally hundreds of different values, but below you'll find a list of the most common ones. Probably, not all of them will be relevant to you. Keep in mind there are no such things as 'right values' or 'wrong values'. It's a bit like our taste in pizzas. If you prefer ham and pineapple but I prefer salami and olives, that doesn't mean that my taste in pizzas is *right* and yours is *wrong*. It just means we have different tastes. And similarly, we may have different values. So pick a domain of life that you want to improve, and read through the list below and write a letter next to each value: V = Very important, Q = Quite important, and N = Not so important - *for the specific domain of life you have picked to work on.*

1. Acceptance: to be open to and accepting of myself, others, life etc
2. Adventure: to be adventurous; to actively seek, create, or explore novel or stimulating experiences
3. Assertiveness: to respectfully stand up for my rights and request what I want
4. Authenticity: to be authentic, genuine, real; to be true to myself
5. Beauty: to appreciate, create, nurture or cultivate beauty in myself, others, the environment etc
6. Caring: to be caring towards myself, others, the environment etc
7. Challenge: to keep challenging myself to grow, learn, improve
8. Compassion: to act with kindness towards those who are suffering
9. Connection: to engage fully in whatever I am doing, and be fully present with others
10. Contribution: to contribute, help, assist, or make a positive difference to myself or others
11. Conformity: to be respectful and obedient of rules and obligations
12. Cooperation: to be cooperative and collaborative with others
13. Courage: to be courageous or brave; to persist in the face of fear, threat, or difficulty
14. Creativity: to be creative or innovative
15. Curiosity: to be curious, open-minded and interested; to explore and discover
16. Encouragement: to encourage and reward behaviour that I value in myself or others
17. Equality: to treat others as equal to myself, and vice-versa
18. Excitement: to seek, create and engage in activities that are exciting, stimulating or thrilling
19. Fairness: to be fair to myself or others
20. Fitness: to maintain or improve my fitness; to look after my physical and mental health and wellbeing
21. Flexibility: to adjust and adapt readily to changing circumstances
22. Freedom: to live freely; to choose how I live and behave, or help others do likewise
23. Friendliness: to be friendly, companionable, or agreeable towards others
24. Forgiveness: to be forgiving towards myself or others
25. Fun: to be fun-loving; to seek, create, and engage in fun-filled activities
26. Generosity: to be generous, sharing and giving, to myself or others
27. Gratitude: to be grateful for and appreciative of the positive aspects of myself, others and life
28. Honesty: to be honest, truthful, and sincere with myself and others
29. Humour: to see and appreciate the humorous side of life
30. Humility: to be humble or modest; to let my achievements speak for themselves

Copyright Russ Harris, 2010 www.actmindfully.com.au

A Quick Look at Your Values – page 2

31. Industry: to be industrious, hard-working, dedicated
32. Independence: to be self-supportive, and choose my own way of doing things
33. Intimacy: to open up, reveal, and share myself -- emotionally or physically – in my close personal relationships
34. Justice: to uphold justice and fairness
35. Kindness: to be kind, compassionate, considerate, nurturing or caring towards myself or others
36. Love: to act lovingly or affectionately towards myself or others
37. Mindfulness: to be conscious of, open to, and curious about my here-and-now experience
38. Order: to be orderly and organized
39. Open-mindedness: to think things through, see things from other's points of view, and weigh evidence fairly.
40. Patience: to wait calmly for what I want
41. Persistence: to continue resolutely, despite problems or difficulties.
42. Pleasure: to create and give pleasure to myself or others
43. Power: to strongly influence or wield authority over others, e.g. taking charge, leading, organizing
44. Reciprocity: to build relationships in which there is a fair balance of giving and taking
45. Respect: to be respectful towards myself or others; to be polite, considerate and show positive regard
46. Responsibility: to be responsible and accountable for my actions
47. Romance: to be romantic; to display and express love or strong affection
48. Safety: to secure, protect, or ensure safety of myself or others
49. Self-awareness: to be aware of my own thoughts, feelings and actions
50. Self-care: to look after my health and wellbeing, and get my needs met
51. Self-development: to keep growing, advancing or improving in knowledge, skills, character, or life experience.
52. Self-control: to act in accordance with my own ideals
53. Sensuality: to create, explore and enjoy experiences that stimulate the five senses
54. Sexuality: to explore or express my sexuality
55. Spirituality: to connect with things bigger than myself
56. Skilfulness: to continually practice and improve my skills, and apply myself fully when using them
57. Supportiveness: to be supportive, helpful, encouraging, and available to myself or others
58. Trust: to be trustworthy; to be loyal, faithful, sincere, and reliable
59. Insert your own unlisted value here:
60. Insert your own unlisted value here:

***

Once you've marked each value as V, Q, N (Very, Quite, or Not so important), go through all the Vs, and select out the top three that are most important to you *in this domain of life, at this point in time.* The next step is to start looking at ways to live these values, in this area of life; things you can say and do, guided by these values.

Copyright Russ Harris, 2010 www.actmindfully.com.au

Appendix H: Anonymous Extracts of Inductive Coding

Extracts, rather than full transcripts, are provided to ensure anonymity of participants.

Example 1: Paula (Lines 624-636)

R: Are there any things that services do that can stop you from being able to feel like you can be assertive? P: Yeah when they cut in. When you're trying to talk to them, I've had it done before when you try to talk to them and they're not really listening and they're not really you know, taking in what you're saying. This is because they see you as someone with problems so you shouldn't really know what assertiveness is, and I didn't at the beginning, but some people can undermine you because of your past, because of your conditions you see.	Cutting in stops assertiveness Others: they're not really listening Others: not taking in what you're saying Others: see you as someone with problems Others perceive you as someone who shouldn't know what assertiveness is Assertiveness: I didn't used to know about it Others: can undermine you because of your past Others: can undermine you because of your conditions

Example 2: Jack (Lines 602-615)

R: Great, so if we get started with Adventure can I start by asking what exactly does adventure mean to you? J: It means trying something new. Yeah, it's experiential so. Getting into that through experience, you know so. I used to do a singing group of (group), so yeah. Yeah, it was nice seeing a notice board saying if you ever thought about singing. And this was a number of years ago now. But I had thought about that. And I thought right I'm going to start saying yes to opportunities that present themselves. So, there's an element of that. Trying something new. Also travel, I think as well, that's something that comes up. I've been to (country) a number of years ago and that was really a good a real adventure as well. I spent a couple of months out there. Yeah, and you find new things, yeah.	Adventure: trying something new Adventure: experiential Adventure: used to do singing It was nice seeing the notice board Adventure: singing years ago Self talk: I'm going to start saying yes to opportunities that present themselves Trying something new Adventure: travel (country) that was a real good adventure, I spent a few months there You find new things

Example 3: Chloe (Lines 55-64)

R: Great. So, my first question is having heard that, does anything kind of immediately jump into your head as something that you really value? C: I don't know if this counts, but I value listening to, if I can't read a book, I'll watch videos my favourite talker is sad guru I don't know if you've heard but he does motivation videos and speeches and I think that's one thing I'd continue. Even though I've been through mental health, and I discovered it through that, if I have never been through it, I think it would be something that I'd value and continue with, I mean cause sometimes picking up a book can be really hard so yeah. My value as well would be looking after myself, I could be eating better as well. Erm, I don't know what else my values would be I've never really thought about this before.	SV: Motivational videos and speeches If I can't read a book, I'll watch videos Mot vid: I think I'd continue even if I hadn't been through MH Mot vid: it would be something I'd value and continue with Sometimes picking up a book can be hard SV: looking after myself, eating better I've never really thought about values before

Appendix I: Anonymous Extracts of Deductive Coding

Key:
1. Value stability
2. Values motivating behaviour
3. A relationship between values and wellbeing
4. Connection to meaning

Example 1: Tom (Lines 65-72)

R: My first question is does anything jump into your mind immediately as something that's always been really, really important to you?

T: My family has always been important to me. But I haven't got no family now. That's one of my mental illnesses now I can't be around people I get anxious and sweaty, and I find an excuse to get out of there. It used to be a violent excuse I couldn't say you know sorry I'm losing it, I used to just go (argh), but now I'm finally learning to find a way. So my values are changing definitely for the better I hope.

Example 2: Hannah (Lines 426-433)

H: Erm no, but I reckon it's a skill like anything else, I mean I don't know about you but I believe its one of those things where the more you practice the easier it gets and like I guess what I just said cause you start building up evidence for hey I've done it and I can do it again, but I'll apply it in a different place. erm I don't find it easy at all I find it really hard but the consequences of being courageous are far better than you know hiding away and not doing anything, that's what its like, to me, I don't want to live in isolation or stuff and it takes courage to receive the kind of, receive the blessing of the universe, my head was going to say that wow (laughs) how spiritual... I would have been channelling now (laughs)

Example 3: Megan (Lines 629-635)

R: fitness. So what exactly does fitness mean to you?

M: Both physical and mental. It's very current for me at the minute cause I broke my knee six months ago and I've just finished physio now. I'm walking in house but not outside. Yeah I've got to keep up with my physio and yeah just being physically fit. It's been more important to me over the last six months,

Appendix J: Extracts of Theme Development

See below an example of how data was organised, and subsequent themes developed. In excel, the researcher created a coding workbook (Image 1). They began by entering the participant pseudonym in column A, line number in column B, inductive code in column C, and the deductive code in column D. Following organisation of the whole dataset, the researcher made a note of their initial theme ideas, having been emerged in the dataset for some time (See Image 2). The research then began to apply initial theme ideas in column E where appropriate.

Image 1: Coding Workbook

	A	B	C	D	E	F
198	Jess	577	Im sick of people letting me down		Risk of values	
199	Jess	643-4	Services: say they're going to do this and that but they made me worse		Risk of values	
200	Jack	245-6	Hard to be self compassionate		Risk of values	
201	Jack	647-8	Try to keep connection whilst being removed for safety		Risk of values	
202	Paula	49	Difficult when its your own son		Risk of values	
203	Hannah	139-40	Caring: I've done too much of that and its not getting me anywhere	Wellbeing	Risk of values	
204	Hannah	140	Its time to try not caring		Risk of values	
205	Emily	695-6	Particularly a person that doesn't want to be encouraged can discourage you.		Risk of values	
206	Kate	90-1	Every time someone gets close to me they take advantage		Risk of values	
207	Chloe	718	I had to start smoking just to get a bit of freedom	Motivate Behaviour	Risk of values	
208	Kate	92-3	I warn people when I cant cope but it gets turned round on me		Risk of values	
209	Chloe	664	Spirituality, the more I talk about it the more I think wow I've come a long v	Meaning	Impact of interview	
210	Hannah	446-7	Courage: didn't realise it was a value till we talked about it		Impact of interview	
211	Chris	224-5	Half of values people have got them but don't realise		Impact of interview	
212	Chris	225-7	It would be nice if you could point them out for people like look this is a va	Meaning	Impact of interview	
213	Emily	652	You have encouraged me to do this (interview)		Impact of interview	
214	Emily	1133-4	Values interview: I've enjoyed it today, I'm glad we've done this	Wellbeing	Impact of interview	
215	Harry	193	PVC: It's going to be interesting how this turns out		Impact of interview	
216	Tom	536-7	It was only like what I've said to you or what we matched up with (values)		Impact of interview	
217	Tom	537-9	Adv: this morning I woke up thinking of going to park and I didn't know you would speak about this, that		Impact of interview	
218	Tom	539	Values interview: its made me feel like I had a jigsaw piece and now you've	Meaning	Impact of interview	
219	Tom	568-9	It's you that's made me think of all of that (adventure) this morning, its helped a lot, put it together in m		Impact of interview	
220	Tom	578-9	Adventure: idea of walk, I probably won't go today but I'm going to do it	Motivate Behaviour	Impact of interview	
221	Tom	580-1	This morning when I thought of (adv walk), if you didn't show the chances of my doing it were slim		Impact of interview	
222	Tom	581-4	With you bring adventure up and the PVS, it made me think if I don't do it t	Motivate Behaviour	Impact of interview	
223	Jess	128-9	This (interview) isn't just about you getting your stuff, its about me taking things away		Impact of interview	
224	Jess	128-9.	Interview: benefitting me at the same time		Impact of interview	
225	Jess	625-7	Respect e.g.: I've never met you but I felty rapport, you're not in it for selfi	Wellbeing	Impact of interview	
226	Harry	409-11	If theres a situation I don't understand I get wound up within my own emotions/thinking impacting how		valued behaviour is harder in context	
227	Megan	687	Working, caring, other commitments get in way of fitness		valued behaviour is harder in context	
228	Megan	707	Finances are barrier to fitness		valued behaviour is harder in context	
229	Kate	452	I can't just concentrate on one thing, theres too many thing in my head		valued behaviour is harder in context	
230	Kate	528-9	Music was the only thing helping me communicate and I got told I had to move my speaker		Valued behaviour is harder in context	
231	Chloe	62	Sometimes picking up a book can be hard		Valued behaviour is hard/er in context	
232	Chloe	147	I'm an artist but I have a mental block		Valued behaviour is hard/er in context	
233	Chloe	148	It's just picking up the pen and doing it		Valued behaviour is hard/er in context	
234	Chloe	340	My past always ruins my future		Valued behaviour is hard/er in context	
235	Chloe	341	I want to live freely without being stuck in the past		Valued behaviour is hard/er in context	

