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Do different understandings of people experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working in homelessness services?

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Portfolio Abstract

Background and Aims: There has been increasing emphasis over recent years on providing more cohesive and person-centred support to individuals experiencing Severe and Multiple Disadvantage (SMD) (defined as having experience of at least 3 intersecting difficulties with homelessness, substance use, mental health, domestic violence, and criminal justice involvement). Individuals experiencing SMD face entrenched inequalities and have frequently survived trauma, which is further compounded by siloed support within services. Despite this, there continues to be limited literature exploring how SMD support could be improved, and there is increasing emphasis for support to incorporate psychologically informed approaches. Evidence suggests professional responses are shaped by how staff interpret service user behaviours, and attribution theory offers a useful framework for understanding the influence of this on support provided. Despite this, little research has examined how different psychological conceptualisations of SMD influence staff attributions and responses. This study investigated whether exposure to different explanatory models of SMD (biographical, CBT-informed, values-informed) produced differences in staff attributions, emotional responses, and behavioural intentions towards individuals facing SMD. A secondary aim explored how such conceptualisations shape staff intentions to provide support, with a view to informing psychologically informed and person-centred practice within SMD services.

Method: A mixed methods design was utilised; the primary aim was examined quantitatively, and the secondary aim was explored qualitatively. Participants were staff working within homelessness services supporting people facing SMD. Seventy-nine participants completed an online survey and were randomly allocated to one of three vignette conditions (biographical, CBT-informed, values-informed) describing a fictional service user experiencing SMD. Demographics, attributions, emotional responses, and behavioural intentions were measured. Participants were then invited to answer two qualitative questions exploring behavioural intentions to support the person described.

Results: Analysis of Variance and Kruskal-Wallis tests revealed significant differences between groups for attributions of 'dangerousness' and emotional response of 'fear'; with both domains being endorsed significantly more by the CBT

group, and the least by the values group. Although not statistically significant differences, staff exposed to the values conceptualisation also endorsed anger and behavioural responses of segregation and avoidance the least. Inductive content analysis generated main categories that substantiated quantitative findings including; prioritising risk, multi-agency approaches, influence of past context on present behaviours, importance of the therapeutic relationship, flexible approaches and promoting autonomy and engagement.

Conclusions: Findings may offer preliminary evidence to indicate that staff attributions and emotional responses are sensitive to different understandings of SMD, and these understandings also influence behavioural intentions to offer support to individuals. Specifically, findings tentatively suggest CBT-informed understandings of SMD may inadvertently increase attributions of dangerousness and emotional responses of fear, whilst values-informed conceptualisations may reduce them. Incorporating information about an individual's values into conceptualisations of their presentation may thus have important implications for practice and quality of support provided to people facing SMD. Findings tentatively highlight there could be some benefit of incorporating values information into clinical practice, when supporting people facing SMD, however future research is needed, and suggestions for this are outlined.

Statement of Contribution

I, Rachael Nolan, declare that this thesis is a product of my own original work, completed whilst undertaking the Trent Doctorate in Clinical Psychology. Credit has been afforded for work cited within both the journal and extended papers.

The original idea for the project was grounded in findings from Dr Sophie Buckley's doctoral thesis, and subsequently further developed and refined by myself, with support from my research and field supervisors; Dr Anna Tickle, Dr Heather Cogger-Ward and Dr Sophie Buckley.

Outlined below are the key areas of the research process, and relevant acknowledgement to those who contributed to each stage.

Application for Ethical Approval and Subsequent Amendment

Rachael Nolan

Vignette Development

Rachael Nolan, with guidance and feedback received from Dr Anna Tickle and Dr Sophie Buckley, and professionals working within gatekeeper services involved in recruitment.

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Write up

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Journal Paper

Do different understandings of individuals experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working in homelessness services?

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Journal Abstract

Background: ‘Severe and Multiple Disadvantage’ (SMD) refers to individuals experiencing intersecting difficulties with homelessness, substance use, mental health, domestic violence, and criminal justice involvement. Different theoretical understandings of individuals experiencing SMD could influence the attributions staff make about the causes of a person’s difficulties and how staff provide support to service-users. This study examined whether different understandings of SMD affect the attributions and behavioural intentions of staff to support affected individuals.

Method: A mixed-methods approach was utilised. Seventy-nine professionals working in homelessness services were randomly assigned to view one of three vignettes describing an individual experiencing SMD (biographical, CBT-informed, values-informed). Participants completed an online measure of attribution and two qualitative questions. Quantitative data were analysed using a one-way ANOVA and Kruskal-Wallis tests. Qualitative data were analysed using inductive content analysis.

Results: CBT-informed conceptualisations were associated with higher attributions of dangerousness and emotional responses of fear. No other significant differences were found between groups. Qualitative findings substantiated significant results. Main categories developed across groups included; prioritising risk, multi-agency approaches, influence of past context on present, importance of the therapeutic relationship, flexible approaches and promoting autonomy and engagement.

Conclusions: Findings tentatively indicate staff attributions and emotional responses are sensitive to different understandings of SMD and influence behavioural intentions to support individuals affected. Specifically, CBT-informed understandings may contribute to increased attributions of dangerousness and fear, whilst values-informed conceptualisations may support to reduce them. Implications for incorporating psychologically informed understandings of SMD within interventions and clinical practice are discussed. Further research is needed, but current findings may tentatively offer preliminary support for integrating values-based understandings of service-users into services supporting SMD.

Keywords: severe and multiple disadvantage, attribution, behavioural intention, vignettes, mixed methodology, qualitative, quantitative

1. Introduction

Severe and multiple disadvantage (SMD) is a term which describes the experiences of people facing intersecting social harms; including homelessness, mental illness, substance use, criminal justice system involvement, and additionally included within broader definitions; domestic violence (Lemkes, 2022; Soskeno et al., 2020). Definitions vary across academic, health, and social discourses; with some suggesting simultaneous experience of two domains of SMD (e.g., Everitt & Kaur, 2019), whilst others stipulating three (e.g., Bramley et al., 2015; Sosenko et al., 2020). Variation amongst definitions can complicate prevalence estimates, however recent figures range from 58,000 (Making Every Adult Matter; MEAM, 2018) to 336,000 (Sosenko et al., 2020) adults experiencing SMD across England. SMD represents a demographic of people who are vulnerable to being, and are, frequently neglected and underserved across services, and thus vulnerable to additional sources of disadvantage not captured within 'mainstream' definitions, such as racism, chronic physical health complexities and/or community isolation (Everitt & Kaur, 2019). Evidence also suggests experiencing one SMD domain may increase vulnerability to experiencing difficulties across other domains (Queen et al., 2017).

Such individuals face entrenched inequalities and are more likely to find accessing services and engaging with interventions, challenging (Jain et al., 2024). One challenge relates to the structure and commissioning of services. Frequently, support is siloed; services are commissioned to provide support for one domain of SMD e.g., homelessness or mental health services and may therefore indirectly exclude people experiencing coexisting difficulties (Bramley et al., 2015). Thus, the interrelatedness of domains and their mutually reinforcing nature, alongside the implications of this for maintaining disadvantage, remains largely unacknowledged. Alongside policies and service structures which perpetuate siloed support, reductions and constraints within resources, and short-term funding, contribute to tightening of service criteria. This can create uncertainty of provision and further reduce service accessibility (Fulfilling Lives LSL Research and Learning Partnership, 2022).

It is well cited that experiences of trauma, particularly early adverse experiences (ACEs) during childhood, are a significant precursor, and predictor, of poorer outcomes associated with SMD in adulthood (Taylor & Sharpe, 2008; Koh &

Montgomery, 2021). A systematic review found the lifetime prevalence of ACEs to be substantially higher for adults experiencing homelessness than the general population, with 89.9% having one or more, and 53.9% with four or more ACEs (Liu et al., 2021). Literature also suggests homelessness itself is a risk factor for psychological trauma (e.g., Goodman et al., 1991; Wiewel & Hernandez, 2022). The high degree of overlap between homelessness and other domains of SMD (Fitzpatrick et al., 2011) means that people experiencing other facets e.g., mental health or substance use problems, are also more likely to have experienced early trauma (Bramley et al., 2015; Bramley et al., 2020; Fitzpatrick et al., 2012).

There is increasing emphasis for services to recognise the impact of trauma within SMD, and reflect this within support, for example by using psychologically informed, strengths-based approaches that prioritise staff-service user relationships (Homeless Link, 2017). Models such as Trauma-Informed Care (TIC) and Psychologically informed Environments (PIEs) share the fundamental aim of emphasising this therapeutic alliance (Homeless Link, 2025). Whilst the pivotal role of the therapeutic alliance in fostering and influencing change is widely recognised across broader literature (e.g., Baier, 2020; Priebe & McCabe, 2008), evidence supporting the importance of professional helping relationships within SMD services is scant but available findings suggest support for the importance of therapeutic relationships (e.g., Granfelt & Turunen, 2021). Sandu et al. (2021) found that the quality of the worker-client relationship contributed significantly to housing stability in individuals facing SMD. Considering this, it is not surprising that within PIEs and TIC models, worker-client relationships are appraised as a principal component in facilitating meaningful change (Phipps et al., 2017). Research also exploring the benefits of one-to-one psychotherapeutic interventions for people facing SMD has also suggested psychologically informed approaches improve positive and more sustained engagement with services (Dowding et al., 2023; Maguire, 2006).

Attribution theory offers a useful framework for understanding how psychologically informed understandings may shape how staff working within services appraise and respond to individuals facing SMD. An attribution is defined as a cognitive process pertaining to how 'perceived causation' is inferred about events and behaviour (Kelley & Michaela, 1980). Attributional theories stipulate that people make causal attributions about an individual's behaviour, which consequently influence emotional and

behavioural intentions, and subsequent behavioural responses (Schmidt & Weiner, 1988; Weiner, 1979). According to Weiner (1979), three central dimensions influence attributional beliefs: locus of causality (internal vs external), stability/globality and controllability. Attribution theory is primarily interested in the consequences of attributions: emotions, behaviours, and expectancies (Kelley & Michaela, 1980). For example, attributing challenging or distressing behaviour to internal and controllable factors is more likely to elicit negative feelings such as anger in others, which may influence a behavioural response of coercion or avoidance (Corrigan, 2000; Weiner, 1979; 1995). Inversely, where the same behaviour is attributed to factors that are appraised as external and uncontrollable to the individual, an emotional response may be more congruent with behavioural intentions to support, resulting in more helping-related behaviours (Corrigan, 2000; Weiner, 1979; 1995).

Empirical support for this attributional relationship has been well cited within parallel literature, e.g., learning disabilities and Autism (Hill & Dagnan, 2002; van den Bogaard et al., 2019). Research demonstrates that within these populations, an attributional style of high perceived controllability, stability, and internality is more likely to elicit emotional responses which are associated with increased behavioural avoidance towards the other (Weigel et al., 2010), thus suggesting a hindering impact on helping behaviour (Sharrock et al., 1990). In comparison, an attributional style that appraises challenging behaviour as uncontrollable, with unstable, external causes, reportedly leads to increased willingness to help (Sharrock et al., 1990). These attributions appear more likely to engender high sympathy and correlate with increased helping-related behaviours (Hill & Dagnan, 2002).

Such findings may offer important implications for staff supporting service-users within an SMD context, particularly when influencing understanding about how individuals and service providers conceptualise the causes of SMD, and how they subsequently respond within their professional roles. Causal attributions related to SMD as a unified construct are under researched and empirical insights into this are limited. Much of the available evidence is focused on attributions of individual domains of SMD e.g., mental health (Haslam & Kvaale, 2015; Kvaale et al., 2013) or substance use (Tolfrey et al., 2011; van Boekel et al., 2015), and some within the broader context of stigma (e.g., Vázquez et al., 2021). Despite this, some research has demonstrated a similar attributional style with regards to attributions made about the causes of homelessness

(Phillips, 2014). External attributions which consider homelessness to be more reflective of the wider social context and are perceived to be largely uncontrollable to an individual are associated with increased caring and helping responses (Meddings & Levey, 2000). Whilst this may offer credit to Weiner's (1979) theory, causal attributions about homelessness may also fluctuate in accordance with the wider economic context e.g., external attributions about homelessness may be more heavily endorsed when societal economic conditions are unstable (e.g., Tompsett et al., 2006).