All Codes | Jack | Jess | Kate | Tom | Megan | Harry | Emily | Chris | Chloe | Paula | Helen | Hannah

The data was sorted to group initial themes together (See Column E in Image 3), the researcher continued this process until every code was grouped into an initial theme. As seen in Image 3, Column F, as themes changed, codes were moved and regrouped. Some codes, for instance 213-215, were originally grouped in 'Valued Behaviour is Harder' however after reflection and returning to the transcript, these codes were moved to the 'Risk and Reward: *Ability of Lack of*'.

Image 2: First Draft of Thematic Map

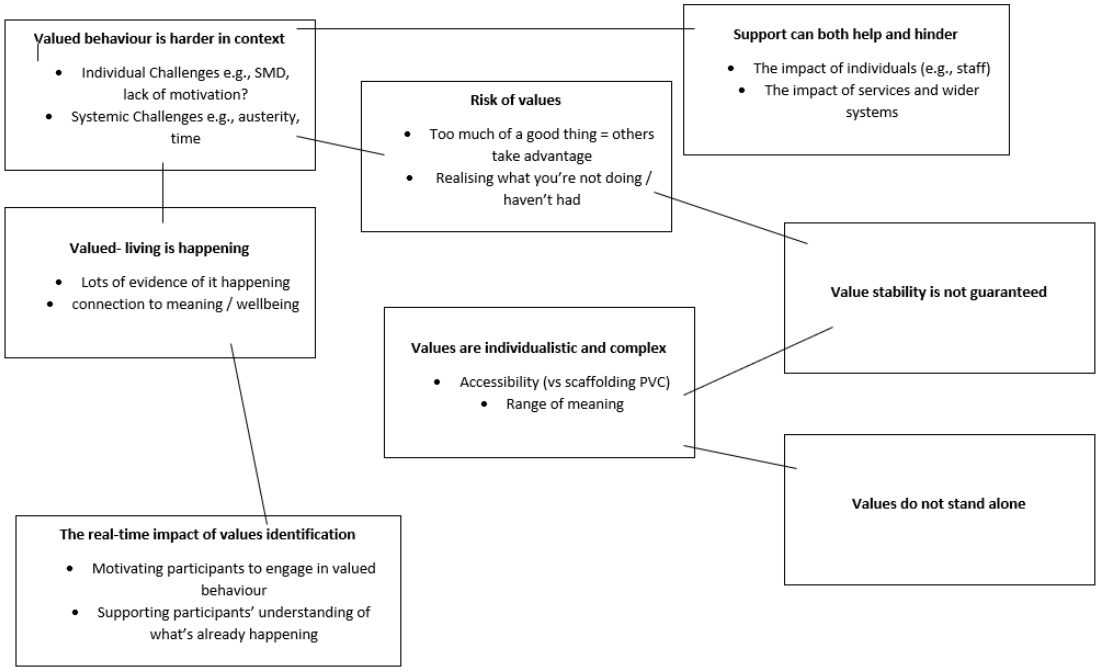


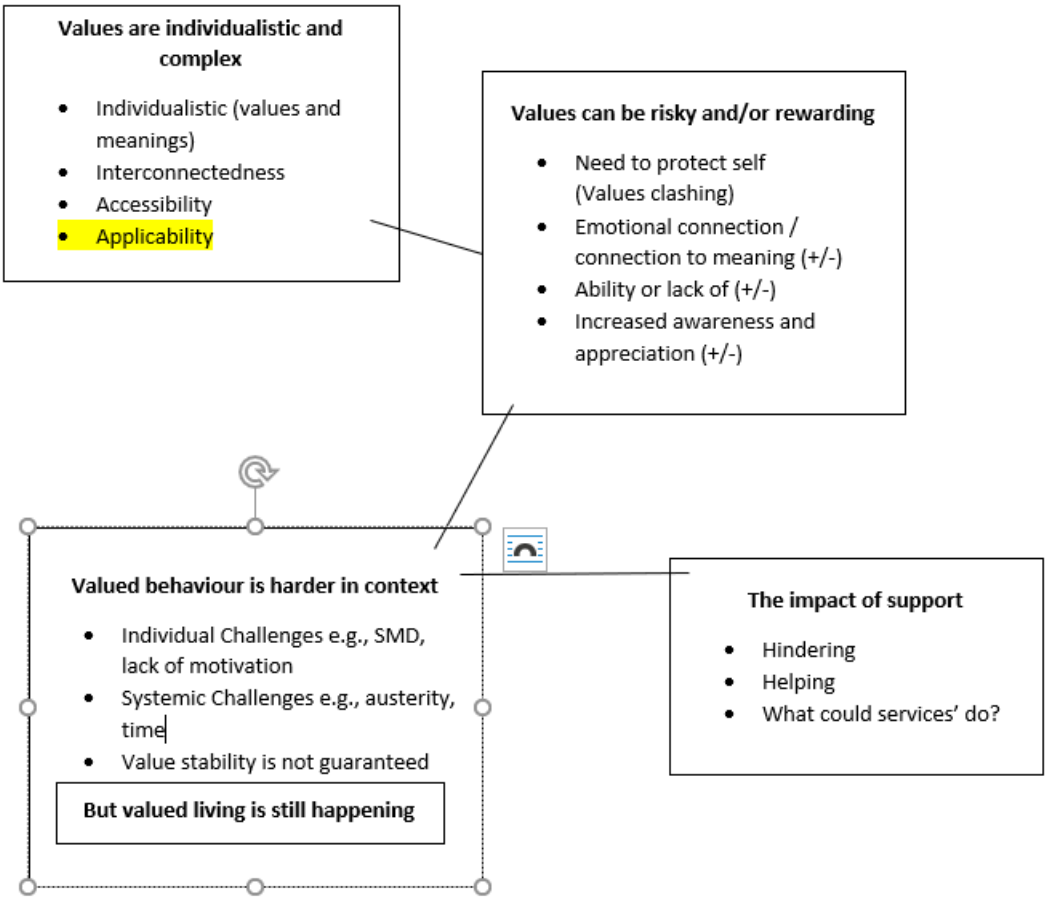
Image 3: Theme Workbook

	A	B	C	D	E	F
179	Jess	479-80	I do need to learn but not important, it's a can of worms, I don't even want to go there atm		Risk of values	Emotional connection
180	Jess	479-80	Fear of values?		Risk of values	Emotional connection
181	Chloe	389	Going to church was crying all the time, spirit books bring something else out of me		Risk of values	Emotional connection
182	Chloe	390	Church is an emotional place it makes me think why me	Wellbeing	Risk of values	Emotional connection
183	Hannah	334	PVC: it feels like an evaluation of where I'm at		Risk of values	Emotional connection
184	Hannah	633-4	Values: I think it would help me but I don't know about the r/ship with a worker and me doin		Risk of values	Emotional connection
185	Emily	260-1	Some people can't receive compassion	Attitudes	Risk of values	Emotional connection
186	Harry	408-9	Acc: It can be tough, I can get frustrated at self,	Wellbeing	Risk of values	Emotional connection
187	Tom	661-2	People haven't helped with my values and what I want because that's the way of life, it isn't		Risk of values	Emotional connection
188	Tom	716-7	I was even thinking about taking (service) to court, but is	Wellbeing	Risk of values	Emotional connection
189	Tom	717-8	If I put aside (what service has done) it goes to childhood	Wellbeing	Risk of values	Emotional connection
190	Jack	245-6	Hard to be self compassionate		Risk of values	Emotional connection
191	Paula	49	Difficult when its your own son		Risk of values	Emotional connection
192	Hannah	632	Values: seem quite an intimate thing		Risk of values	Emotional connection
193	Hannah	638-9	Maybe I'm just emotionally thinking when it comes to values		Risk of values	Emotional connection
194	Emily	1133-4	Values interview: I've enjoyed it today, I'm glad we've d	Wellbeing	Impact of interview	Emotional connection
195	Harry	193	PVC: It's going to be interesting how this turns out		Impact of interview	Emotional connection
196	Jess	128-9	This (interview) isn't just about you getting your stuff, its about me taking things away		Impact of interview	Emotional connection
197	Jess	128-9.	Interview: benefitting me at the same time		Impact of interview	Emotional connection
198	Jess	625-7	Respect e.g.: I've never met you but I felty rapport, you'r	Wellbeing	Impact of interview	Emotional connection
199	Hannah	641-2	Part of the reason im in the situation im in is because I've not been living with my values		Risk of values	Ability or lack of
200	Hannah	642-3	Values: can feel out of reach at times		Risk of values	Ability or lack of
201	Hannah	643	Values: feels like quite a luxury at times		Risk of values	Ability or lack of
202	Hannah	614-5	I'm recognising I want to fly before I can walk		Risk of values	Ability or lack of
203	Hannah	648	Values: there needs to be some set-up-ness, some stability before you can really do that		Risk of values	Ability or lack of
204	Emily	251	Challenge: I don't like jumping in the deep end, you build up to it		Risk of values	Ability or lack of
205	Emily	753-4	One min I'm an expert, then im a SU		Risk of values	Ability or lack of
206	Emily	770	Never been asked about difficulty expert/SU role		Risk of values	Ability or lack of
207	Emily	808	Encouragement: without knowing person you could be adding fire to fire		Risk of values	Ability or lack of
208	Chloe	718	I had to start smoking just to get a bit of freedom	Motivate Behaviour	Risk of values	Ability or lack of
209	Tom	578-9	Adventure: idea of walk, I probably won't go today but I'	Motivate Behaviour	Impact of interview	Ability or lack of
210	Tom	580-1	This morning when I thought of (adv walk), if you didn't show the chances of my doing it wer		Impact of interview	Ability or lack of
211	Tom	581-4	With you bring adventure up and the PVS, it made me th	Motivate Behaviour	Impact of interview	Ability or lack of
212	Emily	652	You have encouraged me to do this (interview)		Impact of interview	Ability or lack of
213	Hannah	610	Values: I'm seeing some of this stuff come further down the line, not hostel		Valued behaviour is hard/er in c	Ability or lack of
214	Hannah	615-6	I'm getting ahead of myself, its Maslows hierarchy	Wellbeing	Valued behaviour is hard/er in c	Ability or lack of
215	Hannah	617	Sometimes you need to get the foundations sorted first	Motivate Behaviour	Valued behaviour is hard/er in c	Ability or lack of
216	Hannah	620	Right now I need someone to remind me to get foundations built		Valued behaviour is hard/er in c	Ability or lack of