Some research has examined whether different explanations for stigmatised groups influences attributions and behavioural responses. Much of the available evidence has looked at 'medicalised' explanations of stigmatised presentations such as mental health problems. This research has generally demonstrated that medical understandings are more likely to result in attributions that afford less personal control, more sympathy, and result in increased helping responses (Kingston et al., 2016; Kvaale et al., 2013) but may increase attributions of dangerousness (Jorm & Griffiths, 2008). Research examining 'psychosocial' understandings e.g., cognitive explanations is more conflicting, with some evidence suggesting these conceptualisations decrease attributions related to perceived dangerousness (Haslam & Kvaale, 2015), compared to medicalised explanations (Kvaale et al., 2013), but may increase attributions of personal responsibility (Kingston et al., 2016). There have also been inconsistencies across different studies about which types of explanation may have the biggest effect on emotional responses such as sympathy and empathy, influencing behavioural intentions (Lebowitz & Ahn, 2014).

Cognitive Behavioural Therapy (CBT) is arguably the most empirically evaluated psychological model, which is recommended within the National Institute for Health and Care Excellence (NICE) guidelines for a range of psychological difficulties and recognised currently as the 'gold standard' of psychotherapy (David et al., 2018). CBT is an adaptable model and has been shown to be effectively applied to several presentations, populations, and services (Carrier et al., 2022; Kariri & Almubaddel, 2024), including those relevant to SMD (e.g., homelessness; Maguire, 2006; substance misuse; Magill et al., 2023). CBT is likely also a model that staff working within healthcare-related services will have some awareness of. In a study by Maguire (2006), hostel staff were trained in CBT to formulate and address the 'underlying

problems' of identified behaviours within homeless males. All staff showed some improvements in self-efficacy, whilst service user risk, rough sleeping, and violence reduced. This may offer promising implications for the potential utility of staff training in, and application of, psychological models to enhance practice in supporting people facing SMD. A study by Buckley et al. (2021) explored the use of CBT-informed team formulation within homeless hostels. Findings showed how psychologically informed (CBT) conceptualisations can support staffs' understanding of service users, encourage reflection, and support behavioural change in practice. Although these improvements were demonstrated on a small scale, and utilising qualitative methods, this study suggests offering psychologically informed understandings of SMD may benefit staff practice.

Perhaps not as widely recognised or empirically evidenced as CBT but still having been found to offer promising therapeutic implications, values have been shown to act as a motivator for behaviour and meaningful change (Engle & Follette, 2007; Yadavaia & Hayes, 2009). Values are loosely defined as "global, desired, and chosen life directions" (Dahl et al., 2005, p.61), they act as distal reinforcers of congruent behaviours (Hayes et al., 2012a) and are an important source of motivation (Hitlin & Piliavin, 2004). Values are an integral facet within the third-wave CBT approach Acceptance and Commitment Therapy (ACT; Hayes et al., 2012b), and some studies have advocated for the application of ACT within homeless services (e.g., Murthy et al., 2020; 2021). Whilst there is currently no research explicitly examining the influence of values and values-informed understandings of SMD on staff practice, some studies have shown that focusing on client values may contribute to increase engagement (Fitzpatrick et al., 2016), sustainment of behavioural changes (Greggs et al., 2007) and may assist in providing person-centred support (Buckley et al., 2024).

1.1. Rationale

Although SMD is a relatively new concept, research highlights that how it is framed may have important implications for practice and policy (Cockersell, 2018; Bramley et al., 2020). Staff working with this population must interpret complex behaviours, and attribution theory suggests that such interpretations shape emotional and behavioural responses. Despite this, little research has examined how different explanatory models of SMD influence frontline practice.

Given the high prevalence of trauma and the risk of services themselves becoming re-traumatising (Bloom, 2010; Hopper et al., 2010), it seems pertinent to investigate whether different psychological understandings, influence attributions, responses and intentions of staff. Understanding whether explanatory framings shape staff responses could strengthen the case for embedding psychologically informed models across services and have implications for staff training, service commissioning, and delivery.

To date, there has been no research comparing different understandings on attributions and behavioural intentions of staff within an SMD context. Thus, findings aim to advance theoretical understanding and inform psychologically informed, person-centred approaches to support frontline practice with people facing SMD.

1.2. Aims

The study had two aims:

Primary aim:

i. To examine whether offering staff different conceptualisations (biographical, CBT-informed, values-informed) about a person facing SMD, would lead to significantly different attributions, emotional responses, and behavioural intentions.

Secondary aim:

ii. To further explore any differences found between groups in terms of staffs' behavioural intentions to support the person facing SMD.

2. Methods

2.1. Epistemological Position¹

An epistemological stance of critical realism was adopted. This position assumes a balance between positivist ideas of an objective, measurable reality, and recognition of the influence of individual subjectivity inherent to this process (Scott, 2007). A critical realist stance thus leverages aspects of both approaches, in assuming social phenomena are generated by real, underlying structures and mechanisms that exist and operate independently of individual perception, and which cannot be directly observed, whilst recognising that knowledge of these is partial, mediated by, and dependent on social and subjective context (Bhaskar, 1978).

The current research aims were aligned with a critical realist position, whereby attributions were understood as real and measurable psychological constructs, whilst also acknowledging that participants' accounts of attributional processes informing their behavioural intentions, are shaped by social, relational, and situational contexts (Danermark et al., 2002).

2.2 Design

A convergent mixed methods design was used. The quantitative arm addressed the primary aim, and adopted a randomised independent groups design, whereby participants were randomly allocated to view one of three vignettes. The independent variable was vignette conceptualisation, with three levels (biographical, CBT-informed, values-informed). The dependent variable was staff attributions (including emotional and behavioural responses). The qualitative arm addressed the secondary aim to explore staffs' behavioural intentions in supporting the individual described within the vignettes.

2.3 Participants

All participants were staff members currently working within a service user facing role within UK homelessness services². A priori power analysis³ determined a target

¹ For further information see Extended section 8.1.1

² For further information see Extended section 8.3.2

³ For further information see Extended section 8.3.1

sample size of 159 participants, to provide sufficient power to detect a medium effect ($d = .25$). Opportunity sampling was used, where several homelessness organisations agreed to act as gatekeepers, to support recruitment to the study⁴. The research was also advertised via a professional account on 'X' (Twitter), created by the researcher for recruitment purposes. Snowball sampling was also used to maximise engagement with the survey and increase the number of respondents. Seventy-nine participants were recruited, and of these, 70 also provided qualitative data.

2.4 Materials

2.4.1 Vignettes⁵

Three vignettes were developed. Each vignette described the experiences of a fictitious individual, 'Alex', described to be experiencing SMD. Descriptions of Alex's history and presentation remained consistent across the vignettes to maximise standardisation where possible, however, crucially, the conceptualisation offered of Alex's behaviour differed across conditions: (1) biographical: described Alex's developmental and current experiences and offered no psychological information to conceptualise their presentation; (2) CBT-informed: conceptualising Alex's presentation linking thoughts, feelings, physiology, and behaviours, or; (3) values-informed: understanding Alex's behaviours as being intrinsically linked to, and motivated by, their values. All vignettes were developed by the researcher; however, feedback and guidance were offered by two Clinical Psychologists with working knowledge and experience of SMD. Vignette length was informed by literature recommending word count to range between 50-500 words (Evans et al., 2015). Vignettes were also checked for readability (e.g., Flesch-Kincaid scores)⁶, and subject to an external feedback process, whereby professionals with working experience of SMD checked the vignettes for accuracy, relevancy, and representativeness of the SMD population, to maximise content and ecological validity.

⁴ For further information see Extended section 8.4

⁵ For further information see Extended section 8.5

⁶ For further information see Extended section 8.5.3

2.5 Measures

2.5.1 *Demographics*⁷

All participants were requested to provide demographic information on gender, age, professional background, and number of years' experience of working with SMD. Demographic data was collected to facilitate describing the sample in terms of its representativeness of the wider population of interest, and for contextualising data collected on attributions and behavioural intentions.

2.5.2 *Adapted Attribution Questionnaire (AQ-27)*⁸

The AQ-27 was originally developed to measure stigmatising beliefs towards people with mental illness (Corrigan et al., 2003) and has been widely used within attribution research employing vignette designs (e.g., Sousa et al., 2012; Gonzales et al., 2024; Wainwright & Mojtahedi, 2020). AQ-27 items are rated using a nine-point Likert scale, with higher scores indicating stronger endorsement of that attributional statement. Core attributional constructs to Weiner's (1979) theory, and associated emotional and behavioural responses, are measured across the 27 items. These are represented by nine domains, each consisting of three questions.

The AQ-27 has demonstrated satisfactory psychometric properties (e.g., Corrigan et al., 2004; Brown, 2008). Research by Pingani et al. (2012) reported the AQ-27 to have good internal consistency ($\alpha = 0.82$) and test-retest reliability ($r = 0.72$) across subscales. The current study replicated this and is indexed by an internal coefficient of $\alpha = .70$ ⁹.

Amendments to language were made for all three questions relating to the 'segregation' domain and one question relating to the coercion domain, to increase face validity and representativeness of an SMD population. For example, changing 'asylum' to 'a place where Alex can be kept away from others'¹⁰. Adaptations were minor and primarily language-based, and care was taken to ensure the underlying

⁷ For further information see Extended section 8.7.1

⁸ For further information see Extended section 8.7.2

⁹ For further information see Extended section 8.7.2

¹⁰ For further information on language amendments to AQ-27 see Extended section 8.7.2

construct of each adapted item was not changed. Following amendments, the adapted measure was subject to feedback from relevant stakeholders working within the SMD sector, to enhance validity.

2.6 Qualitative Questions Exploring Behavioural Intention¹¹

Participants were prompted to answer two open-ended questions to capture idiographic information about their behavioural intentions to support Alex. Participants were asked to provide a behavioural response regarding the actions they would take to support Alex, and the factors they appraised as important in doing so. Quantitative behavioural outcome measures have been used in previous research (e.g., Corrigan et al., 2002; Corrigan et al., 2004), however as behavioural intention does not necessarily translate into behavioural action (Wicker, 1969; Webb & Sheeran, 2006), it was felt that qualitative responses could provide more in-depth detail about how staff may support Alex, and thus help to contextualise and add nuance to their responses.

2.7 Procedure¹²

The study was advertised via a dedicated research account on social media platform, 'X'. The online survey was hosted via 'QuestionPro'. Participants were provided with the study information and then requested to complete three screening questions and provide informed consent. Participants were then requested to complete four demographic questions and randomised to view one of three vignettes. Participants completed the attribution questionnaire (AQ-27) and were then prompted to complete the qualitative questions. Finally, participants were shown a debrief message, providing an overview of the research aims, and outlining details of relevant organisations where further information could be obtained.

2.8. Ethical Approval¹³

Ethical approval was obtained from The University of Nottingham, and all participants provided informed consent prior to their participation in the research.

¹¹ For further information on qualitative questions see Extended section 8.7.3

¹² For further information on study procedure see Extended section 8.8 and Figure 3

¹³ For further information on ethical application and approval see Extended section 8.9 and Appendix B and B1.1

2.9 Analysis

2.9.1 *Quantitative Analysis*

Quantitative analysis was conducted using IBM Statistical Package for the Social Sciences (SPSS) Version 29. The primary aim was analysed using a one-way between-groups analysis of variance (ANOVA). Due to a smaller than anticipated sample size, and associated reductions in statistical power, the decision was made not to apply corrections for multiple testing to the alpha criterion for significance. Where parametric assumptions for normality were violated, a non-parametric, Kruskal-Wallis test was used¹⁴.

2.9.3 *Qualitative Analysis*

Qualitative data were analysed using content analysis, informed primarily by Elo and Kyngäs's (2008) guidelines, and further informed by Hsieh and Shannon 's (2005) recommendations for content analysis¹⁵. Data were analysed inductively to allow for exploration with minimal constraint from pre-existing theoretical categories, enabling greater openness in the interpretation of meanings that would not have been fully captured through a deductive lens. The analysis followed a three-step process cited by Elo and Kyngäs (2008); preparation, organising, and reporting. Across the stipulated phases, initial codes were grouped, and subsequent emergent categories were developed and refined. This was facilitated through a cyclical process of reflection and supervision.

2.9.3 *Quality Appraisal and Reflexivity*

The Good Reporting of A Mixed Methods Study (GRAMMS Checklist)¹⁶ (O'Cathain et al., 2008) was used to self-monitor the quality of research and ensure transparency in describing mixed-methods research reporting. The primary researcher kept a

¹⁴ For further information on parametric assumptions and testing see Extended section 8.10.1 and Appendix K1.3

¹⁵ For further information see Extended section 8.11, 8.12, and Appendix M

¹⁶ For further information see Extended section 8.12.1 Appendix N

reflective journal and frequently attended supervisions throughout the research process. The purpose of this was to facilitate self-awareness regarding potential influence of the researcher's position on the analysis and subsequent categories. An important part of the reflexive process was also to acknowledge the position and professional experience of supervisors working within an SMD context.

3.Results

3.1 Sample Characteristics

Table 1. Summary of sample demographics

Demographics (<i>n</i> = 79)	<i>n</i>	Percentage of sample (%)
Age (Years)		
19-29	23	29
30-39	16	20
40-49	15	19
50-59	19	24
60+	6	7
Gender		
Male	23	29
Female	55	70
Prefer not to say	1	1
Professional Background		
Nursing / Support Worker	18	23
Psychology / Psychotherapy	12	15
Occupational Therapy	1	1
Social Work	5	6
Other Allied HCP*	14	18
None	28	35
Prefer not to say	1	1
Times working in profession (Years)		
0-1	5	6
2-4	32	41
5-10	15	19
10+	27	34

The sample consisted of 79 participants. All participants answered all four demographic questions, related to age, gender, professional background, and number of years' experience working in their given profession. Most of the sample were female (*n* = 55, 70%) and reported to have between 2-4 years' experience working within their professional background (*n* = 32, 41%). However, there was more of a range of ages and professional backgrounds. Interestingly, 28 (35%) participants indicated that they did not come from a specified professional background. Preliminary analysis confirmed there were no significant differences between the three groups' socio-demographic characteristics, thus randomisation of groups was successful.

3.2 Quantitative Results

3.2.1 Primary aim

A mixture of between-groups ANOVAs and Kruskal-Wallis tests were conducted to examine whether attributions (measured by 'blame' and 'dangerousness' domains), emotional responses ('anger', 'pity', 'sympathy/concern', 'fear'), and behavioural responses ('help', 'avoidance', 'coercion', 'segregation') were sensitive to different conceptualisations of an individual experiencing SMD. For variables which did not violate parametric assumptions, five one-way between groups ANOVAs were conducted. Five Kruskal-Wallis tests were conducted, as a non-parametric alternative, for the variables which violated assumptions ('anger', 'help', 'fear', 'segregation', 'coercion').

When examining the influence of different conceptualisations on attributions, there was no significant difference found between groups for 'blame' $F(2, 76) = .153, p = .858$. There was however a significant difference found for attributions of 'dangerousness' $F(2, 76) = 6.56, p = .002$. The effect size, calculated using η^2 , was .147, which is indicative of a large effect, according to Cohen (1988). Tukey's HSD was conducted to allow for post-hoc comparisons, which revealed that the mean scores for the biographical conceptualisation group ($M = 7.04, SD = 2.84$) were significantly different from the CBT group ($M = 9.38, SD = 3.29, p = .027$), and the mean scores for the values conceptualisation group ($M = 6.34, SD = 3.24$) were significantly different from the CBT group ($M = 9.38, SD = 3.29, p = .002$). This suggests that those who received the CBT conceptualisation endorsed attributions relating to dangerousness more highly, compared to the other two groups.

ANOVA revealed that the emotional responses of 'pity' or 'sympathy/concern' towards SMD did not appear to be sensitive to different conceptualisations. There were no significant differences found between conceptualisations and emotional responses of 'pity' $F(2, 76) = .541, p = .585$ or 'sympathy/concern' $F(2, 76) = .892, p = .414$. A Kruskal-Wallis test also demonstrated no significant differences between conceptualisations of SMD and emotional responses of 'anger' $X^2(2) = 1.80, p = .40$. Kruskal-Wallis test did however reveal a significant difference between groups for the emotional response of 'fear' $X^2(2) = 6.46, p = .03$, with an effect size of $\eta^2 = .09$,

which would constitute a moderate size effect (Cohen, 1988). The mean rank scores for the three groups were 36.81 (biographical), 49.52 (CBT), and 34.98 (values). Post-hoc pairwise comparisons using Dunn's test revealed that the mean rank for the emotional response of 'fear' for the CBT conceptualisation group was significantly higher than for those who received the biographical conceptualisation, $p = .04$ and the values group, $p = .02$.

ANOVA revealed there was no significant difference found between conceptualisation and the behavioural response variable of: 'avoidance' $F(2, 76) = .285$, $p = .753$. Kruskal-Wallis tests also showed there were no significant differences between conceptualisation and behavioural responses of 'help' $X^2(2) = .304$, $p = .864$, 'segregation' $X^2(2) = 4.247$, $p = .120$, and 'coercion' $X^2(2) = .481$, $p = .792$, thus suggesting that behavioural responses did not appear to be sensitive to different conceptualisations of SMD.

Means and standard deviations for each group are presented in Table 2. Mean rank results for variables analysed using Kruskal-Wallis test are presented in Table 3.

Table 2. Means and Standard Deviations for variables analysed using ANOVA

	Attributions (SD)		Emotional Responses (SD)		Behavioural Responses (SD)
	Blame	Dangerousness	Pity	Sympathy/Concern	Avoidance
Conceptualisation N=79					
Biographical (n = 26)	8.77 (3.17)	7.04 (2.84)	5.04 (2.72)	14.92 (2.83)	13.38 (4.89)
CBT (n = 24)	9.25 (3.33)	9.38 (3.29)	4.42 (2.80)	13.88 (3.07)	13.33 (4.57)
Values (n = 29)	9.10 (3.05)	6.34 (3.24)	5.10 (2.27)	14.28 (2.56)	12.59 (3.74)

Note: Each item was scored on a scale of between 1 and 9. Items scored as 1 indicate that constructs were not held, whereas items scored as 9 indicate a construct is held completely.

Table 3. Mean Rank for variables analysed using Kruskal-Wallis test

	Emotional Responses			Behavioural Responses	
	Anger	Fear	Help	Segregation	Coercion
Conceptualisation (N = 79)					
Biographical (n = 26)	42.08	36.81	41.10	40.48	38.12
CBT (n = 24)	43.00	49.52	37.90	46.73	42.46
Values (n = 29)	35.66	34.98	40.76	34.00	39.66

3.3 Qualitative Results

3.3.1 *Secondary aim*

A synthesis of the qualitative findings is presented in Table 4. The table is organised around superordinate analytic categories, to illustrate areas of convergence and divergence across the groups. For each superordinate category, a brief summary is presented for each group, alongside illustrative quotes, to ground the synthesis in participants' accounts, whilst foregrounding key similarities and differences across the three groups.

Table 4. Qualitative synthesis of the superordinate categories across biographical, CBT, and values groups.

Superordinate Categories	Biographical Group	CBT Group	Values Group
Understanding Alex's present difficulties through continuity of their present experience and context	Alex's current behaviour was understood through biographical continuity; with past experiences being central to explaining and legitimising present difficulties	Past experiences were acknowledged to shape understanding of the present	Alex's behaviour was understood as emerging from environmental and relational contexts
<i>Illustrative quote(s)</i>	<i>"Explore if Alex has been let down by professionals and take in to account their past experiences" (P25)</i> <i>"Anger and threats are part of how Alex is surviving" (P58)</i>	<i>"Consider past trauma as a reason for their behaviour and beliefs" (P74)</i> <i>"Educate others about Alex's background and the reasons they behave this way" (P59)</i>	<i>"Behaviour as a result of circumstances, not them inherently as a person" (P9)</i> <i>"Keep in mind the journey they have had to get to where they are" (P16)</i> <i>"The environment as a trigger" (P12)</i>
Role and function of the therapeutic relationship	The relationship supports engagement and autonomy, forming a foundation for collaborative working	The relationship is a necessary mechanism that enables the effective delivery of interventions	The relationship was centralised, with safety and trust positioned as integral to support
<i>Illustrative quote(s)</i>	<i>"Get to know them, develop a therapeutic relationship and build trust" (P36)</i>	<i>"Alex needs consistency and to know they are fully supported before they can progress" (P79)</i>	<i>"Help Alex feel safe and then try and access their needs" (P26)</i>

Superordinate Categories	Biographical Group	CBT Group	Values Group
	<i>"Advise and encourage, but don't force anything" (P44)</i>	<i>"Develop rapport and trust first" (P50)</i>	<i>"A trusting relationship helps work towards goals" (P64)</i>
Conceptualisation of change; interventions and responding to Alex	Change is collaborative and flexible, guided by Alex's priorities and responsiveness to their needs	Change is technically mediated, with different difficulties requiring different targeted interventions	Change emerges through flexible responding, grounded in empathic and relational understanding of Alex's position
<i>Illustrative quote(s)</i>	<i>"We should assume Alex can lead us and is best place to do so" (P58)</i> <i>"Always go at Alex's pace" (P47)</i>	<i>"Recognising Alex has multiple issues co-occurring which require different interventions" (P31)</i> <i>"Giving Alex alternative strategies to manage conflict" (P23)</i>	<i>"Long-term positive engagement needs to be on Alex's terms" (P32)</i> <i>"Keep in mind the impact of their background on their engagement" (P43)</i> <i>"Keeping Alex's values in the forefront" (P43)</i>
Staffs' positioning and understanding of Alex	Alex is positioned as an active agent, with staff foregrounding Alex's voice, autonomy and perspective	Staffs' understanding of Alex influences how they respond	Staffs' positioning of Alex shapes a continuum of person-centred, contextually responsive and ethically negotiated support

Superordinate Categories	Biographical Group	CBT Group	Values Group
<i>Illustrative quote(s)</i>	<i>“Allow Alex to understand and make decisions for themselves, making them feel they have agency and control over their life to change it” (P5)</i> <i>“Supporting Alex to have a voice in the system” (P61)</i>	<i>“Not forcing Alex into services or scenarios they are not comfortable in” (P31)</i> <i>“Others may be judgmental towards Alex due to their choices” (P79)</i>	<i>“Ensuring Alex is at the heart of every decision” (P51)</i> <i>“Take a person-centered approach, so primarily led by Alex’s wishes” (P12)</i> <i>“Be aware Alex may not be open to recovery process, or that they may have relapses” (P60)</i>
Attention to risk and safety	Risk was considered as part of a broader, negotiated understanding of Alex’s need and context	Risk and staff safety were prioritised, often through structures and decision-making processes	Risk was backgrounded within a broader ethic of care, with emphasis on contextual and relational safety
<i>Illustrative quote(s)</i>	<i>“We wouldn’t be unduly worried if Alex presented with anger or threats, that appears to be part of their way of surviving” (P58)</i> <i>“How does accommodation create risk for Alex?” (P61)</i>	<i>Staff to have an escape route if Alex were to become aggressive” (P74)</i> <i>Establishing boundaries with Alex and risk to others” (P62)</i> <i>We need to be careful to assess risk” (P48)</i>	<i>“Important to consider past trauma is likely having a significant impact on Alex’s current behaviours” (P60)</i> <i>“Relationship supports feelings of safety” (P64)</i> <i>“Being mindful of Alex’s values and how this can influence how Alex may interpret my [staff] behaviours” (P38)</i>

Superordinate Categories	Biographical Group	CBT Group	Values Group
Systems and multi-agency working	Holistic, multi-agency collaboration framed as necessary to address complex and interconnected needs	Multi-agency working to support risk management and coordinated delivery of specific support	Multi-agency collaboration framed as relational coordination to meet Alex's needs ethically and contextually
<i>Illustrative quote(s)</i>	<i>"Working closely with other agencies to work towards a holistic approach" (P17)</i> <i>"Gather all professionals involved to get a clear picture of Alex's needs and plan the best course of action to support them to access support" (P25)</i>	<i>"Encourage Alex to engage with interventions or services to support different problems" (P50)</i> <i>"Importance of services working with Alex in a joined-up way" (P31)</i> <i>"Ensure all support staff communicate in multi-agency meetings to ensure Alex is getting necessary support" (P74)</i>	<i>"Asking everyone involved with Alex to come together" (P67)</i> <i>"Involving multiple agencies to support Alex" (P66)</i> <i>"Once Alex has been supported with life skills and had a period of stability, then move onto wider community" (P77)</i>

3.3.2 Narrative of qualitative synthesis across groups

Table 4 incorporates the developed superordinate categories, to illustrate the key convergences and divergences across groups. Across all groups, Alex's difficulties were understood through continuity of their past experience and context; however the emphasis differed subtly. The biographical group positioned previous experience as central to understanding current behaviours (e.g., anger as part of how Alex is surviving), whilst the CBT group acknowledged trauma primarily to inform present-focused understanding and intervention. In contrast, the values group placed less explicit emphasis on understanding the connections between Alex's past and present experiences. Behaviour was understood as emerging from environmental and relational contexts, which may be interpreted as including past experiences, as well as situational meaning-making.

Similarly, all groups emphasised the importance of the therapeutic relationship, yet there were subtle differences in its function. The biographical and values group highlighted more of a relational function to the therapeutic relationship, with the biographical group emphasising its role in building a collaborative foundation for engagement and autonomy, whilst the values group noted its importance for developing trust and safety. Whilst the CBT group did note trust building, they however, understood the therapeutic relationship as being an important vehicle for the delivery of interventions, e.g., teaching skills for conflict navigation. Although this was seen as requiring a relationship to enable effective delivery of interventions, the CBT group placed less central emphasis on collaboration, empathy and connection.