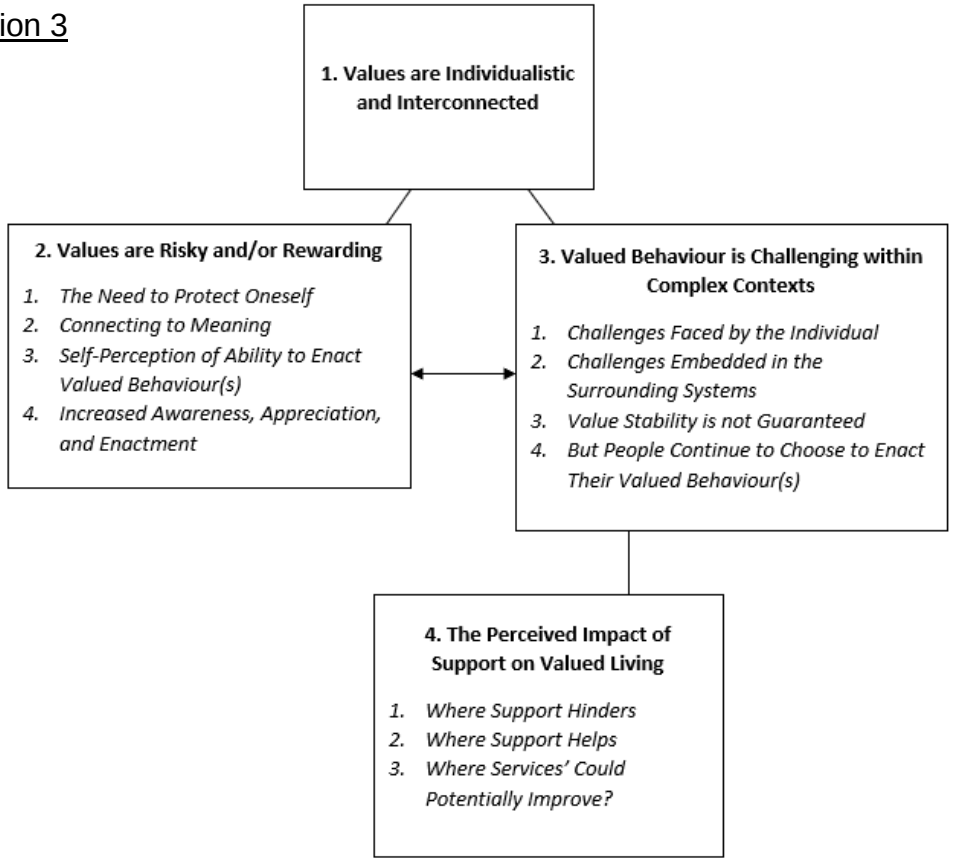
Values individual | High Risk High Reward | Value beh. | Valued living | Support | Bad support | Value stability | connect | impact | MISC

As analysis, reflection, and supervision continued, the thematic map continued to shift and change, as did the names of the themes and subthemes. The remaining images show the progression and shifting of the thematic map over time. For instance, originally 'Value Stability is not Guaranteed' was included in 'Valued Behaviour is harder in context' (See Version 2 & 3), but later moved to 'Values can be risky, rewarding, and unstable' (See Version 4) which was later renamed to 'The Risks and Challenges of Value Identification and Enactment'.

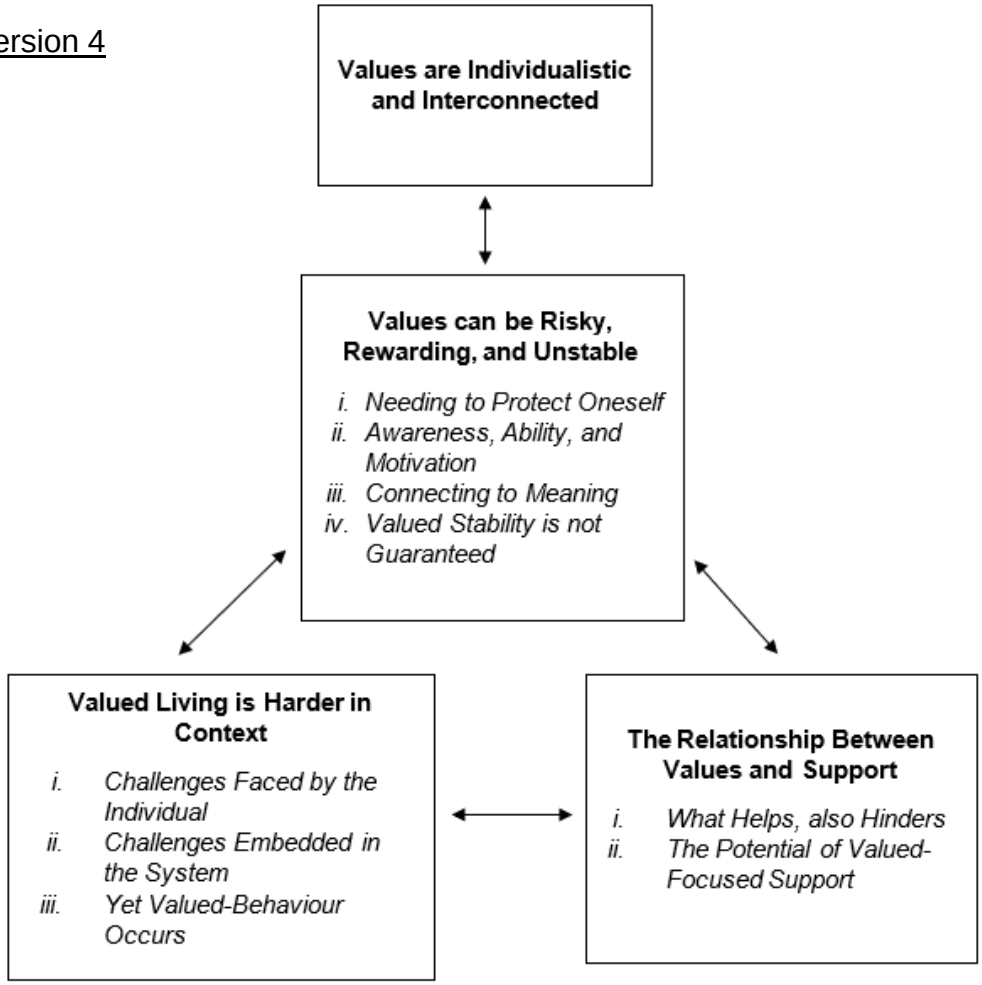
Thematic Map: Version 2



Thematic Map Version 3



Thematic Map Version 4



Appendix K: CASP Qualitative Checklist - completed by primary researcher

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✓ | Can't Tell | No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: The following aims were stated clearly in the introduction: the following research aims to 1) identify and explore the personally held values of individuals experiencing SMD and the barriers and facilitators to enacting such values in their daily lives and 2) explore the perceived helpfulness of service provision in encouraging individual's ability to engage in values-based behaviours and/or change.

2. Is a qualitative methodology appropriate?

Yes ✓ | Can't Tell | No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: The research aims to gain a deeper understanding of the subjective values and experiences of individuals facing SMD. Given the lack of previous literature, the exploratory nature of the research aims, and the desire to gather rich, in-depth data all suggest that qualitative methodology is most appropriate.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✓ | Can't Tell | No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: TA is capable of delivering detailed, rich, and complex data for almost any qualitative research question (Braun & Clarke, 2013); furthermore, TA can span across various theoretical and epistemological stances (Braun & Clarke, 2006). TA therefore appears an appropriate methodological choice that allows the researcher to inductively explore participant's experiences and understanding, as well as deductively explore how values in the SMD population map on to previous literature that can be critiqued for not easily generalising to this population. By utilising such a flexible, multi-faceted approach the researcher was able to explore the research aims, staying true to the data whilst offering a unique insight into the literature base.

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:	The researcher has outlined the participant inclusion criteria, as well as the recruitment process in detail. Purposive sampling was appropriate given the population being recruited and the practical and ethical implications of this are considered. The researcher offers a transparent outline of the recruitment timeline, showing how many individuals were estimated to have been invited to take part in the research, how many people showed interest, how many people took part/refused.

5. Was the data collected in a way that addressed the research issue?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:	Semi-structured interviews are a useful tool to explore participant experiences. The develop of, and final interview schedule are outlined in the research. As well as reporting the use of an expert by experience group to consult on the interview schedule. The researcher offers reflective comments on data collection.

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:	The main researcher approached the research as someone with a desire to improve support for individual's experiencing significant disadvantage or exclusion. With some previous experience researching and working with this population, the researcher readily acknowledges that they approach the project with a number of biases. The researcher does however offer an outline of how these biases were addressed, offering numerous reflective examples of decisions made during the process. Numerous quality checking strategies were implemented.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:	The researcher outlines the process of gaining ethical approval and offers evidence of ethical approval and subsequent amendments. The researcher considers and outlines the ethical implications for completing the study (e.g. informed consent, confidentiality, participant comfort).

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:	The researcher offers an in-depth description of the analysis process, including examples of coding, and theme development. The progress of theme development is outlined through several versions of the thematic map. The researcher offers a reflective account of completing data analysis, considering bias and using supervision and reflection. All findings are supported by numerous quotes from participants. Contradictory findings are discussed.

9. Is there a clear statement of findings?

Yes	✓
Can't Tell	
No	

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:	Findings are discussed and explored in relation to the research aims and relevant literature/theory. Critical reflection and contrary evidence for the findings is offered. The researcher offers detail on the reflective process and use of supervision to bolster findings.

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	The researcher discusses a wide variety of ways in which the findings can be implicated in service provision at a variety of levels. The research discusses what the findings add to the literature base, as well as where further research is needed. The researcher considers generalising the findings to the SMD population in different settings, however does not generalise the findings further as that is counter to the aims of the project.

Appendix L: CASP Qualitative Checklist - completed by independent party

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✔ | Can't Tell | No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: A clear statement of aims is provided in the introduction - an extended account is also provided of the research goals, a rationale for the research, and how the research will contribute to the extremely small existing research base.

2. Is a qualitative methodology appropriate?

Yes ✔ | Can't Tell | No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: A qualitiative methodology appears to be extremely appropriate - the researcher aimed to, amongst other research foci, identify and explore the values of people facing SMD. A methodology intended for exploring subjective experiences therefore appears appropriate and suitable for helping the research to address their research aims.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✔ | Can't Tell | No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: The use of a thematic analysis is explained and justified more than once in this project and the benefits of this approach include its flexible application which allowed the researcher to use a hybrid inductive-deductive approach which allowed them to meet their research aims.

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	✔
Can't Tell	
No	

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:	Yes - the researcher provides a clear explanation of how participants were selected and the lengths the researcher went to in order to access participants who were best-placed to participate in the research whilst ensuring representativeness. Explanations are given as to why some may not have taken part which is also related to the nature of the wider SMD research population, as is discussed by the researcher.

5. Was the data collected in a way that addressed the research issue?

Yes	✔
Can't Tell	
No	

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:	Extensive detail is offered around data collection, as well as clarifying the effortful and flexible lengths the researcher went to in order to access the research population. It is clear that semi-structured interviews were used and this method is justified e.g. it is a useful way of capturing participants' subjective experiences. An interview schedule - which was refined over the course of the study - is provided to make the interview tool explicit. The forms of data generated are clear.

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes	✔
Can't Tell	
No	

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: An extended reflection where researcher highlights how "I was keen to continually check my biases and transparently reflect upon these to ensure the research was of a high quality": the researcher's own role and positioning is considered across a range of domains. The researcher takes a holistic view of events which occurred during the study, including the impact of Covid-19 pandemic, as well as considering the impact of changes in research design e.g. how collecting extra demographic information may have helped to further contextualise the study sample.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	✔
Can't Tell	
No	

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: Appendices demonstrate the information that participants received as well as how the interview was phrased with verbatim quotes provided of how the researcher phrased questions to the participants. This demonstrates key ethical priniciples e.g. right to withdraw and confidentiality. Potential impacts on the study participants are also explored which demontrates the researcher's awareness of the topic - there is a 'risks of harm' section which also clarifies this further. Approval was sought and gained from the ethics committee which is documented in both the text and the appendices.