Divergences were further evident in the conceptualisation of change and staffs' positioning and understanding of Alex. The biographical group framed change as collaborative and paced according to Alex's readiness, with Alex being an active agent in the change process. Whereas the CBT group emphasised differentiated and mediated responses that were tailored to co-occurring difficulties, for example, this group explicitly focused on teaching skills for navigating challenges, whereas the other two groups did not. The values group however, framed engagement as contingent on Alex's terms and values, positioning support along a continuum shaped by empathy, moral stance, and a sharing of power.

These differing positions were particularly pronounced in relation to attention to risk. Whilst all groups attended to the importance of risk management and safety, the CBT group foregrounded risk management and staff protection through boundaries and procedural safeguards, perhaps reflecting a heightened vigilance. The biographical group situated risk within a broader contextual understanding, demonstrating an understanding of anger as having been adaptive for Alex, whereas the values group embedded safety within relational and contextual care. Finally, although multi-agency working was emphasised across all groups, the biographical group framed it as holistic and person-centred, whereas the CBT group framed multi-agency working as necessary for coordinating specific interventions and risk management. A further subtle difference is seen in the values group; who applied a more relational emphasis to multiagency working, highlighting a need for collaboration around Alex's needs and values within their context. Collectively, the findings suggest shared domains across groups, but qualitatively distinct orientations to meaning-making, responsibility, and the ethics around supporting Alex.

4. Discussion

This study examined whether different understandings of SMD influenced the attributions, emotional responses, and behavioural intentions of staff. Staffs' behavioural intentions to offer support were also explored.

4. 1 Attributions

Quantitative analysis revealed that attributions of dangerousness were sensitive to the conceptualisation offered. Participants exposed to the CBT-informed conceptualisation endorsed attributions about Alex's dangerousness more highly, compared to participants in both the biographical and values-informed groups. This also appeared to be mirrored within the qualitative findings; participants' behavioural intentions to support Alex in the CBT-informed group focused more on assessing and managing risk, ensuring staff safety, and establishing and holding clear boundaries. This may reflect a heightened sense of threat and unpredictability attributed to Alex by this group, which is congruent with the increased attributions of dangerousness.

Although CBT does not explicitly blame individuals for their distress, the focus and emphasis of the model on the individual in modifying cognitions and behaviour, may inadvertently afford greater agency or responsibility to the person. Thus, locating the causes of their difficulties within them, rather than attributing them to external, uncontrollable factors (Gaudiano, 2008). According to Weiner's (1979) attribution theory, beliefs about causality are sensitive to, and dependent on, whether behaviour is attributed to internal, stable, and controllable causes. Even though CBT explanations may offer a degree of clinical nuance, the framework's emphasis on the individual being responsible for change, may be unconsciously interpreted by professionals as the individual having a greater degree of volition or agency over their adversity.

The SMD evidence base is limited, and there is currently no research examining staff attributions of SMD as a unified construct. There is one known study by Maguire et al. (2017) that examined the impact of CBT training and supervision on attitudes of staff working with homeless people. Results demonstrated a reduction in negative beliefs about service users; however, the authors note these changes were not significant.

The measure used in this study did not allow for staff attributions to be explicitly examined, and it is also unclear to what extent the effects observed can be attributable to CBT training offered, versus how much may be attributable to supervision.

Aside from this, a significant proportion of available evidence, which could be considered relevant to SMD, examines professional attributions within the context of mental health. Some research examining the influence of different conceptualisations on professional stigma towards those experiencing mental health difficulties has found that medicalised explanations increase attributions of dangerousness (Jorm et al., 2012) but may reduce attributions of perceived controllability (Kvaale et al., 2013; Haslam & Kvaale, 2015; Read et al., 2006; Walker & Read, 2002). This may be because individuals are more likely to associate biological causes with permanence and unpredictability, which can heighten perceived risk or threat. Whilst this study did not apply a medicalised conceptualisation to SMD, the CBT group's increased dangerousness attributions may reflect findings from parallel literature suggesting biomedical explanations reduce perceived controllability. In contrast, some research suggests psychosocial frameworks may inadvertently foster attributions of unpredictability and danger (Baek et al., 2022; Walker & Read, 2002), which may therefore help to explain why psychosocial understandings are linked to higher attributions of controllability and responsibility (Berry et al., 2009; Miresco & Kirmayer, 2006). Literature explicitly exploring attributions towards homelessness is limited and studies have tended to focus instead on stigmatising attitudes, demonstrating more complex attitudes regarding the causes (e.g., Phelan et al., 1997; Toro et al., 2007). This may be partly attributable to wider public attitudes and understandings of the causes of homelessness being nuanced, where multiple causes are recognised (Markowitz & Syverson, 2019).

The values group were found to endorse dangerousness attributions the least, which may offer some congruency with the idea that values-informed explanations naturally place more emphasis on an individual's context, and acceptance of internal experiences (thoughts and feelings), rather than trying to change these (Hayes & King, 2024). Research by Ye et al. (2024) found that when no value-expressive information is provided about a person, people tend to project their own values onto the other, which subsequently informs their understanding of the individual. The values-informed

conceptualisation did give information about Alex's values, and participants' knowledge of this was subsequently reflected within the qualitative findings, where participants emphasised responding to Alex in a values-informed way and positioning this understanding at the forefront of their approach to offer support.

Within the AQ-27, 'blame' is conceptualised as resulting from attributions of responsibility and incorporates constructs integral to Weiner's (1979) theory (controllability, stability, internality), to measure the extent to which participants attribute causality to an individual. Blame may typically be associated with causal beliefs that attribute an individual's behaviour to internal, stable, and controllable factors (Weiner, 1979; Corrigan et al., 2003). Whilst there was no significant difference between groups for 'blame', descriptive data shows a subtle difference. Blame mean scores were lowest in the biographical group, whilst the CBT group endorsed blame items the most. Interestingly, this is somewhat congruent with existing evidence demonstrating that psychosocial explanations may inadvertently increase attributions of controllability and responsibility (Lincoln et al., 2008; Read, 2007), which could result in increased blame. If behaviour is appraised as originating from internal 'psychological' processes, individuals are more likely to be perceived as responsible and 'blameworthy' for their difficulties, compared to when behaviour is understood within medical frameworks, that largely emphasise uncontrollable causes (Miresco & Kirmayer, 2006). This is congruent with the findings from this study, and the idea posited by Weiner's (1979) theory; explanations which afford the individual less controllability and responsibility, are more likely to result in fewer attributions that place agency and blame onto the individual. Despite there being a varying degree of acknowledgement of early adversity and trauma across all groups within the qualitative findings, the biographical groups' emphasis on Alex's developmental context and appraisal of behaviour as survival adaptations, may have reduced internal and controllable attributions, buffering against blame, in the absence of any information applying a psychological appraisal.

4.2 Emotional Responses

A significant difference was found between groups across one emotional response domain. Participants in the CBT group endorsed items related to fear significantly more, compared to the biographical and values groups. This appears congruent with

the findings for dangerousness attributions and aligned with Weiner's (1979) theory; attributing behaviour to controllable and internal causes is more likely to result in emotional responses such as fear or anger (Weiner, 1982). Within a CBT framework, it could be expected that fear may be increased if behaviour is perceived as more controllable, internally driven, and there is a perceived threat to others' safety (Corrigan et al., 2003). This finding is also congruent with qualitative findings; whereby the CBT group placed more emphasis on risk, staff safety, and increased rigidity around boundaries. Interestingly, the values group had the lowest mean score for fear, which was also echoed within qualitative findings; behaviour was appraised as a response to systemic injustice and environmental adversity, rather than resulting from factors intrinsic to Alex.

Despite not reaching statistical significance, the biographical group endorsed sympathy and concern the most, and the CBT group the least. This may support previous research which has found psychosocial explanations may result in less sympathy (Kingston et al., 2016; Monterosso et al., 2005). Interestingly, qualitative findings for the CBT group found participants advocating an empathic stance, rather than sympathetic, which may partially account for the CBT group endorsing the sympathy domain the least. Some research has however, shown the inverse (e.g., Haslam & Kvaale, 2015; Lebowitz & Appelbaum, 2019), instead suggesting that offering psychosocial understandings of behaviour can contribute to increased sympathy.

4.3 Behavioural Responses

No significant differences were found between groups across any behavioural response domains. Whilst this could suggest a baseline of supportive behavioural intentions and responses across different conceptualisations, there were subtle, nuanced differences across the qualitative findings, in terms of how support was interpreted and operationalised. The biographical groups' responses were grounded in offering support that is trauma-informed and non-judgmental, whereas the CBT group focused more on supporting behavioural change, promoting conflict resolution, and risk mitigation, which could be interpreted as offering support that is more directive and subtly coercive in tone. Conversely, the values group adopted a less directive stance, emphasising an ethos of co-production, shared decision making, respecting

autonomy, and contextual attunement to Alex's values. This difference may be congruent with quantitative findings whereby segregation and coercion domains were endorsed highest by the CBT group and echoed in research by Valenti et al. (2015), which highlights how well-intended interventions can mask subtle coercion, especially when delivered within the context of an expert-driven paradigm e.g., CBT.

Research exploring behavioural intentions and responses has been conflicting, with some studies supporting a mediating role of emotions e.g., fear, pity, sympathy on behavioural responses, posited by Weiner's model of helping behaviour (1986) (e.g., Palazzolo & Roberto, 2011; Zuo et al., 2022), but not others (Bailey et al., 2006). The CBT group findings largely supported Weiner's (1986) model, endorsing attributions of controllability, internality, and anger most highly, and sympathy and help the least. Whilst it was beyond the scope of this study to examine a mediating role, this relationship has been evidenced in available literature (Corrigan et al., 2003; Obonsawin et al., 2013). However, despite the values group endorsing fear and anger the least, and help the most, they did not score the lowest across attributions of controllability or responsibility, highlighting an incongruency between this study and Weiner's (1979. 1986) model.

It is also important to note that intentions are not the sole determinant of behaviour (Viglia et al., 2024), and differences between intentions, hypothetical responses, and actual behaviour should be acknowledged. This is known as the intention-behaviour gap (Sheeran, 2002). As such, despite measuring both intentions and hypothetical responses, this is unlikely to explain all the variance in behaviour (Conner & Norman, 2022).

4.4 Clinical Implications

Whilst further research is needed, these findings have important implications for professionals working with individuals experiencing, and services that support, SMD. Findings tentatively suggest that explanatory conceptualisations of SMD might not be neutral, and may have the potential to influence how practitioners understand and respond to service users facing SMD. Attributional frameworks may support in facilitating and framing this understanding; highlighting that the way staff interpret behaviour, may influence how they subsequently respond, which has important

implications for assessing and managing risk, and deciding on which interventions are implemented within services. Current findings appear to suggest that offering no psychological information (biographical conceptualisation) or offering information about an individual's values, may support in fostering more sympathetic and collaborative responses and helping intentions within staff, and may contribute to reducing perceptions of dangerousness and blame. Conversely, despite the proliferation of CBT-informed services and its widespread clinical merit, findings indicate that CBT framings alone, may inadvertently reinforce internal and controllable attributions; perhaps due to their focus on individual cognition and internal locus of change. This may have important implications for appraisals of risk, which may contribute to reinforcing of stigma and negative attitudes towards those experiencing SMD. However, despite findings offering some clinical merit, findings should be interpreted as tentative, in consideration of the relatively modest effects, limited sample size and associated statistical power. The wider methodological and systemic factors, which could influence findings e.g., vignette-based design, differences in language associated with differing psychological framings of SMD, should also be acknowledged as potential contributors to the differences found.

More broadly, Oexle and Corrigan (2018) acknowledge the importance of considering intersectionality when offering interventions for individuals who experience disadvantage across several areas, including mental health and homelessness, and ensuring flexibility and person-centered approaches.

Values are a relatively simple concept to understand and integrate within psychosocial interventions (LeJeune & Luoma, 2019). Values fit within a CBT framework as they connect closely to core beliefs, feelings, and behaviour, thus information about service-user values could be easily and readily integrated into existing interventions (i.e., CBT-based formulations) (Tunç et al., 2024). Some research has suggested there are benefits of strengthened rapport and engagement, if values are incorporated into supportive interventions for people facing SMD (Buckley et al., 2024).

Attribution research within an SMD population is currently limited, with studies predominantly focusing on facets of disadvantage relevant to SMD, such as mental

health or substance use. Whilst such findings may be somewhat transferable, the current narrow focus potentially ignores the inherent intersectionality in SMD and highlights how SMD as an integrative construct may be overlooked within the literature. Within clinical practice, professionals are likely to make attributions about the entire individual, rather than just about one part of their presentation. Thus, to ensure research is clinically useful in informing interventions, it is important to consider the intersectionality of difficulties when understanding and responding to individuals.

4.5 Strengths and Limitations

This is the first study to examine whether staff attributions, emotional, and behavioural intentions are sensitive to different understandings of SMD, and to additionally explore how different understandings influence behavioural intentions to support service users. Despite a smaller than anticipated sample, diverse demographic data were collected to support in describing and contextualising the sample. A mixed-methods approach was adopted to enable quantitative findings to be further contextualised by qualitative data. Although the research is foregrounded within attribution theory, an inductive approach was adopted when undertaking the qualitative analysis. This could be considered both a strength, and a potential limitation of the research. Whilst a deductive approach could have enabled more direct comparisons between groups, which may have facilitated clearer convergence or divergence between the attributional framework and the qualitative findings, inductive analysis was chosen to minimise the imposition of a priori theoretical assumptions on the data. This allowed for greater openness in interpretation of unanticipated meanings and patterns within the data, particularly where participants' attributional reasoning may have been complex, ambivalent, or contextually embedded. Since the current aims were not endeavouring to test or confirm specific attributional hypotheses at a group level, inductive analysis supported greater flexibility and exploration in addressing the secondary research aim, which a deductive approach would not have allowed for. This choice is also underpinned by the critical realist position, which recognises participants' accounts as being interpretations of context dependent underlying attributional processes, rather than direct representations of reality. An inductive approach was therefore appropriate for exploring how underlying attributional

processes were expressed in participants' lived accounts without imposing predetermined theoretical categories.

Bespoke vignettes were developed with stakeholder and expert input, which enhanced the representativeness to an SMD population, ecological validity, and offered a means of collecting data that may not otherwise be available (Erfanian et al., 2020). However, conceptualisations were hypothetical, and feedback was not sought from an individual with lived experience of SMD, potentially limiting the external validity.

Also, despite steps to ensure consistency and rigor in vignette content across the groups, it is important to consider the specifics of the language used within the vignettes and the potential of inadvertently priming participants' attributions, emotional, and behavioural responses. For example, the CBT-informed vignette, framed violence as being "helpful" to Alex for protection, compared to violence being a means of upholding values of fairness and justice, within the Values-informed vignette. Whilst subtle, these differences could have influenced participants to respond not only to the differing psychological descriptions of Alex, but also to the interpretive lens implied by the language itself. Future vignette-based research should consider the implications of this when making methodological decisions and consider appropriate steps to mitigate bias during the development process. When considering the current findings, it is also important to note however, that different psychological framings of Alex were central to the research aims, thus well-considered differences in vignette descriptions were necessary.

A further limitation was the sample size and associated reduced statistical power, increasing Type II error risk, making smaller effects harder to detect (Field, 2018) and restricting representativeness. Thus, the quantitative analysis should be appraised as indicative, considering discussed limitations, and interpreted cautiously. Also, most participants were female (70%) and from support worker / nursing (23%), or non-professional backgrounds (35%), which may reflect SMD service staffing demographics, but limits wider representativeness and generalisability to other professional groups.

There may also have been a self-selection bias present (Heckmann, 1990), favouring potential participants more interested in psychological understandings of SMD, or those with greater awareness of attribution as a construct.

4.6 Future Research

Future research should endeavor to address highlighted limitations and to replicate the current findings with greater statistical power. It would be interesting to look at whether there are any differences in staff attributions and responses depending on professional background, or length of professional experience working with service users. It may also be useful to capture more in-depth qualitative data, to further explore how different understandings of SMD may influence staffs' appraisals and how this may connect to the support offered to service-users. This may also enable further exploration of the nuances of factors e.g., professional background, professional experience of SMD, and it might be that current findings are important for other staff groups that work with complex populations. Finally, future vignette-based research should be mindful not to consider descriptive language of phenomenon as neutral, but instead as potential subtle primers that may influence findings. Current findings highlight both the experimental utility and potential limitations of vignette-based research in examining attributions. To negate limitations of vignette-based research, it could be useful to adopt a more naturalistic representation of an individual's experience of SMD, e.g., by replacing vignettes with a realistic depiction such as a film detailing events those experiencing SMD may encounter.

5. Conclusion

This study offers a novel contribution and insight into whether different understandings of SMD influence attributions, emotional responses, and behavioural intentions towards people facing SMD. Quantitative findings tentatively suggest offering a CBT-informed understanding may contribute to increased attributions of dangerousness and emotional responses of fear, whilst values-informed understandings may help to reduce them. Findings are, however, indicative, and should be interpreted with appropriate caution, given the discussed limitations of the research. Qualitative findings regarding staffs' behavioural intentions are largely congruent with the quantitative differences. Taken together, findings suggest that there may be some benefit and utility of incorporating values information into clinical practice, when supporting people facing SMD.

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EXTENDED PAPER

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7. Extended Introduction

7.1 Severe and Multiple Disadvantage

7.1.1 *Definitions*

Severe and multiple disadvantage (SMD) may also be referred to as Multiple Complex Needs, Multiple Disadvantage, Chronic Exclusion, or Multiple Needs, across different health and social discourses. SMD, however, is the most utilised term within academic literature. Compared to other commonly used terms to describe this population, the term SMD avoids locating responsibility and perhaps therefore the onus of change solely on the individual, and instead places the person's experience within their wider, systemic context. Definitions of SMD can be operationalised and differentiated by the number of domains an individual is described to be experiencing, for instance, 3SMD and 5SMD denote the presence of disadvantage across three and five domains, respectively.

A widely cited definition characterises SMD as “people facing multiple disadvantages experiencing a combination of problems including homelessness, substance misuse, contact with the criminal justice system, and mental ill health” (MEAM, 2018). However, both this definition and much of the research that has followed has been critiqued for reproducing a gender bias in recruitment, largely by privileging experiences more commonly associated with men, and perhaps overlooking and obscuring the ways in which women may encounter SMD (Bramley et al., 2015). For example, women's pathways into disadvantage may often be shaped by experiences of domestic abuse, sexual violence, and caregiving responsibilities, some of which are experiences not included within mainstream definitions and are factors that may be less visible within conventional measures of SMD. Whilst earlier research has suggested that approximately 80% of individuals experiencing SMD are men (Bramley et al., 2015), more recent evidence suggests this figure may perhaps be more reflective of methodological blind spots rather than reality, with updated estimates indicating near gender parity: 167,000 men and 169,000 women (Sosenko et al., 2020). Crucially, amongst those experiencing disadvantage across four domains (4SMD), women represented a substantial majority, accounting for 70% of this

subgroup (Sosenko et al., 2020). This appears to highlight both the severity of women's experiences and the inadequacy of earlier approaches that rendered them less visible within the evidence base.

In response to concerns about the gendered invisibility of SMD, the *Gender Report* (Sosenko et al., 2020) examined how disadvantage manifests differently for men and women. Their findings highlighted that, whilst men were most affected by poor mental health and substance misuse, women were more frequently affected by poor mental health in combination with interpersonal violence and abuse (Sosenko et al., 2020, pp. 36–37). In the present study, the vignette character was given a gender-neutral name and gender was not specified. To reflect evidence of both men's and women's experiences and recognising the central role violence plays in women's pathways into and through SMD, domestic violence was included as a domain within the study's operational definition, to avoid reproducing earlier biases.

Despite growing research interest, there remains no official consensus regarding the threshold at which SMD is defined. In practice, eligibility for services and inclusion in research typically requires individuals to meet three or more domains. While employing a two-domain threshold could increase recruitment, it risks misaligning with commissioners and services who typically apply more stringent SMD criteria. Aligning with established frameworks such as *Fulfilling Lives* (MEAM, 2019), this study was therefore informed by the three-domain threshold. Nonetheless, it is important to acknowledge that such thresholds are not neutral; they reflect policy and service priorities that may inadvertently exclude individuals, who experience other forms of systemic disadvantage, which are not included within conventional definitions of SMD.

Mainstream definitions of SMD have been criticised for their narrow focus on some domains, such as homelessness and mental health difficulties, whilst somewhat overlooking broader structural difficulties and other social harms. Available data suggests that people facing SMD will be more likely than the general population to have other coinciding needs, which may be related to, or as a direct result of SMD. This may include but is not limited to; chronic physical health challenges, poverty, racism, and disability (Everitt & Kaur, 2019). By excluding such dimensions of intersecting experience, these definitions may be individualising disadvantage, and obscuring the social, political, and economic structures that create and sustain it. For

example, experiences of structural poverty can operate as both a pathway into more 'mainstream' SMD, such as homelessness, and as a compounding factor which contributes to SMD (Bramley et al., 2015; Queen et al., 2017), yet there is limited recognition of such experiences within their own right. This omission reinforces a service-driven framing of SMD that appears to privilege what is perhaps most measurable or administratively functional for service provision and delivery, rather than what most accurately and effectively reflects the lived realities of systemically marginalised groups (Bramley et al., 2015; Jain et al., 2024). Consequently, mainstream definitions may understate the prevalence and complexity of SMD, and risk perpetuating forms of exclusion by failing to capture cumulative impact of intersecting social harms.

7.1.2 Prevalence

Earlier UK prevalence estimates have suggested that approximately 364,000 individuals experience disadvantage in one domain of SMD (1SMD), 164,000 in two domains (2SMD), and 58,000 across three or more domains (3SMD+) (Bramley et al., 2015). However, more recent data has revised these figures, and indicates that the UK prevalence of SMD is a growing concern. Figures from 2020 indicate 5.2% of the general population experience 2SMD, around 336,000 experience 3SMD, and a further 17,000 experience 4SMD (Sosenko et al., 2020). However, these estimates should perhaps be interpreted with caution, as the two principal studies available to date adopt differing definitions of SMD, in terms of the domains of disadvantage they include. Bramley et al.'s. (2015) *'Hard Edges'* report drew upon more traditional domains of disadvantage, including homelessness, mental ill health, substance use, and offending, whereas Sosenko et al. (2020), incorporated more of a focus on women's experiences, to include domestic violence in place of offending as a core domain. Although offending behaviours were explored, they were addressed in less depth; nevertheless, Sosenko et al. (2020, pp. 46-51) identified a strong association between substance use (particularly drug use) and offending behaviours. This was reportedly an association that appeared to be slightly stronger for women than men. It could be argued that the way the present study operationalised SMD was perhaps more aligned with Bramley et al.'s. (2015) definition, with less focus on domestic violence as a core domain.

7.2 Framing SMD within the Wider Context

Beyond questions of prevalence and definitional boundaries, it is important to situate SMD within its wider social, political, and theoretical context. The concept of SMD has its roots in policy discourses on multiple needs, particularly following the *Hard Edges* report (Bramley et al., 2015) and the work of the MEAM coalition, which framed disadvantage in terms of overlapping domains of; homelessness, mental ill health, substance use, and criminal justice contact. However, this framing has been shaped by shifting political priorities and the austerity context, which significantly reduced welfare and local authority budgets, further embedding disadvantage and constraining service provision.

Economically, the costs of SMD are significant, both in direct public spending and in the “failure demand” created when systemic gaps result in greater downstream costs across health, housing, and criminal justice. Yet these calculations also reflect the political choices embedded in how SMD is defined and measured, raising questions about whose disadvantage is made visible. There is pressing need for more updated estimates with regards to the financial cost of SMD. Most recent available figures estimate an annual cost of £10.1 billion per year, with wider cumulative costs across criminal justice, physical and mental healthcare, and substance use services, potentially reaching £58 billion per year (Bramley et al., 2015). Evidently, there is a noticeable gap in more recent, UK-wide economic cost estimates based on current definitions and data.

Despite the significant human and economic costs, much research continues to emphasise individual-level risk factors rather than the systemic and social conditions that give rise to and sustain SMD. These conditions include structural poverty, limited access to affordable housing, inadequate support for people leaving prison (Fitzpatrick et al., 2021), unemployment, and the prevalence of insecure or precarious work (Shier et al., 2012). The neglect of such contextual factors exemplifies what Shinn and Toohey (2003) describe as “context minimisation error,” whereby individual behaviours are divorced from their broader social realities.