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ✔
Can't Tell
No

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: The analysis process is explained in the journal paper and expanded on in great depth in the extended paper. Appendices and extended explanation support reader understanding of how themes were developed as well as the process behind the selection of data to display analysis. A wealth of data is supplied and more is provided in the extended paper, supporting the reader's understanding of the project and quality assurance. Contradictory data is explicity considered with a range of viewpoints represented. The lead researcher also honestly and reflectively considers their own position in relation to the research at several points throughout the project.

9. Is there a clear statement of findings?

Yes ✔
Can't Tell
No

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: The findings are clearly outlined on more than one occasion throughout this project. A balanced critique of the work is offered by the researcher, who presents ample evidence to support their own arguments whilst also highlighting limitations which could, to a limited extent, provide evidence against the arguments e.g. self-selection bias. Quality assurance is discussed at length and numerous measures demonstrate the use of this in the project. Findings are also highlighted in relation to the original question at several points within the project to orient the reader.

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	The researcher provides an elaborated account of how the study will contribute to the extremely limited exisiting knowledge/understanding in this area and relevant practice and policy is considered. The researcher also considers gaps in knowledge which future research could work towards addressing. The researcher does not discuss different populations that this work could be transferred to as this would be not be in keeping with the aims of the study which are specific to a circumscribed population. However, findings are discussed in relation to different settings for individuals experiencing SMD.

Appendix M: Primary Researcher's Completed Values Checklist

A Quick Look at Your Values – page 1

Values are your heart's deepest desires for how you want to behave as a human being. Values are not about what you want to get or achieve; they are about how you want to behave or act on an ongoing basis; how you want to treat yourself, others, the world around you.

There are literally hundreds of different values, but below you'll find a list of the most common ones. Probably, not all of them will be relevant to you. Keep in mind there are no such things as 'right values' or 'wrong values'. It's a bit like our taste in pizzas. If you prefer ham and pineapple but I prefer salami and olives, that doesn't mean that my taste in pizzas is *right* and yours is *wrong*. It just means we have different tastes. And similarly, we may have different values. So pick a domain of life that you want to improve, and read through the list below and write a letter next to each value: V = Very important, Q = Quite important, and N = Not so important - *for the specific domain of life you have picked to work on.*

1. Acceptance: to be open to and accepting of myself, others, life etc
2. Adventure: to be adventurous; to actively seek, create, or explore novel or stimulating experiences
3. Assertiveness: to respectfully stand up for my rights and request what I want
4. Authenticity: to be authentic, genuine, real; to be true to myself
5. Beauty: to appreciate, create, nurture or cultivate beauty in myself, others, the environment etc
6. Caring: to be caring towards myself, others, the environment etc
7. Challenge: to keep challenging myself to grow, learn, improve
8. Compassion: to act with kindness towards those who are suffering
9. Connection: to engage fully in whatever I am doing, and be fully present with others
10. Contribution: to contribute, help, assist, or make a positive difference to myself or others
11. Conformity: to be respectful and obedient of rules and obligations
12. Cooperation: to be cooperative and collaborative with others
13. Courage: to be courageous or brave; to persist in the face of fear, threat, or difficulty
14. Creativity: to be creative or innovative
15. Curiosity: to be curious, open-minded and interested; to explore and discover
16. Encouragement: to encourage and reward behaviour that I value in myself or others
17. Equality: to treat others as equal to myself, and vice-versa
18. Excitement: to seek, create and engage in activities that are exciting, stimulating or thrilling
19. Fairness: to be fair to myself or others
20. Fitness: to maintain or improve my fitness; to look after my physical and mental health and wellbeing
21. Flexibility: to adjust and adapt readily to changing circumstances
22. Freedom: to live freely; to choose how I live and behave, or help others do likewise
23. Friendliness: to be friendly, companionable, or agreeable towards others
24. Forgiveness: to be forgiving towards myself or others
25. Fun: to be fun-loving; to seek, create, and engage in fun-filled activities
26. Generosity: to be generous, sharing and giving, to myself or others
27. Gratitude: to be grateful for and appreciative of the positive aspects of myself, others and life
28. Honesty: to be honest, truthful, and sincere with myself and others
29. Humour: to see and appreciate the humorous side of life
30. Humility: to be humble or modest; to let my achievements speak for themselves

A Quick Look at Your Values – page 2

31. Industry: to be industrious, hard-working, dedicated
32. Independence: to be self-supportive, and choose my own way of doing things
33. Intimacy: to open up, reveal, and share myself -- emotionally or physically – in my close personal relationships
34. Justice: to uphold justice and fairness
35. Kindness: to be kind, compassionate, considerate, nurturing or caring towards myself or others
36. Love: to act lovingly or affectionately towards myself or others
37. Mindfulness: to be conscious of, open to, and curious about my here-and-now experience
38. Order: to be orderly and organized
39. Open-mindedness: to think things through, see things from other's points of view, and weigh evidence fairly.
40. Patience: to wait calmly for what I want
41. Persistence: to continue resolutely, despite problems or difficulties.
42. Pleasure: to create and give pleasure to myself or others
43. Power: to strongly influence or wield authority over others, e.g. taking charge, leading, organizing
44. Reciprocity: to build relationships in which there is a fair balance of giving and taking
45. Respect: to be respectful towards myself or others; to be polite, considerate and show positive regard
46. Responsibility: to be responsible and accountable for my actions
47. Romance: to be romantic; to display and express love or strong affection
48. Safety: to secure, protect, or ensure safety of myself or others
49. Self-awareness: to be aware of my own thoughts, feelings and actions
50. Self-care: to look after my health and wellbeing, and get my needs met
51. Self-development: to keep growing, advancing or improving in knowledge, skills, character, or life experience.
52. Self-control: to act in accordance with my own ideals
53. Sensuality: to create, explore and enjoy experiences that stimulate the five senses
54. Sexuality: to explore or express my sexuality
55. Spirituality: to connect with things bigger than myself
56. Skilfulness: to continually practice and improve my skills, and apply myself fully when using them
57. Supportiveness: to be supportive, helpful, encouraging, and available to myself or others
58. Trust: to be trustworthy; to be loyal, faithful, sincere, and reliable
59. Insert your own unlisted value here:
60. Insert your own unlisted value here:

***

Once you've marked each value as V, Q, N (Very, Quite, or Not so important), go through all the Vs, and select out the top three that are most important to you *in this domain of life, at this point in time.* The next step is to start looking at ways to live these values, in this area of life; things you can say and do, guided by these values.

POSTER

"My values keep me well... would they help other people?": A thematic analysis exploring the values and valued behaviours of people facing severe and multiple disadvantage

Sophie Buckley, Anna Tickle, Rob Eagle, & Dave Dawson
Trent Doctorate in Clinical Psychology
University of Nottingham UK | CHINA | MALAYSIA
University of Lincoln

Introduction

Severe and Multiple Disadvantage (SMD[1]) equals 3 – 5 of the domains as seen in the image to the right. Individuals experiencing SMD face poorer service provision and outcomes.[2]



Values are personally important beliefs that motivate behaviour across any context or situation[3]. Research so far has failed to explore the role of values in SMD.

Aims

1. identify and explore the personally held values of individuals experiencing SMD, and the barriers and facilitators to enacting such values in their daily lives.
2. explore the perceived helpfulness of service provision in encouraging individuals' ability to engage in values-based behaviours and/or change.

Method

Participants. 12 people with experience of SMD completed an interview and were given a £10 voucher as a thank you.

Procedure. Participants were recruited via outreach to local services.

Analysis. The recorded interviews were transcribed and analysed using an inductive-deductive Thematic Analysis[5].

Results

There are significant challenges in enacting valued living when facing SMD, however when people choose to do so they find it rewarding, improving their motivation and wellbeing.

Values are Idiosyncratic and Interconnected

Inconsistency in Value Stability

Participants identified a wide range and type of interconnected values they enact in their lives.

The Benefits of Value Identification and Enactment

Support can motivate people and allow them to reap the rewards of valued living. Participants reflect on what services could do to better support valued living.

Services' and service provision can create complex barriers to valued living.

The Risks and Challenges of Value Identification and Enactment

Challenges faced by the individual; challenges embedded in the system; needing to protect oneself

The Relationship Between Values and Support

What helps, also hinders; the potential of value-focused support

Key:
Theme
subtheme

Discussion

The results show that regardless of their context of exclusion and disadvantage, people facing SMD still have a wide range of complex, interconnected values.

Unlike in other populations[6], valued living is much riskier and harder for people facing SMD. In spite of this, people still find ways to live in line with their values. Support can both help and hinder an individuals' progress.

Limitations. Participants were recruited from only two services, limiting generalisability. Twice as many women took part as men. Areas of disadvantage not captured by the definition were missed.

Recommendations. Further research on the use and efficacy of values-focused interventions in SMD is needed. Values work could arguably be integrated into any level of support for those facing SMD to support valued living and change.

References: [1] Making Every Adult Matter (2018), *'About Multiple Disadvantage'*, available at: http://meam.org.uk/multiple-needs-and-exclusions/ (accessed 24 June 2021); Sosenko, F., Bramley, G. and Johnsen, S. (2020), *'Gender Matters'*, available at: https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf (accessed 24 June 2021) [2] Moore, G., Manias, E., & Gerdtz, M. F. (2011). Complex health service needs for people who are homeless. *Australian Health Review, 35*(4), 480-485. [3] Wilson, K. G., & DuFrene, T. (2009). *Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy.* Oakland, CA: New Harbinger.; Chase, J. A., Houmanfar, R., Hayes, S. C., Ward, T. A., Vilardaga, J. P., & Follette, V. (2013). Values are not just goals: Online ACT-based values training adds to goal setting in improving undergraduate college student performance. *Journal of Contextual Behavioral Science, 2*(3-4), 79-84. [5] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. [6]LeJeune, J., & Luoma, J. B. (2019). *Values in Therapy: A Clinician's Guide to Helping Clients Explore Values, Increase Psychological Flexibility, and Live a More Meaningful Life.* New Harbinger Publications.

SMALL SCALE RESEARCH PROJECT

Implementing Psychologically Informed Environments in Homelessness Services: A Qualitative Exploration of Staff Teams' Self-Assessments.

Author(s)

Sophie Buckley[1], Dr Anna Tickle[2]

[1] University of Nottingham

[2] University of Nottingham

Statement of Contribution

I, Sophie Buckley, declare that this systematic literature review is the product of my own work completed as part of the Trent Doctorate in Clinical Psychology. Dr Anna Tickle provided supervision and guidance throughout.

Abstract

Purpose: To explore perceptions of staff in four teams regarding the implementation of Psychologically Informed Environments (PIE) across a community service and three hostels supporting individuals facing severe and multiple disadvantage.

Design: Utilising a pre-post design, the PIEs Assessment and Self-Development for Services (known as the PIZAZZ) was completed by staff before the implementation of PIEs and at a six month follow up. A narrative review of the results and thematic analysis of the qualitative data is presented.

Findings: The majority of the PIZAZZ elements were rated as improved following PIE implementation. Thematic analysis developed three themes influencing staff members' ability to develop a PIE: Complexities of Our and Wider Systems; Ready-made or Baked from Scratch; and Reflective and Responsive Staff.

Limitations / Implications: A planned one-year follow up was obstructed by the coronavirus pandemic, limiting understanding of longer-term impact. Having only gathered data from staff members, the results cannot corroborate staff members' perceptions. Further research could explore other stakeholder perspectives, as well as the impact of PIE implementation on staff perception of resources, and of a possible ceiling effect for hostels trying to develop PIE.

Originality: To the authors' knowledge, this is the first UK study to use the PIZAZZ to evaluate the implementation of PIE.

Introduction

Severe and Multiple Disadvantage (SMD) can be defined as experiencing at least three of the following: homelessness, substance use, offending, mental health, and domestic violence (Making Every Adult Matter, 2018). Those facing SMD endure challenges grounded in local contexts and wider social inequalities (Shin and Toohey, 2003). The UK government austerity agenda has created a context of limited resources, increasing pressure on service providers (Watson *et al*., 2018). This has been exacerbated by the impact of COVID-19, which has further highlighted pre-existing structural barriers and led to growing concern over funding in the immediate and long-term (Boobis and Albanese, 2020). Arguably, the need to provide evidence-based support that accounts for the systemic and individual complexities existing for individuals facing SMD is more important than ever. The interest in implementing Psychologically Informed Environments (PIE; Johnson and Haigh, 2010) in homelessness settings has grown since good practice guidelines were published (Keats *et al*., 2012) and services have moved towards the PIE approach to improve the support offered (Homeless Link, 2018).

PIEs represent a system-wide approach to working, rather than a specific intervention, and have five key elements: *psychological awareness*; *staff training and support*; *learning and enquiry*; *spaces of opportunity*; and the *three R's* (the roles, rules, and responsiveness of the service). Crucially, these elements are underpinned by a central focus on developing and maintaining trusting and positive relationships across the system (PIElink, 2020a). Furthermore, no two PIEs look the same as the ways to implement the underlying elements are as varied as the individuals accessing the service (e.g., Keats *et al.,* 2012).

The evidence base for PIE is emergent, but as PIEs rely on 'innovative localism' (Haigh *et al*., 2012), there is a lack of comparable data available to rigorously answer the question 'are PIEs effective?' (Cockersell, 2016). Given the complexities of homelessness service provision, it is difficult to elicit results that align with the strict parameters of research and clearly quantifiable and definable 'hard' outcomes; expecting to start with a problem, provide a service, and achieve clear results narrows one's ability to focus on *real* outcomes for *real* people (Knight *et al*., 2017). Alternatively, 'soft' outcomes (achievements on the way towards 'hard' outcomes) arguably represent the primary outcomes achieved by disadvantaged groups (Welsh

European Funding Office, 2003). As such, research in this area is faced with the challenge of balancing the need for comparable and robust studies with being realistic about what is possible, and what will be helpful for stakeholders. It has been argued that such practice-based evidence, linked to theory and tested against hypotheses, is more of a "gold standard" for evidence compared to randomised control trials (Cartwright, 2007).

Nevertheless, one can tentatively conclude emerging evidence that PIEs can achieve more positive outcomes or staff and service users than services not run as PIE (e.g., Cockersell, 2016; Breedvelt, 2016; Phipps, 2016; Homeless Link, 2018; Williamson, 2021). A primary recommendation of Breedvelt's (2016) review of the effectiveness of PIE was the development of an evaluative framework that could be used comparatively across services. Subsequently, Johnson (2018) developed a freely accessible PIE self-assessment tool (PIZAZZ; PIElink, 2020b). Whilst used in practice (Middleton, 2018), there remains a lack of peer-reviewed literature using the measure. Middleton (2018) argues that organisations tend to be anxious about exposing their internal self-assessments to judgement from others; however, assessment of current services sets the foundation for further service development and is fundamental to the 'learning and enquiry' element of PIE.

Baking this PIE

Evidence suggests that the effectiveness of PIE is probably linked to the support from qualified clinicians (Cockersell, 2016). As such, two clinical psychologists were employed to lead a programme of service development. The approach to PIE implementation was multifaceted: intensive training for all teams; regular team psychological formulation meetings; and a regular presence of the psychologists in the services to support day-to-day psychological thinking and offer support to staff. Each of the five PIE areas were considered in the development and delivery of each aspect.

Training

An intensive four-day training was written and delivered by the clinical psychologists, a social worker, and a cognitive behavioural therapist. These were delivered to four teams, from three hostel and one community service. Team members were mixed during training, both to share ideas across services and allow services to continue to run. The training was split into two days focusing on PIE and two dedicated to trauma-

informed care (TIC) due to the high prevalence of trauma experienced by service users (Cockersell, 2018). Staff were introduced to the five key PIE elements alongside principles of cognitive-behavioural and attachment theory (Beck, 1970; Bowlby, 1969) to support understanding of individuals facing SMD (Connolly, 2018). The TIC days focused on the complex trauma experienced by service users, such as the relationship between adverse childhood experiences and mental and physical health difficulties (Felitti *et al*., 1998). Staff were encouraged to consider vicarious trauma (McCann and Pearlman, 1990) and their responses, as individuals and as a service. All four days were in keeping with the PIE approach, but the TIC elements were evaluated separately (Burge *et al*., 2021); results suggested TIC training had a beneficial effect on some components of TIC and is a necessary foundation to embed TIC, but also that a wider culture shift is essential to cement meaningful change in practice.

Team Formulation Meetings

Concurrently, a clinical psychologist facilitated team psychological formulation meetings in the four services. Each focused on a single service user staff wished to discuss and was structured to develop cognitive-behavioural developmental formulations (Beck, 1970), incorporating attachment theory (Bowlby, 1969). A separate evaluation (Buckley *et al*., 2020) showed these meetings increased staff members' psychological awareness and understanding of service users, and encouraged staff to stop, think, and do something different. However, they also highlighted the various difficulties of working within a constrained system.

The aim of the current study was to conduct a broad evaluation of team members' perceptions of the implementation of PIE across a community service and three homeless hostels providing services for individuals facing SMD. The objectives were to compare staff team 'PIZAZZ' self-assessments of their service before and after implementation, and identify reported helping and hindering factors in the implementation of PIE.

Method

Approval for the present evaluation was gained through the governance and approval processes of the organisations involved. Ethical principles were maintained throughout e.g., informed consent was gained, participation was voluntary, and the services remain anonymous.

Participants

Four staff teams supporting individuals facing SMD in the Midlands, UK participated. One team were from a charity funded community outreach programme, developed with some of the preliminary ideas of PIEs in mind and good financial resource to support service users. Three teams were from ‘complex needs’ hostels commissioned to provide temporary housing and support for up to six months. Data on individual staff members were not collected data were a collective ‘team’ assessment.

Measure

The PIEs Assessment and Self-Development for Services i.e., PIZAZZ (PIElink, 2020b) was used. The PIZAZZ is a ‘distance-travelled’ measure created to facilitate a more informed discussion between service providers, frontline staff, and researchers (PIElink, 2020c). The key elements of PIE are divided into sixteen categories (Table 14); teams collectively rate each of these on a sliding scale from poor, basic, progressing, and finally advanced. To reduce potential subjectivity in responses, guidance is available to define these levels (PIElink, 2020b). Participants then record evidence their rating, as well as factors that ‘help’ or ‘hinder’ the services PIE progress, and then write an action plan.

Table 14: PIE Elements and Corresponding PIZAZZ Categories.

PIEs Element	PIZAZZ Category
Psychological Awareness	Psychological awareness Approaches and techniques Psychological Model
Staff Training and Support	Staff training Staff support
Learning and Enquiry	A Culture of Enquiry Reflective Practice Sector Engagement Evidence-generating practice
Spaces of Opportunity	Building and grounds Networks and surroundings Systems integration
Three R's	Rules Roles Responsiveness
Centrality of relationships	Centrality of relationships

Procedure

Staff completed the PIZAZZ at time one, prior to PIE implementation, and at time-two roughly six-months after training. All members of staff were invited to complete the PIZAZZ individually and anonymously to contribute their anonymous views to the collective team-wide discussion, although only three people did so. These anonymous responses were brought to a team meeting facilitated by a psychologist and attended by as many team members as possible. The team members completed each section of the PIZAZZ through discussion. The feedback from this meeting was written up by the facilitator into the online PIZAZZ (the iAbacus; PIElink, 2020d), as such, the quotes presented throughout the study reflect paraphrasing of discussion in the session, rather than a single staff member. At time two, the staff did not have access to the responses at time one, to limit any bias towards improvement in the responses given. A one-year follow up had been planned but coincided with first UK lockdown in response to the Covid-19 pandemic. Due to pressures on services at this time, it was not possible to adapt data collection.

Analysis

An independent third party anonymised the time point and service identifier of each data set prior to analysis. A narrative review of the PIZAZZ ratings will be provided alongside a thematic analysis (Braun and Clarke, 2006; Braun *et al*., 2020) of the qualitative data extracted from the sections focused on evidence and helping and hindering factors. A critical realist epistemological stance was taken, i.e., that there is no 'one truth' but that reality is heavily influenced by the context within which it is placed (Benton and Craib, 2011; Bhaskar, 2009). As such, the researcher un-blinded themselves to the service and time point of each data set prior to finalising themes or writing up the report.

Reflexivity

The first author has experience working in the services being evaluated, as well as a general interest in using psychology to support disadvantaged individuals. The second author is one of the psychologists who delivered the training and was based in the services. Prior to starting the research, the authors acknowledged the likelihood of researcher bias towards positive results and as such, preventative steps were taken. This included the decision to anonymise the data prior to analysis, keeping a reflective diary, and utilising supervision to support ongoing reflection.

Results

All four staff teams rated the majority of PIZAZZ categories as improved at time two (Figure 7). Whilst the community service rated more areas as unchanged or decreased at time two, it should be noted that their initial scores at time one were much higher than in the hostels (Figure 8). Interestingly, Hostel A was the only service to rate themselves as improved in every area (Figure 9); whilst Hostels B (Figure 10) and C (Figure 11) both identified the same number of (albeit different) areas that remained unchanged or decreased at time two. Qualitative analysis developed three themes regarding the helping and hindering factors of implementing PIE: Complexities of Our System and Wider Systems; Ready-made or Baked from Scratch; and Reflective and Responsive Staff. For brevity, the hostels are referred to as HA, HB and HC respectively and the community service as CS. T1 and T2 refers to Time 1 and Time 2 PIZAZZ results.