More contemporary developments, including the COVID-19 pandemic, have further intensified the challenges both for those experiencing SMD, and for those responsible for providing adequate provision and support. This has contributed to increasing

concerns around funding and provision and further highlighted pre-existing structural barriers (Boobis & Albanese, 2020). Despite this, the *Everyone In* (Fitzpatrick et al., 2020) initiative was launched, which was a UK Government emergency response to homelessness during the first COVID-19 lockdown in March 2020. The initiative instructed local authorities in England to bring all people sleeping rough, in night shelters, or at risk of homelessness, into safe, but notably temporary, accommodation. An integral feature of this initiative was a suspension of eligibility criteria that would otherwise restrict access to housing services, meaning that many groups usually excluded, could access accommodation support. The goal of the initiative was to reduce transmission of COVID-19 amongst a highly vulnerable population, protect the NHS, and prevent deaths. Research examining the impact of the *Everyone In* initiative suggests that it provided an unprecedented opportunity for engagement with services, with some individuals also accessing healthcare, drug and alcohol services, and longer-term housing for the first time (Coombs & Gray, 2020). However, it was criticised for being temporary and inconsistent across local authorities, with concerns about what would happen once the funding and accommodation contracts ended. Whilst this reduced visible street homelessness and may have improved access to some services in the immediate term, it highlighted the reactive, rather than systemic, nature of much available provision.

At a systems level, people facing SMD often navigate fragmented and siloed services that rely on strict thresholds and eligibility criteria, which can exclude those with the most complex of needs (Moore et al., 2016) and may reduce complex social needs to simplistic service-performance indicators. Ultimately, this serves to obscure the extent of exclusion, given that data on service refusals are not routinely and systematically recorded (Cockersell, 2018). Within homelessness services, the demand for “hard” outcomes, such as total abstinence from substances, exemplifies this tension. Such targets are not only often unrealistic but also unnecessary, as many people in the general population consume substances without it precluding health or stability. Thus, assuming a linear progression from problem identification to service input and measurable resolution narrows the focus away from what may constitute meaningful outcomes for individuals (Knight et al., 2017). Further, calls for trauma-informed and relational models of support highlight the inadequacy of these approaches.

This tension creates a fundamental challenge for research into homelessness and SMD: balancing the demand for robust and comparable evidence with the need for methodological flexibility that reflects lived realities. In this context, practice-based evidence, anchored in theory and iteratively tested against hypotheses, has been argued to offer a more appropriate “gold standard” for applied research than the rigid application of randomised controlled trials (Cartwright, 2007).

7.2.1 Local Context

Nottingham has one of the highest prevalence rates of SMD in England, reported to rank eighth nationally (Bramley et al., 2015). More recent estimates suggest that over 5,000 individuals in Nottingham experience at least two domains of disadvantage (2SMD), with approximately 1,620 meeting three domains (3SMD) and 294 meeting four domains (4SMD) (Everitt & Kaur, 2019). Although, these figures are likely now even higher. As discussed above, there is an evident need for more updated estimates regarding both national and local prevalence of SMD. Nottingham city hosts a diverse range of services attempting to address SMD, ranging from interventions with a clearly defined focus such as charity funded outreach programmes (e.g., Opportunity Nottingham, Changing Futures, Improving Lives), in addition to more generalist provision including hostels commissioned for anyone experiencing homelessness, and wider agencies such as health services and local housing departments, who frequently encounter individuals facing SMD or who have multiple complex needs.

Local data indicate that domestic abuse, whether as a survivor or perpetrator, is disproportionately prevalent among those experiencing SMD. Research by Everitt & Kaur (2019), on behalf of Nottingham City Council, estimated a prevalence of 1.75% based on police records, though this falls below the national average of 2.5%, likely reflecting underreporting. To address these complex and intersecting needs, Nottinghamshire has adopted a systems-focused and person-centred approach. By joining the *Making Every Adult Matter (MEAM)* network and integrating SMD priorities within the Nottinghamshire Integrated Care System (ICS), the county has implemented targeted initiatives such as embedding specialist housing support within substance use services and piloting intensive, interdisciplinary support for cohorts of individuals experiencing SMD. These developments exemplify a coordinated effort to mitigate

structural barriers, improve service access, and deliver meaningful outcomes for those facing the most entrenched disadvantage.

7.3 The Role of Trauma in SMD

It is well cited within available literature that trauma contributes to cycles of instability and has been associated with the prevalence of SMD (e.g., Taylor & Sharpe, 2008; Koh & Montgomery, 2021). Research has found that people experiencing homelessness are more likely than the general population to have experienced physical or sexual abuse within childhood (Sundin & Baguley, 2015). Cumulative disadvantage theory may help to explain the increased risk of mental health and other difficulties experienced by those facing SMD as being the result of an accumulation of past and concurrent stressors. Cumulative disadvantage theory (Dannefer, 2003; O’Rand, 2009) suggests that disadvantages accumulate over the life course, with early disadvantage increasing vulnerability to further disadvantage later. Within the context of SMD, trauma, particularly early on within the lifespan, can act as an initial disadvantage that may set individuals on a trajectory towards poorer outcomes (Liu et al., 2021). ‘Compound trauma’ is the term used to describe experiences of several traumatic events, without the time, support, or capacity to process each of them, or to recover from their impact (Cockersell, 2018). Trauma also plays a central role in this cumulative process because it can be said to be both additive and cyclical; the experience of disadvantage increases exposure to further risks and harms and has been associated with poorer outcomes (e.g., Gómez-Quintero et al., 2020; Koegel et al., 1995; Koh & Montgomery, 2021).

Many people experiencing SMD often encounter services and systems intended to support (e.g., housing, healthcare), that are fragmented, siloed, and potentially even punitive. Strict eligibility criteria, repeated assessments, and short-term interventions can re-trigger experiences of trauma by replicating dynamics of rejection, scrutiny, control / coercion, and powerlessness. Consequently, services can serve to exacerbate trauma, reinforcing mistrust in systems designed to provide support (Coates & McKenzie-Mohr, 2010; Hopper et al., 2010). Perhaps understandably, trauma shapes how individuals interact with support systems and may be further compounded by the development of coping strategies which further serve to exclude people from siloed provisions (Moore et al., 2011).

A socio-ecological perspective (Bronfenbrenner, 1979) situates trauma not only within the individual, but also within the wider systems and relationships that can both contribute to its emergence, and shape opportunities for recovery. Trauma is therefore understood as relational and systemic, rather than solely intrapersonal within the individual. Importantly, the impact of trauma extends beyond those directly experiencing SMD; organisations working with traumatised populations are also vulnerable to vicarious trauma and chronic stress, which can undermine staff wellbeing and the quality-of-service provision (Bloom, 2010). This recognition underscores the imperative for homeless and other SMD services to embed trauma-informed approaches, which move beyond symptom management to create environments of safety, trust, and empowerment for both service-users and staff (Hopper et al., 2010).

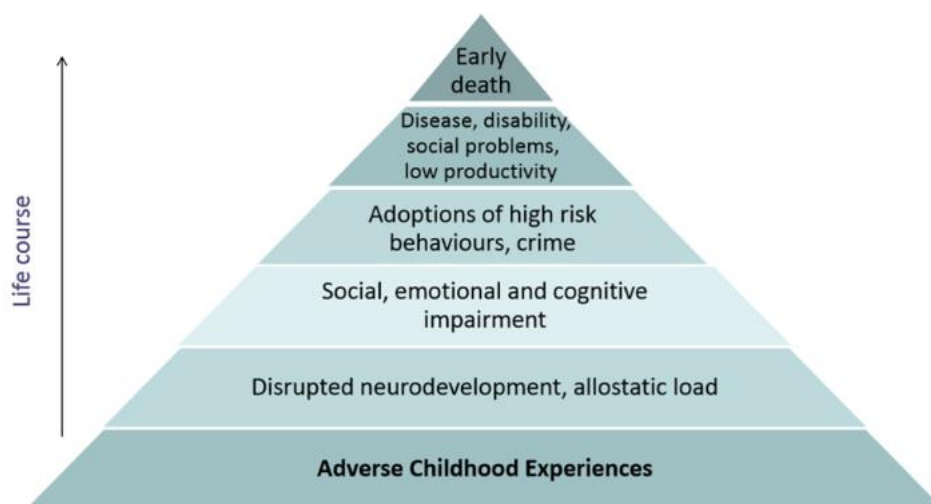
7.3.1 Adverse Childhood Experiences (ACEs)

ACEs have been consistently and reliably associated with an increased risk of poor health and social outcomes across the lifespan, including mental illness, substance use, and physical ill-health (Choi et al., 2017; Felitti et al., 1998; Leza, et al., 2021). Evidence indicates that around half of people experiencing homelessness report four or more ACEs (De Bellis et al., 2014), with repeated episodes of homelessness linked to higher rates of ACEs (e.g., Bassuk et al., 2001; Koh & Montgomery., 2021; Liu et al., 2021). ACEs are also disproportionately prevalent amongst populations experiencing SMD, where multiple disadvantages intersect and compound across time (Cockersell, 2018). The relationship appears to follow a clear dose-response pattern, the more ACEs an individual experiences, the higher their likelihood of subsequent adversity. Research by Felitti (2004) and Cockersell (2018) both demonstrated dose-response relationships of a fivefold increase in alcoholism and a 46-fold increase in injectable drug use, respectively. This may offer some understanding of the entrenched cycles of disadvantage observed in SMD populations. UK-based studies reinforce these findings, showing that ACEs are not only predictive of substance misuse, and offending but also of homelessness, unemployment, and repeated victimisation (e.g., Grey et al., 2019; Hardcastle et al., 2018). A UK systematic review and meta-analysis by Hughes et al. (2017) found that experiencing multiple ACEs is a major risk factor for many health-related conditions and concerns (including cancer, heart and respiratory disease, problematic alcohol

use, sexual risk taking, and poor mental health). Hughes et al. (2017) also reported that individuals with at least four ACEs were at an increased risk of all health outcomes measured, compared with individuals without any ACEs. This suggests that experiencing multiple ACEs may be linked to a wide spectrum of poor health and social outcomes across the life course, reinforcing the notion that childhood adversity has broad, systemic consequences, rather than isolated effects, and thus could be said to support cumulative disadvantage theory.

The 'ACE Pyramid', shown below, is a commonly referenced diagram, which illustrates the mechanisms by which ACEs exert influence on health and wellbeing across the lifespan. The pyramid depicts how early adversity cascades through, and impacts upon, social, emotional, and cognitive impairment, to health-risk behaviours, leading ultimately to disease, disability, and premature death (Felitti et al., 1998). The ACE Pyramid emphasises the idea that early adversity doesn't just end with emotional or psychological impact, but that it initiates a trajectory which can shape physical and mental health through to adulthood.

Figure 1. ACE Pyramid (Felitti et al., 1998)



The ACEs framework has however been critiqued for its limitations. Much of the evidence relies on retrospective, self-report measures, and critics argue that a narrow focus on ACE 'scores' may risk decontextualising trauma from wider socio-political and structural determinants such as poverty, racism, or gender-based violence (Kelly-Irving & Delpierre, 2019). If understood in isolation, ACEs may risk reinforcing

individual or familial blame, rather than situating adversity within broader systemic inequalities. Consequently, whilst ACEs may provide a useful lens for offering a degree of understanding possible pathways into SMD, they must be interpreted within a structural, systemic, and socio-ecological framework that accounts for the intersecting contexts in which disadvantage accumulates and is sustained.

7.4 Improving Provision and Support

As acknowledged within the journal paper, whilst provision such as homelessness services, are designed and intend to provide support to address trauma, services themselves in practice can inadvertently become sites of re-traumatisation. Some research has supported this, suggesting that trauma may be considered both a predictor and outcome of homelessness (e.g., Goodman et al., 1991; Wiewel & Hernandez, 2021). National initiatives have focused on homelessness prevention and targeted support, as well as system reforms and investment in prevention and system-wide responses. For example, the government has committed £1 billion in 2025-26 towards tackling homelessness and rough sleeping, which constitutes the largest allocation to this cause, to date (UK Parliament, 2024). Of this, £633 million has been directed towards the 'Homelessness Prevention Grant', with at least 49% earmarked for prevention to support people from first becoming homeless (Public Sector Executive, 2024).

Earlier plans e.g., the House of Commons also pledged to increase homeless individuals' access to health services, welfare benefits, food, training and employment, as well as improved access to accommodation (Greaves & Wilson, 2025). Further, the Changing Futures programme, which began being rolled out across local authorities in 2021, supports innovative, trauma-informed approaches in fifteen local areas, to target intersecting areas of SMD, and emphasise co-production, flexible service delivery, and whole-person centred approaches. Alongside nationally based initiatives, there is a local drive from Nottingham City Council (Everitt & Kaur, 2019) towards improving support for individuals facing SMD, with the inclusion of strengths-based approaches within services. Everitt & Kaur (2019, p. 32) advocate for the importance of "no longer viewing 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". They further emphasise the need for a move away from siloed services and systemic

disconnect, towards provision that is holistic and addresses multiple, interacting factors. This is perhaps echoed further at a systemic level, within public health agencies such as the Office for Health Improvement and Disparities (OHID), and within NHS inclusion frameworks, which encourage embedding SMD within local Integrated Care System strategies and joint needs assessments, to ensure coordinated and inclusive interventions (e.g., A National Framework for NHS: Action on Inclusion Health; NHS England, 2023).