Figure 7: Overview of Changes in PIZAZZ Ratings

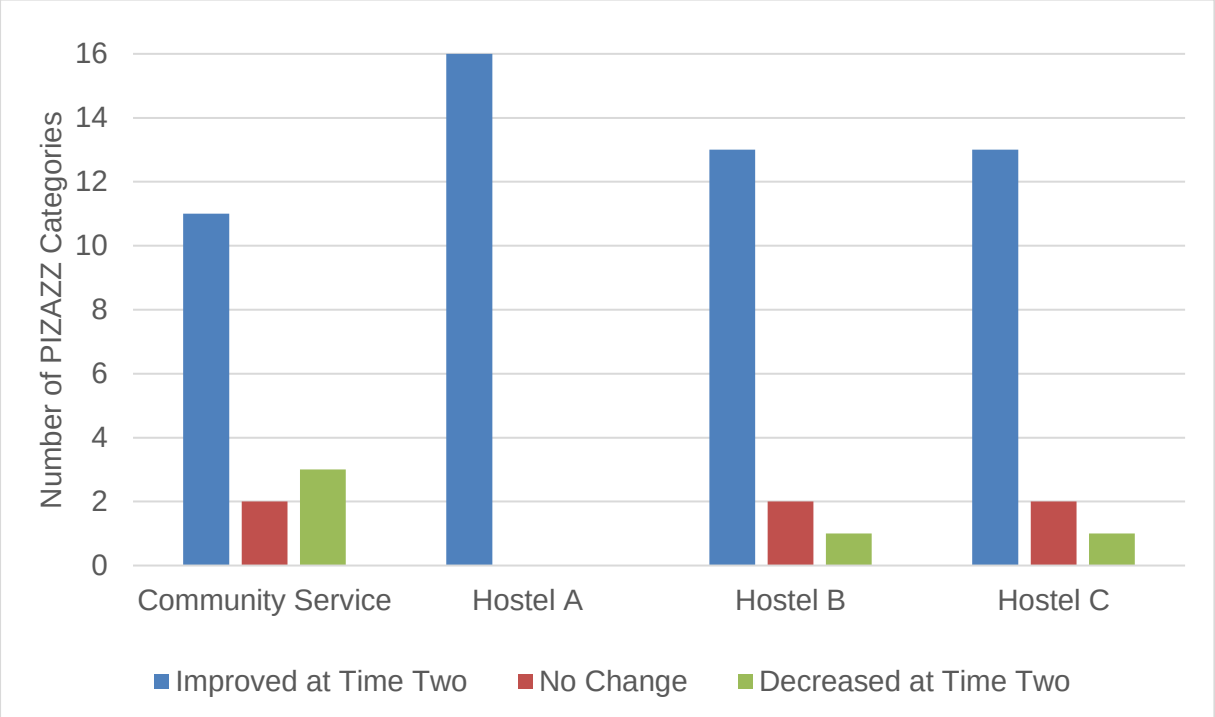


Figure 8: Community Service PIZAZZ Ratings

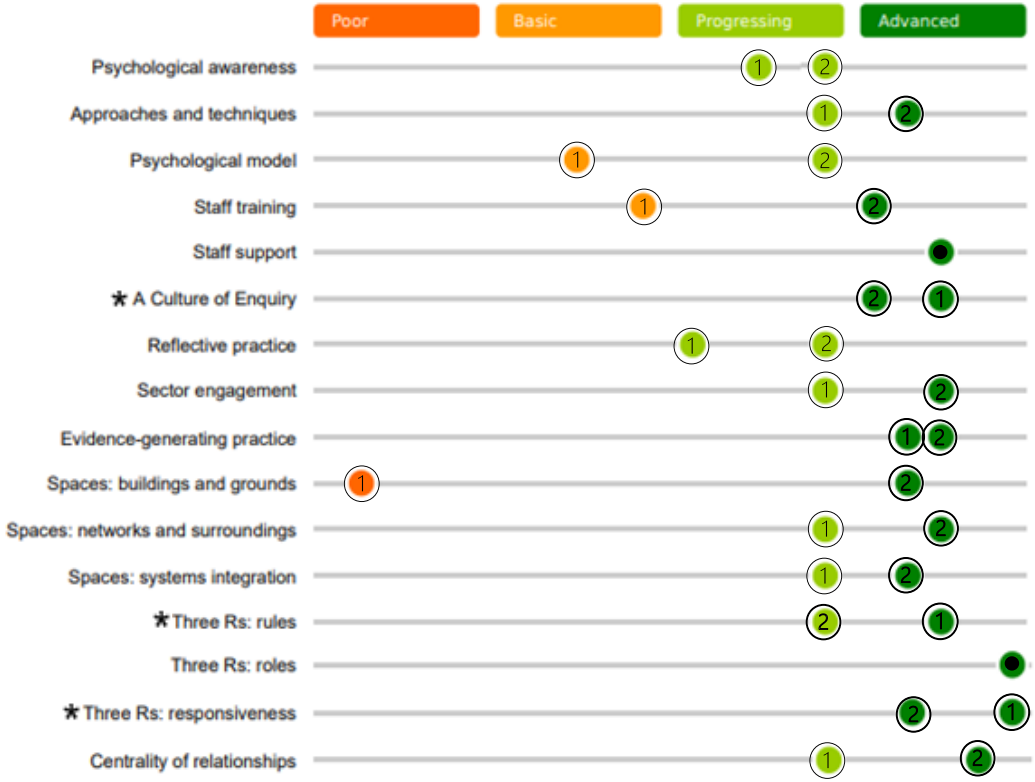
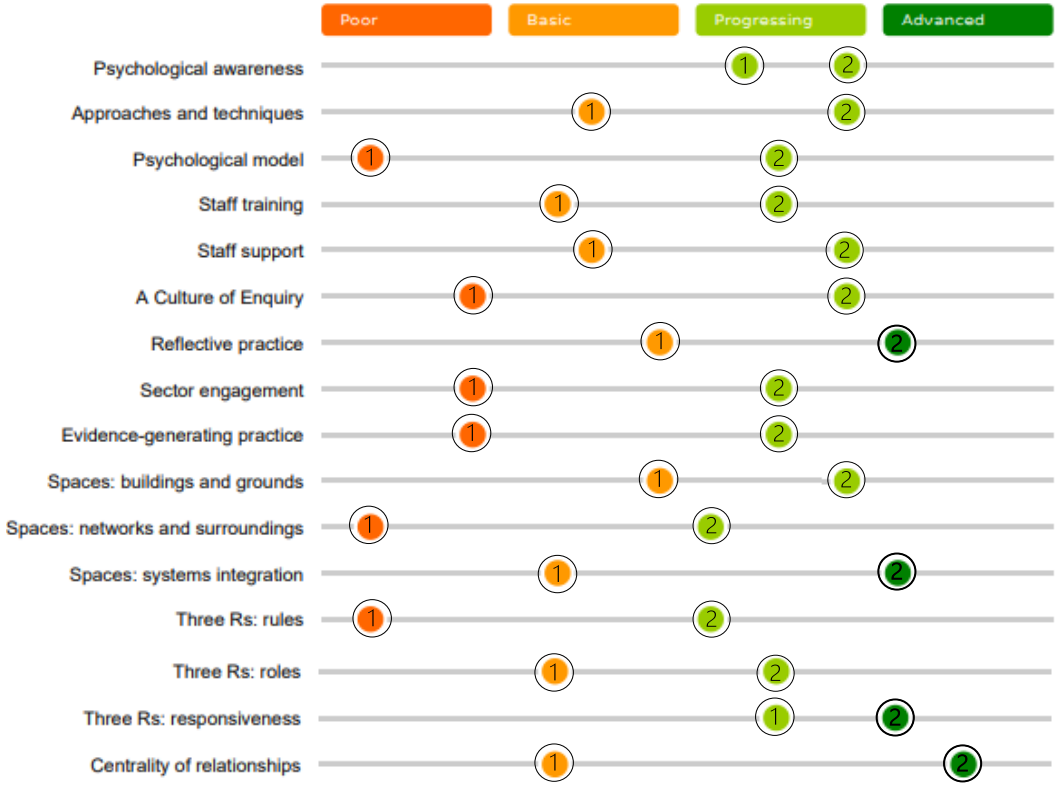


Figure 9: Hostel A PIZAZZ Ratings



*N.B.: ① ② refer to time 1 and 2 respectively; • refers to no change between times; * refers to a decreased score at time two.*

Figure 10: Hostel B PIZAZZ Ratings

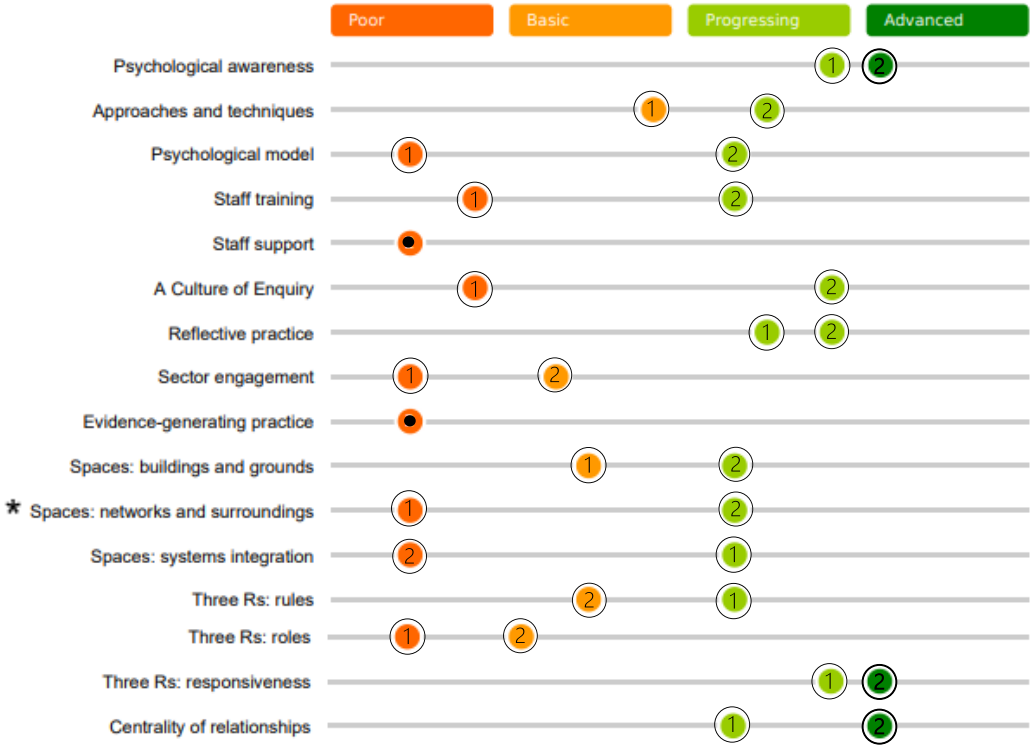
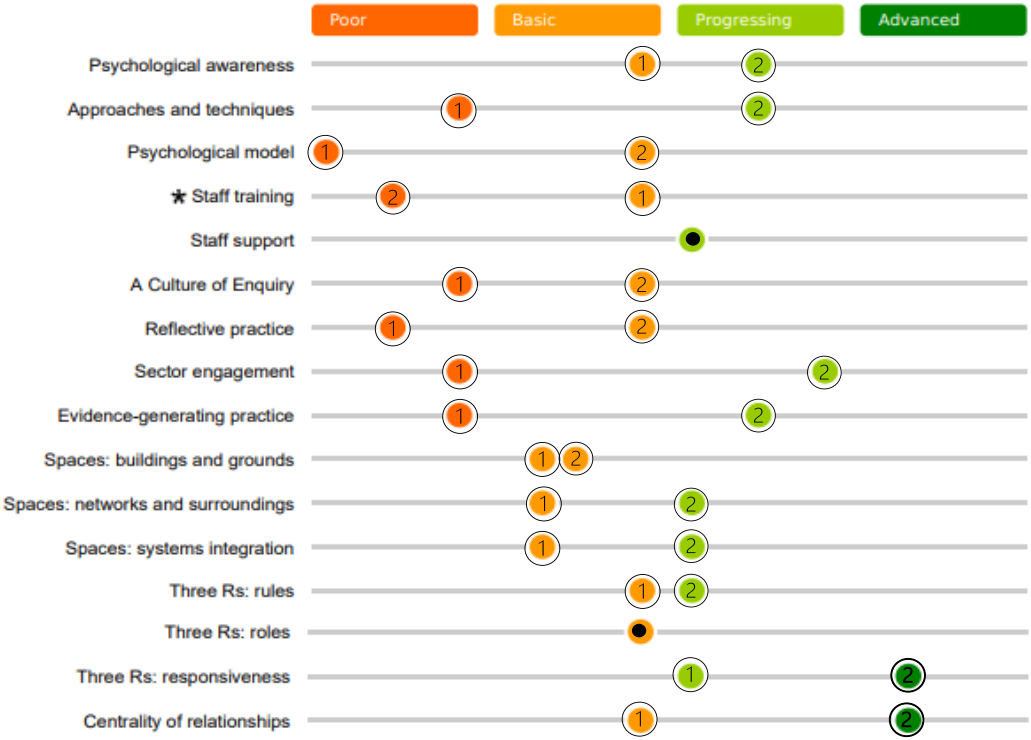


Figure 11: Hostel C PIZAZZ Ratings



*N.B.: ① ② refer to time 1 and 2 respectively; • refers to no change between times; * refers to a decreased score at time two.*

Complexities of Our System and Wider Systems

Staff expressed that working within such a complex system can hinder their progress towards PIE. Whilst the community service (CS) and all thee hostels (HA, HB, and HC) referred to the impact of "*austerity*" (Sector Engagement, Hindering, CS, T1, T2) the community service, being well-funded, focused on the indirect ways in which the limited resources impacted their role, such as the "*lack of funding for other services*" (Systems, Hindering, CS, T2) rather than their own service.

Alternatively, the hostel teams were more likely to discuss direct impacts such as the limited *"organisational resources"* (Staff Support, Hindering, HC, T1) leaving *"very limited options…(where) only the most chaotic are provided for."* (Systems Integration, Hindering, HA, T1). Furthermore, hostel staff highlighted the pressure created by their six-month contract length, identifying they have *"more scrutiny than ever and demands to justify"* (Psychological Awareness, Hindering, HC, T1), as well as the negative impact this has on the service users:

> *"It can take (six months) for someone to… open up"*
> Psychological Awareness, Hindering (HA, T1)

Systemic attitudes were identified as a hindering factor for all teams, however the focus of these attitudes differed; staff from the community service felt that these attitudes could lead to resistance from other local services.

> "*Some partner / fellow agencies not so open to being psychologically minded"* and "*Resistance to change from other services, in some cases."*
> Systems Integration, Hindering (CS, T1, T2).

Whereas hostel staff highlighted how these attitudes influence their own sense of worth within the wider system:

> *"Other services do not value the views of hostel staff… or recognise what we know about / do for service users"*
> Sector Engagement, Evidence (HB, T1)

Further to the complexities of the wider system, staff across all four services discussed how, when working with complex clients, many individual and systemic barriers can arise:

> *"For some … the prospect of change is too difficult / there are too many barriers*"
> Approaches and Techniques, Hindering (CS, T2)

Furthermore, staff in the community team alluded to the interactions between complexities of the client group and the wider system:

> *"(Service users) might test the surrounds*" and "*public reactions have been unwelcoming*"
> Networks and Surroundings, Hindering (CS, T1)

Staff may face the difficult job of trying to create a PIE in a non-psychologically informed space. Whilst staff from all four services reported service user involvement as a positive which can *"support reflection on practice and leads to change"* (Reflective Practice, Evidence, CS, T1), hostel staff were more likely to refer to the difficulties of engaging service users:

> *"Some involvement… (some) lack of interest by (service users) in consultation exercises"*
> Roles, Helping and Hindering (HC, T1)

As the community team has various well-established service-user groups, it is unsurprising they had more positive experiences of service user consultation to draw upon. For example, stating that service users *"inform what we do"* (Psychological Awareness, Helping, CS, T1) and *"do a lot of work towards (sector engagement)"* (Sector Engagement, Helping, CS, T1).

Overall, although affected differently, all four teams identified how systemic constraints can hinder their progress towards PIE, whether directly (e.g., lack of funding) or indirectly (e.g., systemic attitudes). Engaging service users in consultation is helpful yet challenging. Interestingly, whilst the community service referred to this theme roughly the same amount at both time points, staff from all three hostels referred to this theme roughly half as often at time two.

Ready-made or Baked from Scratch

Services clearly differed in their development of PIE. The community team's PIE was ready-made within *"the brief of the service, (being) creative, flexible"* (Approaches and Techniques, Helping, CS, T1). In contrast, the hostel staff were posed with the challenge of baking a PIE from scratch; at time one indicating their *"lack of knowledge / training"* (Psychological Model, Hindering, HC, T1) and not *"knowing where to start"* (Psychological Awareness, Hindering, HC, T1). This contrasts starkly with staff in the community team, who already felt psychologically informed:

> *"We are underpinned by an ethos that is about understanding people*"
> Psychological Awareness, Helping (CS, T1)

Community team staff at both time points identified how they differ from other local services, benefitting from a *"lack of time limitation"* (Responsiveness, Helping, CS, T1) and budget to support "*activities / engagement"* (Approaches and Techniques, Helping, CS, T1) within the service. Alongside the benefits in engaging service users, staff indicate that the presence of support is another helpful factor:

> *"Availability of support – debriefing, supervision" and "Value placed on supervision"*
> Staff Support, Helping (CS, T2)

The community team also referred to the presence of ongoing research in their service and at time two boasted how this has been used in supporting wider systems change:

> *"Systems change is the core value of (the service)"* and *"Learning from (the service is) quoted in strategies / planning"*
> Sector Engagement, Evidence (CS, T1, T2)

Alternately, staff in the hostel felt less positive and "*unclear if there is senior management support for creative approaches"* (Approaches and Techniques, Hindering, HB, T1) and that organisational "*priorities change quickly and often"* (Culture of Enquiry, Hindering, HC, T1). Furthermore, staff alluded to feelings of fear regarding changing their approach, describing the barriers created by the perceived organisational culture:

> *"Sense that higher management do not understand… seem to be punitive… culture of punishment… lack of communication from above"*
> Staff Training, Hindering (HA, T1)

Interestingly, these fears appeared to have shifted at time two, with staff indicating that the "*training gave (us) permission to focus on relationships"* (Relationships, Evidence, HB, T2). Staff reported a *"boost of confidence following successes"* (Buildings and Grounds, Helping, HA, T2), such as developing "*more connections than we had… with the sector"* (Sector Engagement, Helping, HA, T2). Furthermore, staff reported feeling an:

> *"Increased sense of value and confidence as hostel workers"*
> System Integration, Helping (HA, T2)

Staff evidenced a variety of ways in which their service had become more psychologically informed, from increased awareness of and engagement with service users to "*making time to reflect in meetings and handovers"* (Reflective Practice, Helping, HA, T2).

> *"(We are) giving more time to relationship building…trying new things (like) informal or ad hoc approaches to suit individuals"*
> Approaches and Techniques, Evidence (HB, T2)

Finally, across all services, at time two staff were still considering what they could improve, in line with the ethos of PIE. For example, community staff identified that they could more readily consider the longer-term impacts of their response towards service users, indicating that they can at times respond in a way that is less helpful for the individual in the long term.

> *"There are some occasions that we may be more responsive than… helpful in the long term… there could be some work on boundaries"*
> Responsiveness, Evidence (CS, T2)

A potential improvement mentioned across all services relates to how organisations can ensure that staff all benefit from training:

> *"Range of training has been attended… some really good training… no strategy relating to attending and bringing back learning from training"*
> Staff Training, Helping and Hindering (HB, T2)

Although there were some similarities, staff experienced the implementation of PIE differently based upon the foundations, or lack thereof, that existed at time one.

Reflective and Responsive Staff

The final theme focuses on staff members' reflections on themselves. Across all teams, staff acknowledged that they are *"highly motivated"* (Staff Training, Helping, HA, T1) and their person-centred approach helped them be psychologically informed:

> *"We take time to get to know service users… offer person-centred support… with (staff) asking what people need and responding… without prejudice"* (CS, T1) and *"Staff willing to support each other – practically and emotionally"*
> Psychological Awareness, Evidence and Helping (CS, T2)

Staff highlighted similar strengths at time two compared to time one, such as their ability to *"find a way of making things work, (we) don't impose power and control"* (Responsiveness, Evidence, HC, T2) but acknowledged their ongoing development such as getting *"better at recognising other's needs"* (Staff Support, Helping, HA, T2). In contrast to the hostels, community staff again referred to the helpful ethos of their service and how this has impacted decisions such as recruitment:

> *"Caring staff team and supportive ethos / culture - recruited and selected for this as well as skill / qualification"*
> Staff Support, Evidence (CS, T1)

Although staff identified many strengths, they also acknowledged how working in such a demanding environment can lead to "*stress and compassion fatigue"* (Psychological Awareness, Hindering, CS, T1). Staff identify this can hinder PIE progression as the work can *"wear you down and you can lose approaches and techniques"* (Approaches and Techniques, Hindering, CS, T1), as well as at times reducing *"openness to learning / trying new things"* (Culture of Enquiry, Hindering, CS, T2).

Staff across all services indicated that individual staff differences can also impact their ability to be psychologically informed, such as having *"differences in boundaries /*

humour etc." (Staff Support, Hindering, CS, T2), which can impact consistency within the team:

> *"Consistency across the team is not always as high as it could be"*
> Approaches and Techniques, Hindering (HB, T2)

At time one staff in the hostels identified some fears regarding reflection and "*getting things wrong"* (Reflective Practice, Hindering, HC, T1). At time two staff from all services offered reflective responses in considering their role such as how their *"own experiences of relationships can challenge the building of relationships (with service users)"* (Relationships, Hindering, CS, T2) as well as how they could continue to improve this in the future:

> *"(It) can feel like we're firefighting and needing to be more reactive than reflective"*
> Culture of Enquiry, Hindering (HA, T2)

Staff from both the community service and hostels all referred to how staff can experience the *"temptation to be (the service user's) hero"* (Responsiveness, Hindering, CS, T2) as well as discussing the impact this can have on their own wellbeing:

> *"(We can) spend more time / focus (on) supporting (service users) than ourselves after incidents"*
> Staff Support, Hindering (HB, T2)

Overall, staff identified that, although they bring many strengths that help development of a PIE, stress and burnout due to the complex nature of the role can hinder their ability to engage with being a PIE.

Discussion

Overall, the four staff teams rated themselves as being more PIE following the implementation of training, formulation meetings and the support of clinical psychologists. However, some aspects of the PIZAZZ had not changed, or decreased. The results offer an insight into how unique a service's PIE development is; even within those areas that improved at time two, the range in distance travelled was visibly different within and between the four teams.

There may be various hypotheses regarding why some areas of the PIZAZZ were unchanged or lower following PIE implementation. As staff members developed a deeper understanding of PIEs, their perception of how psychologically informed they are may have shifted. For example, all areas of the community team's PIZAZZ that decreased were initially considered advanced; one may argue that staff were able to identify more areas for improvement than at time one. Alternatively, some decreased scores may have been in response to a particular incident or frustration identified at time two; for example, one team commented on their decreased score:

> *"This low rating particularly refers to move on from the service to other [move on] accommodation provided by the same organisation."*
> Systems Integration, Evidence (HB, T2)

Without further exploration it is impossible to conclude why some scores of the PIZAZZ decreased following the PIEs implementation. This indicates the importance of using the PIZAZZ as it was intended, 'to facilitate a more informed discussion between service providers, frontline staff, and researchers' (PIElink, 2020c). To utilise results, conversations need to be continued, creating an ongoing cycle of learning and enquiry.

The first theme mirrors previous findings that, although generally perceived positively, PIE development can highlight the difficulties caused by wider systemic constraints (Phipps, 2016). Perhaps most interestingly, the hostels referred to this theme roughly half as much at time two; one could hypothesise that although implementing PIE in these services had no direct influence on the systemic constraints (funding and contracts remained the same), it influenced perceptions of them and approaches to circumnavigating them. However, it should be noted that although significant investment was made in the hostels in terms of professional support, staff still rated various categories as poor or basic, including staff training and staff support.

One could hypothesise that resource limited services such as hostels may face a ceiling that limits their ability to develop to the point of progressing or advanced across all domains, compared to better-resourced services. Given the point that PIE implementation changes perceptions of resource constraints, alongside the fact that resource constraints may lead to a 'ceiling effect', further research may benefit from exploring this in more detail in an attempt to reconcile such a challenge. While PIE may lead to greater creativity in meeting challenges, it is also imperative that PIE is not seen as a framework through which staff should be encouraged to positively shift their perceptions of unacceptably constrained resources.