Perhaps then, it is more essential than ever to deliver evidence-based support, that recognises both the systemic and individual complexities experienced by people facing SMD. Despite this however, there continues to be a notable gap within the literature regarding what may constitute the most effective or meaningful support, and how differing ways of understanding the difficulties associated with SMD may influence the support individuals may receive. Encouragingly however, there has been an increasing interest in the application of psychological theory and thinking to enhance interventions for people experiencing SMD. Two such approaches are highlighted within the journal paper and expanded upon below.

7.4.1 Trauma Informed Care

Trauma Informed Care (TIC) was first described by Harris and Fallot (2001), and describes a paradigm shift in the way in which trauma, and its impact is recognised across services and systems. Despite there being a lack of consensus regarding a definition (Champine et al., 2019), TIC has been described as a strengths-based framework and incorporates a set of six guiding principles designed to recognise the widespread impact of trauma and promote person-centred care: safety, trustworthiness, choice, collaboration, empowerment, and cultural consideration (Berring et al., 2024). Homeless Link (2017) frame TIC as: (1) recognising the impact of trauma and the potential for recovery, (2) identifying the signs and 'symptoms' of trauma, (3) applying trauma knowledge to shape and improve practice, and (4) actively seeking to avoid or prevent re-traumatisation. Emerging evidence suggests that TIC training can enhance certain aspects of frontline homelessness practice; however, embedding TIC effectively requires a broader organisational and cultural shift that extends beyond individual training (Burge et al., 2021). Current commissioning frameworks, funding models, and performance metrics often prioritise short-term,

measurable outcomes over relational or process-based work, limiting the capacity of services to implement TIC in a sustained and meaningful way (Cockersell, 2018; Knight et al., 2017). Whilst anecdotal accounts highlight potential benefits, such as improved relationships with service-users and increased service effectiveness these claims remain underexplored in empirical research, indicating the need for more robust evaluation of TIC within SMD services.

7.4.2 Psychologically Informed Environments

Given the high prevalence of traumatic experiences amongst individuals experiencing SMD, and the re-traumatising impact of SMD itself, the development of approaches that explicitly address psychological needs within service contexts has been recognised as essential (Keats et al., 2012). Psychologically Informed Environments (PIEs) provide a systematic framework for working with people experiencing SMD, rather than a discrete intervention. PIEs were originally developed to build on the earlier work of Johnson and Haigh (2010), who developed the Enabling Environments framework, to support increased psychological awareness within criminal justice and high secure services. The fundamental aims of PIEs positions relationships and the psychological needs of service-users, be it those experiencing SMD or otherwise, at the centre of the approach (Keats et al., 2012; Johnson et al., 2018). Where PIEs diverge from trauma-informed models is within the idea that the work is flexibly underpinned by psychological, social, and anthropological understandings of the wider contexts that individuals facing SMD exist within, alongside the understanding of how trauma impacts and operates in people's lived experience (Keats et al., 2012).

PIEs are built upon five key principles: psychological awareness, staff training and support, learning and enquiry, the creation of spaces of opportunity, and attention to the three R's (roles, rules, and responsiveness of the service). Central to PIEs is the recognition that trusting and consistent relationships across the system are the foundation for engagement and recovery (PIElink, 2020). This relational focus is particularly significant for individuals facing SMD, whose experiences of trauma, exclusion, and service fragmentation often erode trust in statutory and voluntary systems. While the five principles are consistent, PIEs are designed to be flexible, adapting their implementation to the specific needs of the individuals and communities they serve (Keats et al., 2012). Although the evidence base remains emergent and

difficult to standardise, partly because PIEs rely on local innovation and adaptation (Haigh et al., 2012), initial findings suggest that psychologically informed approaches improve both staff wellbeing and service-user outcomes, compared with traditional models of service delivery (e.g., Breedvelt, 2016; Buckley et al, 2021; Cockersell, 2016; Homeless Link, 2018). This tentatively highlights the importance of embedding psychological theory and thinking within SMD services, not only to respond to trauma and complexity but also to address systemic barriers to engagement and recovery.

7.5 Biographical / Descriptive Explanation of SMD

Of the three different conceptualisations of SMD offered within the present study, one is a biographical or descriptive understanding of SMD, to facilitate comparative analysis between different groups, to compare how different explanatory frameworks may influence staff members interpretations and suggested interventions. Descriptive explanations have been used within previous vignette-based research as a means of providing a baseline for comparison when examining the influence of different conceptualisations of a given phenomenon (e.g., Miller-Perrin et al., 1990). Further, experimental studies within healthcare have used factorial vignette designs to isolate how specific variables may influence decisions or judgments (e.g., Sheringham et al., 2021). Within the current study, use of a biographical vignette, without any psychological framing of SMD, can be said to serve as a control group, which may minimise priming towards one explanation or another. When compared with the other two groups which do offer psychologically informed understandings of SMD, the biographical conceptualisation enables the study to examine: how attributions and judgments may shift depending on framing, tentatively highlight the potential importance and impact of different explanatory models, and whether responses, in terms of attributions, emotions, and behaviours, change when psychological context is provided.

7.6 Cognitive-Behavioural-Informed (CBT) Explanation of SMD

CBT is one of the most universally recognised and empirically evaluated psychological models (Kariri & Almubaddel, 2024), which has been shown to reduce distress in people experiencing a wide range of disorders (Kinderman & Tai, 2007; Morrison, 2001). Subsequently, CBT has become an established first line psychological

intervention for many mental health problems, with effect sizes that some studies have shown to be at least as good as those established in randomised clinical pharmacotherapy trials (Emmelkamp et al., 2014). CBT is also recommended by NICE guidelines as an effective intervention for a variety of psychological conditions including anxiety disorders, depression, and post-traumatic stress disorder (NICE, 2020; 2022; 2018), as well as physical health presentations e.g., management of chronic pain (NICE, 2021). As such, CBT has been termed the 'gold standard' of psychotherapy (David et al., 2018). NICE guidance also suggests that CBT is an effective psychosocial intervention for the treatment of 'drug misuse' (NICE, 2007).

NICE guidance has also gone some of the way in conceptualising and addressing evidence-based guidance for coexisting conditions (severe mental illness and substance misuse) (NICE, 2016). These guidelines aim to improve community care for individuals experiencing co-occurring problems with mental health and drug / alcohol use and stipulate that people facing coexisting conditions should be able to access psychological interventions such as CBT for problems such as depression and anxiety (NICE, 2016). Whilst not explicitly related to CBT, these guidelines recommend that care for coexisting conditions should be partnership-based, integrated, flexible, person-centred, coordinated with other agencies, and address social determinants of disadvantage (e.g., housing, employment, social inclusion) (NICE, 2016). This is important as it offers clear markers for addressing challenges faced by people experiencing SMD, some of which could be feasibly met via the implementation of psychologically informed approaches into available SMD support and services.

An advantage of CBT is that it is an adaptable model and has been shown to be effectively applied across a range of different services and settings (Kendall et al., 2023) including mental health services (Lopez & Basco, 2016), medical settings (Magidson & Weisberg, 2022), schools (Chiu et al., 2013), and prison and custodial settings (Beaudry et al., 2021). This may support its efficacy and utility as a psychological model of choice for being implemented into services which support people facing SMD, due to its flexibility and scope for being adapted in terms of its implementation and delivery, whilst maintaining efficacy, to meet different population needs.

CBT is underpinned by an amalgamation of two theoretical standpoints; behavioural and cognitive theory and affords primacy to the hypothesised mediating role cognitions and thoughts have in influencing emotions and behaviour (Beck et al., 1979). This has its grounding within the cognitive model, which suggests that events and phenomena themselves do not directly cause emotional or behavioural responses; rather it is the individual's appraisal that drives these. Based on this, there is a clear conceptual overlap between the principle of cognitive primacy postulated by CBT and attribution theory; there is a shared central assumption that cognitive interpretations and appraisals drive emotional and behavioural responses. As such, both frameworks postulate causal meaning making as a cognitive process. In CBT terms, cognitive appraisals may be conceptualised for example as *negative automatic thoughts*, and in attribution theory they are conceptualised as *causal explanations* (e.g., they are homeless because of structural barriers).

Given CBT's vast application and demonstrated efficacy across a range of presentations and settings, it was felt that CBT would be a psychological model that staff would have a degree of awareness of, and some research has applied CBT within homelessness services. Maguire (2006) conducted a case series pilot study with four participants, which aimed to assess whether a CBT-based intervention could help homeless men who were also experiencing substance use problems and instability in housing. Participants also had criminal justice involvement and difficulties engaging with hostel services, as such could be said to be experiencing SMD. The study involved delivering staff training in CBT formulations, and regular supervision to support staff and their fidelity to the model. Individual CBT formulation was undertaken with participants, and the hostel was structured as a therapeutic environment, which was run collaboratively with residents. Quantitative and qualitative data were collected on domains related to mental health, risk behaviour, social functioning, self-efficacy, substance use, violent/anti-social behaviour, and frequency of rough sleeping. Findings showed over a 10-week period, incidents of theft, violence, and alcohol consumption reduced, and residents' risk to self and others. Amongst staff, perceived self-efficacy increased slightly, and staff reported feeling less hopeless and stressed.

Although this study may present the obvious critique of a small sample, it may offer some support for the utility and applicability of CBT within homelessness settings, that support people facing SMD. Benefits appear apparent for both service users and staff;

all be this demonstrated on a small scale. However, the longer-term effectiveness of this intervention was not measured via a follow up period, and without a comparator (e.g., another psychological approach or control) it's difficult to ascertain how much of the variance can be attributed to the CBT intervention. Although the study did attempt to measure and ensure fidelity to the model, it may have been that some of the improvements observed could also be attributable to other factors known to improve therapeutic outcomes with service-users within SMD populations (e.g., the therapeutic alliance; Granfelt & Turunen, 2021; Sandu et al., 2021). Despite this, other studies applying CBT-informed understandings within SMD services have supported these findings. Maguire et al. (2017) found providing frontline homelessness support workers with training in basic CBT formulation/intervention techniques, together with ongoing clinical supervision, reduced burnout, increased staff confidence in their ability to support individuals experiencing intersecting difficulties and reduced negative beliefs about the client group. Negative beliefs were found to decrease following the initial training and continued to reduce with ongoing clinical supervision, which may hold some merit for the impact of causal attributions about service users, the association with staff practice, and the influence of applying psychologically informed understandings in altering these. Further research by Buckley et al. (2021) has also explored the use of CBT-informed team psychological formulation within homeless hostels. Findings showed how CBT-informed conceptualisations can support staffs' understanding of service users, encourage reflection, and support behavioural change in practice. Whilst similar critiques may apply to Buckley et al. (2021), the qualitative stance of this research offers an interesting exploration of the utility of psychological formulation with teams in developing staffs' psychological understanding, reflection, and collaboration in services.

As well as team-based interventions, research exploring the benefits of one-to-one psychotherapeutic interventions for people facing SMD has also suggested psychologically informed approaches improve positive and more sustained engagement with services (Dowding et al., 2023; Maguire, 2006). Taken together, available literature, although limited, appears to suggest that psychologically informed understandings of SMD that apply CBT, can offer benefits for both service users and staff, however more rigorous, larger scale research is needed to substantiate these emerging benefits.

7.7 Values-Informed Explanation of SMD

Within psychotherapy, values have been considered for several years, across a range of theoretical standpoints. For example, Carl Rogers (1959) discusses actualisation within humanistic approaches, B. F. Skinner (1976) understood values as positive reinforcers that serve many functions (Yadavia & Hayes, 2009), and psychoanalysts e.g., Zinberg (1967) have argued values represent complex motivations closely associated with underlying drive states. Values have been more accessibly defined as; (1) *patterns of behaviour* (ways of living, rather than abstract words), (2) *freely chosen* (emerging from personal choice rather than external pressures, reasoning, or imposed moral rules, (3) *life directions* (values tend to be stable life paths to follow rather than finite goals to be completed, but may be expressed flexibly in behaviour, and (4), *approach-orientated* (values represent things we want to move towards, rather than away from) (LeJeune & Juoma, 2019, p.11). Values are thought to act as distal reinforcers of congruent behaviours (Hayes et al., 2012a) and are an important source of motivation (Hitlin & Piliavin, 2004). Distinctly different from but related to values, value domains are an overarching life context within which values are expressed (LeJeune & Juoma, 2019), e.g., family, social networks, employment, the wider community. Value domains provide the framework in which values operate.