The second theme evidences the individuality in baking a PIE and highlights the importance of considering the context and function of different services. Temporary accommodation services aim to support people to 'move on' from the moment of arrival, and also hold a huge amount of power over individuals because of the potential for eviction. They house multiple individuals who would not likely choose to live together, or indeed in a hostel at all. This may influence dynamics in the environment and the extent to which activity such as service user involvement can meaningfully happen for everybody. This is in contrast with the community team, which could offer a more flexible, outreach approach, e.g. meeting people in their preferred environments and not having to enforce boundaries relating to shared accommodation. The community team, being ready-made and well-resourced, were more positive and open towards PIE at time one. In spite of this, the hostel teams did show noticeable development across a variety of domains. The results clearly show that, with appropriate support, accommodation services can move towards greater implementation of PIE, in line with wider systemic aims of using hostels to support ending homelessness (Homeless Link, 2018). However, the inherent limits of such services must be acknowledged, and this raises questions about expectations placed on staff.

Staff reflected upon their own role in developing a PIE. In line with wider research on healthcare workers (Korunka *et al.,* 2009), staff simultaneously report being exhausted, yet absorbed and motivated towards their work. Staff in homelessness services are more likely to experience anxiety and depression compared to the general population (Lemieuz-Cumberlege and Taylor, 2018). Given this and reference in the results to compassion fatigue, it is crucial to provide staff with access to evidence-

based approaches that can reduce exhaustion and increase work engagement, e.g. the work of Reeve *et al*. (2021), which has been adapted into a freely available online 'ACT on Wellbeing' resource for anybody to access via www.pdunottingham.org. It is equally crucial to acknowledge that the responsibility does not lie with individuals, but the wider system. Meaningful outcomes can only be created by systems, accounted for within the commissioning and evaluation of services (Knight *et al*., 2017).

Limitations

The results of the present study, whilst offering a novel insight into staff members' perceptions of PIE implementation, are influenced by practical and methodological limitations. One-year follow up was hampered by the impact of the COVID-19 pandemic. This would have allowed consideration of whether improvements were sustained, or any other changes occurred.

Given the self-assessment function of the PIZAZZ, it is difficult to corroborate whether staff members' perceptions are shared by others. Future research should consider triangulating evidence through engaging other stakeholders. Research is currently being undertaken to adapt the PIZAZZ to make it more service-user friendly (PIElink, 2020e); development of such a tool will inevitably support future evaluations and research.

As the PIZAZZ data was primarily collected collaboratively with a psychologist responsible for PIE implementation, social desirability bias (Fisher and Katz, 2000) may have influenced responses. As not every member of staff was present, and some present may have felt less able to share in a group, some conflicting views may not have been captured. However, collecting data in such a collaborative manner fits with the PIE culture of learning and enquiry. Low ratings also suggest participants felt able to be open in their views.

These issues highlight the importance of completing further research exploring PIE in homelessness settings and subsequently developing controlled, comparable data in order to test to effectiveness of PIE (Cockersell, 2016). The evidence suggests that striving to obtain 'hard' outcomes can be damaging and demotivating for workers and depersonalises service users' experiences (Knight *et al*., 2017); as such, the present study offers an example of using 'soft' outcomes generated by the PIZAZZ to draw some comparisons between community and accommodation services.

Conclusion

Staff across four homelessness services generally evaluated their service as more progressed in relation to the elements of PIE following training, formulation meetings, and ground-level support from clinical psychologists. Although key differences between the community and hostel services were identified, there were also some similarities, namely that working within a complex and constrained system hinders progress and that, although consulting service users can be challenging, it helps the development of PIEs. Whilst developing a PIE does not influence available resources, a question arises regarding whether PIE implementation changes staff members' perceptions of how constraining such limitations are? Further areas for development include corroboration of evidence through service-user feedback; exploration of the longer-term impact of implementing PIEs in homelessness services for staff, service users, organisations, and the wider systems in place; and exploration of a possible ceiling effect for hostels in trying to develop as PIEs given their limited resources.

References

Beck, A. T. (1970), 'Cognitive therapy: Nature and relation to behavior therapy.', *Behavior Therapy*, Vol. 1 No. 2, pp. 184–200. https://doi.org/10.1016/S0005-7894(70)80030-2

Benton, T. and Craib, I. (2011), *Philosophy of social science: the philosophical foundations of social thought,* Palgrave Macmillan, UK.

Bhaskar, R. (2009), *Scientific realism and human emancipation,* Routledge, UK.

Boobis, S. and Albanese, F. (2020), 'The impact of COVID-19 on people facing homelessness and service provision across Great Britain', a*vailable at:* https://www.crisis.org.uk/media/244285/the_impact_of_covid19_on_people_facing_homelessness_and_service_provision_across_gb_2020.pdf (accessed 24 June 2021)

Bowlby, J. (1969), *Attachment and loss: Vol. 1: Attachment*, Hogarth Press, UK.

Braun, V. and Clarke, V. (2006), 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* Vol. 3 No. 2, pp.77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., Clarke, V., Boulton, E., Davey, L. and McEvoy, C. (2020), 'The online survey as a qualitative research tool', *International Journal of Social Research Methodology.* https://doi.org/10.1080/13645579.2020.1805550

Breedvelt, J.F. (2016), 'Psychologically informed environments: a literature review', *available at*: https://www.mentalhealth.org.uk/sites/default/files/pies-literature-review.pdf (accessed 24 June 2021).

Buckley, S., Tickle, A.sos and McDonald, S. (2020), 'Implementing psychological formulation into complex needs homeless hostels to develop a psychologically informed environment', *Journal of Social Distress and Homelessness.* https://doi.org/10.1080/10530789.2020.1786922

Burge, R., Tickle, A. and Moghaddam, N. (2021), 'Evaluating trauma informed care training for services supporting individuals experiencing homelessness and

multiple disadvantage', *Housing, Care and Support.* https://doi.org/10.1108/HCS-01-2021-0002

Cartwright, N. (2007), 'Are RCTs the gold standard?', *BioSocieties*, Vol. 2 No. 1, pp.11-20. https://doi.org/10.1017/S1745855207005029

Cockersell, P. (2016), 'PIEs five years on', *Mental Health and Social Inclusion*, Vol. 20 No. 4, pp. 221-230. https://doi.org/10.1108/MHSI-08-2016-0022

Connolly, J. (2018), 'A pre-treatment therapy approach for single homeless people: The co-construction of recovery/discovery', Cockersell, P. (Ed.), *Social exclusion, compound trauma and recovery: applying psychology, psychotherapy and PIE to homelessness and complex needs*, Jessica Kingsley, UK, pp. 109–133.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. and Marks, J.S. (1998), 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine,* Vol. 14 No. 4, pp. 245-258. https://doi.org/10.1016/s0749-3797(98)00017-8

Fisher, R. and Katz, J. (2000), 'Social-desirability bias and the validity of self-reported values', *Psychology & Marketing,* Vol. 17 No. 2, pp.105-120. https://doi.org/10.1002/(SICI)1520-6793(200002)17:2%3C105::AID-MAR3%3E3.0.CO;2-9

Haigh, R., Harrison, T., Johnson, R., Paget, S. and Williams, S., (2012), 'Psychologically informed environments and the "Enabling Environments" initiative', *Housing, Care and Support*, Vol. 15 No. 1, pp. 34-42. http://dx.doi.org/10.1108/14608791211238412

Homeless Link, (2018) 'The Future Hostel: the role of hostels in helping to end homelessness' *available at:* https://www.homeless.org.uk/sites/default/files/site-attachments/The%20Future%20Hostel_June%202018.pdf (accessed 01 July 2021)

Johnson, R. and Haigh, R. (2010), ‘Social psychiatry and social policy for the 21st century - new concepts for new needs: the ‘psychologically-informed environment’’, *Mental Health and Social Inclusion*, Vol. 14 No. 4, pp. 30-35. https://doi.org/10.5042/mhsi.2010.0620

Johnson, R. (2018), ‘The Pizazz basic assessment sheets’, *available at:* http://pielink.net/download/the-pizazz-basic-assessment-sheets/ (accessed 24 June 2021)

Keats, H., Maguire, N., Johnson, R. and Cockersell, P. (2012), ‘Psychologically informed services for homeless people’, *available at:* https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf (accessed 24 June 2021)

Knight, A. D., Lowe, T., Brossard, M. and Wilson, J. (2017), ‘A Whole New World: Funding and Commissioning in Complexity’, *available at:* https://collaboratecic.com/a-whole-new-world-funding-and-commissioning-in-complexity-12b6bdc2abd8 (accessed 24 June 2021)

Korunka, C., Kubicek, B., Schaufeli, W. B., & Hoonakker, P. (2009), ‘Work engagement and burnout: Testing the robustness of the job demands-resources model’, *The Journal of Positive Psychology*, Vol. 4 No. 3, pp. 243–255. https://doi.org/10.1080/17439760902879976

Lemieux-Cumberlege, A. and Taylor, E.P. (2019), ‘An exploratory study on the factors affecting the mental health and well-being of frontline workers in homeless services’, *Health and Social Care in the Community,* Vol. 27 No. 4, pp. 367-378. https://doi.org/10.1111/hsc.12738

McCann, I.L. and Pearlman, L.A. (1990), ‘Vicarious traumatization: A framework for understanding the psychological effects of working with victims’, *Journal of Traumatic Stress*, Vol. 3 No. 1, pp.131-149. https://doi.org/10.1002/jts.2490030110

Making Every Adult Matter (2018), ‘About Multiple Disadvantage’, *available at:* http://meam.org.uk/multiple-needs-and-exclusions/ (accessed 24 June 2021)

Middleton, R. (2019), ‘Psychologically Informed Environments (PIE) – Our early learning points’, *available at:* https://www.fulfillinglivesevaluation.org/psychologically-informed-environments-pie-our-early-learning-points/ (accessed 24 June 2021)

Phipps, C.M.J. (2016), ‘"Living here has changed me": Resident and staff perceptions of Psychologically Informed Environments for homeless people’, doctoral dissertation, University College London, UK.

PIElink, (2020a), ‘PIEs 2.0 – the basics’, *available at:* http://pielink.net/pies-2-0-the-basics/ (accessed 24 June 2021)

PIElink, (2020b), ‘The Pizazz on paper – the paperwork’, *available at*: http://pielink.net/the-pizazz-paperwork-version/ (accessed 02 July 2021)

PIElink, (2020c), ‘The Pizazz – on paper or on screen’, *available at:* http://pielink.net/pizazz-on-paper-or-screen/ (accessed 24 June 2021)

PIElink, (2020d), ‘An on-line version of the Pizazz (summary)’, *available at*: http://pielink.net/the-pizazz-online-summary/ (accessed 02 July 2021)

PIElink, (2020e), ‘Service Users PIE Assessment’, *available at:* http://pielink.net/service-users-pie-assessments (accessed 24 June 2021)

Reeve, A., Moghaddam, N., Tickle, A. and Young, D. (2021), ‘A brief acceptance and commitment intervention for work-related stress and burnout amongst frontline homelessness staff: A single case experimental design series’, *Clinical Psychology & Psychotherapy.* https://doi.org/10.1002/cpp.2555

Shinn, M. and Toohey, M. (2003), ‘Community contexts of human welfare’, *Annual Review of Psychology*, Vol. 54, pp. 427-459. https://doi.org/10.1146/annurev.psych.54.101601.145052

Watson, C., Nolte, L. and Brown, R. (2018), ‘Building connection against the odds: project workers relationships with people experiencing homelessness’, *Housing, Care and Support*, Vol. 22 No. 2, pp. 129-140. https://doi.org/10.1108/HCS-10-2018-0030

Welsh European Funding Office, (2003), 'A Practical Guide to Measuring Soft Outcomes and Distance Travelled', *available at:* http://www.networkforeurope.eu/files/File/downloads/A%20Practical%20Guide%20to%20Measuring%20Soft%20Outcomes%20and%20Distance%20Travelled%20-%20Guidance%20Document%202003.pdf (accessed 24 June 2021)

Williamson, E. (2018). 'Psychologically Informed Environments.' Conference presentation given at the Greater Manchester Mental Health and Homelessness conference, 3rd October 2018, Manchester, UK, *available at*: https://www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n3796.pdf&ver=5615 (accessed 22 September 2021)