Research has shown that identifying someone's values can contribute to increased behavioural change (e.g., Fitzpatrick et al., 2016) and psychological models which incorporate and draw upon the importance of values e.g., Acceptance and Commitment Therapy (ACT) utilises measures and assessment tools such as the Personal Values Checklist (Harris, 2010) and the Valued Living Questionnaire-2 (Wilson & Dufrene, 2009) to capture self-reported values and committed actions (Reilly et al., 2019). Acting in line with values has been demonstrated to support psychological wellbeing (Bramwell & Richardson, 2018; Grégoire et al., 2021). Values may also help provide a sense of meaning and purpose to individuals (Sheldon & Krieger, 2014) thus feeling disconnected from this has been linked to reduced physical and psychological wellbeing (Creswell et al., 2005). Given this, such evidence may hold implications for identifying and incorporating information about an individual's values when supporting people facing SMD.

Values have been shown to act as a motivator for behaviour and meaningful change (Engle & Follette, 2007; Yadavaia & Hayes, 2009), which may have a positive impact on engagement with services, something that is at the centre of improving support for people experiencing SMD (Everitt & Kaur, 2019). Research has also suggested that values may influence attitudes, which subsequently can influence behaviour (Homer & Kahle, 1988). In this way, perhaps values could be understood as one example of an organising principle from which sense can be made of a person and their actions. Values could thus be considered as an element of a person's belief system (Usó-Doménech & Nescolarde-Selva, 2016), that play a role in shaping our understanding of the world and guiding actions (Mifsud & Sammut, 2023).

Values are an integral element of ACT (Hayes et al., 2012a; Hayes et al., 2012b); a third-wave psychological approach, rooted within traditional CBT. As such, values could be said to fit more broadly within a CBT framework, as they connect closely to constructs such as core beliefs, as well as feelings and behaviour. ACT is a transdiagnostic model, which has been shown in a recent review of 20 meta-analyses to be an effective intervention for anxiety, depression, pain, substance use, across transdiagnostic populations (Gloster et al., 2020). Whilst the focus of CBT is to modify unhelpful cognitions and thoughts, to influence affect and behaviour, ACT encourages the individual to change their relationship with thoughts and beliefs to alleviate distress, since it is proposed that psychological rigidity in responding to distress is what leads to suffering (Hayes, 2016). ACT aims to improve wellbeing via enhancing psychological flexibility, which can be achieved through six core processes; acceptance, cognitive defusion, engagement with the present moment, self as context, values, and committed action (Hayes et al., 2006, 2012; Levin et al., 2016). Whilst values work is only one facet of this, in fostering psychological flexibility, foundations are laid for values-based behaviours (Pielech et al., 2017). ACT is rooted in functional contextualism, which highlights the importance of accepting behaviour as 'helpful' if it is contextually functional to the individual. Whilst the current study is not concerned with utilising an ACT approach, it is helpful to ground values within the broader context of this modality.

Literature utilising values-based interventions within homelessness and services supporting SMD is scant. A study by Reeve et al. (2021) explored the use of ACT with four frontline staff working in a homelessness setting using a single-case experimental

design, and found ACT to be helpful in reducing exhaustion, increasing engagement and psychological flexibility. Other studies have explored the use of ACT with people facing SMD and found it to be an effective intervention for fostering the therapeutic relationship (Shepherd et al., 2021) and improvements in experiential avoidance (Murthy et al., 2020). Whilst these studies are not isolated applications of incorporating values into SMD support, they may offer some support for the use of values within homelessness and SMD services. Research by Buckley et al. (2024) did explicitly explore the utility of identifying values with people experiencing SMD, the barriers and facilitators to enacting these, and the perceived helpfulness of service provision in encouraging valued behaviour. Although this was a qualitative, exploratory study, findings revealed that values-focused support could help individuals facing SMD orientate towards making positive behavioural changes and concluded that given the role services play in helping or hindering valued action of service-users, staff may benefit from integrating values-based information into their understandings of the individuals they support. This aligns with wider systemic drives to provide more cohesive and person-centred support to individuals experiencing SMD (Everitt & Kaur, 2019).

7.8 Attribution Theory Extended

The journal paper outlines the core facets of Weiner's (1979) attribution theory and describes how the main components are proposed to intersect to influence 'perceived causation' and behaviour. The early roots of attribution theory can be found in the work of Fritz Heider (1958) on social perception. He distinguished between internal (dispositional) and external (situational) causes of events and behaviour, proposing that people make sense of their actions and the actions of others by constantly inferring internal or external attributions about causality. In this way, Heider can be said to have laid the early, and one of the most influential, foundations for attributional thinking (Hewstone, 1989).

Moving into the 1970s, Heider's broad distinction was further expanded by researchers into testable models (e.g., the Correspondent Inference Theory; Jones & Davis, 1965, and the Covariation Model; Kelley, 1967;1973). These frameworks were further expanded by Bernard Weiner to propose the integral dimensions of attribution theory. Weiner suggested that there are three core dimensions to attribution theory: (1) locus

on causality (causes being perceived as internal vs external to the individual), (2) stability/globality (how stable are perceived causes across time and different situations), and (3) controllability (how much control do individuals have over their behaviour), which explained how causal perceptions influence emotions, behaviours, and expectations. The work of Weiner (1979; 1980; 1982; 1985; 1990) and colleagues shifted attribution theory from purely cognitive models of reasoning to an integrative framework linking cognition, affect, and behaviour particularly within contexts like education, responding to stigmatised groups, and helping behaviour. More recent research continues to extend the evidence base in applying attribution theory to areas of study which hold relevance to SMD (e.g., stigma, mental illness, homelessness), often finding that perceptions of controllability influence whether people respond with increased blame, and related emotional and behavioural responses (e.g., fear, anger, help, avoidance).

Attribution theory incorporates variations of different attributional models (Corrigan 2000), which are specific frameworks that operationalise and apply the ideas proposed within attribution theory and are primarily interested in the consequences of attributions: emotions, behaviours, and expectancies (Kelley & Michaela, 1980). Specifically, attribution theory predicts that attributions made about the causes of an individual's behaviour influence an emotional response, which in turn mediates a behavioural response. Weiner conceptualises this as a mediational relationship because the theory hypothesises that resultant behavioural responses are mediated by, and dependent upon, the elicited emotional response. For example, attributing challenging or distressing behaviour to internal and controllable factors is more likely to elicit negative feelings such as anger in others, which may influence a resultant behavioural response of coercion or avoidance (Corrigan, 2000; Weiner, 1979; 1995). Inversely, where the same behaviour is attributed to factors that are appraised as external and uncontrollable to the individual, an emotional response may be more congruent with behavioural intentions to offer support, resulting in more helping-related behaviours (Corrigan, 2000; Weiner, 1979; 1995).

Whilst stability attributions do play a role within attribution theory, they are generally considered to be slightly less central to helping behaviour than internality and controllability, because stability attributions primarily influence expectations for change of future outcomes rather than immediate helping or punitive responses (e.g., Weiner,

1980). However, some research has suggested that stability can influence attributions of responsibility, e.g., perceiving a behaviour as unstable and controllable may increase emotional responses of anger and punitive behavioural intent (e.g., Yao & Siegel, 2021), whilst perceiving behaviour as stable but uncontrollable can increase sympathy and willingness to help (e.g., Graham et al., 1997).

Later work by Corrigan (2000) applied Weiner's attribution framework to understand how causal attributions influence emotional and behavioural responses towards mental illness stigma. A key dimension he explored was perceived dangerousness; whether people believe that someone with a mental health problem poses a risk of harm to others. Corrigan (2000) identified that in addition to the influence of internality, stability, and controllability, people's perceptions of dangerousness influenced coercive behavioural intentions, which Corrigan (2000) considered to be mediated by an emotional response of fear, and frequently resulting in an increased desire for social distance and coercive behavioural intentions (e.g., Corrigan & Shapiro, 2010). Research demonstrated that attributions of dangerousness lead people (e.g., Corrigan et al., 2002; 2003) to avoid those with mental health difficulties. This model was however developed to examine attributions towards the psychiatric label 'Schizophrenia', which may risk judgments of, and attributions about, individuals being more reflective of the 'diagnostic label' than of the actual presentation or behaviour of the individual. This may have implications for its ecological validity. Corrigan's work may help to highlight why mental health stigma is so persistent; beliefs about dangerousness have been shown to amplify feelings of fear, even when the condition is appraised as uncontrollable (e.g., Angermeyer & Matschinger, 1996; Corrigan et al., 2003). Despite its merits, a limitation of attribution theory is that it examines behavioural intention, rather than explicitly behavioural outcomes (actual behaviour). To mitigate this, the current study explored both.

7.8.1 Evidence for Attribution Theory

The core components of Weiner's attribution theory are grounded within an extensive evidence base and have been demonstrated to be consistent across a variety of contexts (Weiner, 2018). The central hypothesis of the theory stipulates that attributions of controllability and internality, and associated emotional responses, are key in contributing to people's motivation to either help or punish others (Graham,

2020), and perceived responsibility for a problematic behaviour has been shown to elicit an emotional response of anger (Graham, 2020). This attributional relationship has received a substantial degree of empirical support (e.g., Rahimi et al., 2016; Weigel et al., 2010; Willner & Smith, 2008; Weiner, 2000).

A meta-analysis by Rudolph et al. (2004) examined evidence for Weiner's theory of social conduct; specifically, the causal chain that he proposed connects attributions, emotions (sympathy, anger), and behaviours (helping and aggression). The research tested the robustness of the model across 64 studies involving varying cultures and populations. Associations between attributions, emotions, and behavioural intentions and actions were examined, as well as moderator variables such as culture, or type of sample (i.e. students, community). Findings revealed attributions of responsibility / controllability strongly shaped emotional responses, supporting Weiner's proposed model; more responsibility led to increased anger, less sympathy, and more aggression and less helping. The inverse relationship was also found. Responsibility / controllability attributions were found to be a better fit for, and have a more direct effect on, aggression than helping behaviour, which may indicate that helping behaviour has more determinants than those included in Weiner's theory. The authors hypothesised that this was due to practical limitations in helping such as the social context and ability to give the type of help needed. Results were however consistent across different cultures and populations, and real or hypothetical situations. These findings appear to offer support for attribution theory as an explanation of social responses and may highlight the importance of reducing blame attributions to promote helping and reduce punitive behavioural responses. Reframing behaviour as less controllable may be especially useful for interventions in stigma reduction and healthcare to foster more sympathetic and supportive responses.

Attribution theory has been widely applied across the parallel literature, for example within intellectual disabilities (Snow et al., 2007; van den Bogaard et al., 2019; Wanless & Jahoda, 2002) and Autistic populations (e.g., Hartley et al., 2013; Whittingham et al., 2008). However, in applying attribution theory in these named studies, researchers assumed the fit of Weiner's model and did not explicitly test this. Several studies have also focused on attributions of staff supporting individuals with intellectual disabilities, with regards to challenging behaviour (e.g., Cudré-Mauroux, 2010; Noone et al., 2006; Rose et al., 2014), however these studies did not focus

specifically on the attributional styles of support staff with regards to challenging behaviour. Examining the attributional styles of support staff is important, as these may shape both their emotional and behavioural responses within relationships (Dix & Reinhold, 1991) and influence the overall quality of those relationships (Fincham & Beach, 1988). To address this, a study by van den Bogaard et al. (2019) examined the attributional styles of 19 support staff working with people with intellectual disabilities, who exhibited challenging behaviour. Findings demonstrated that attributional styles differed significantly depending on whether behaviour was aggressive, self-injurious, or sexualised in nature. Generally, staff were more likely to attribute the causes of all three types of challenging behaviour to the service-user, rather than to themselves, or the external context, however the extent to which this held true depended on the type of behaviour exhibited. For sexualised challenging behaviour, staff were more likely to attribute the causes as factors that were more controllable to the client but less controllable to themselves, compared to aggressive and self-injurious behaviours. Whilst this study may offer implications for the importance of supporting staff to understand the ways in which their attributions influence the existence and maintenance of challenging behaviour, the researchers did not explicitly explore resultant emotional and behavioural responses of staff, which limits the extent to which these findings could be useful in practice.

Despite empirical support for attribution theory evidenced across some studies, other research has found there to be discrepancies. For example, discrepancies within the role of stability attributions. Weiner (1986) postulated that stability was more relevant to outcome expectancies (e.g., optimism about change), than helping behaviour. However, research has shown that stability interacts with controllability i.e. perceiving behaviour as stable and controllable increases anger and punitive responses, whilst stable and uncontrollable attributions increase sympathy (e.g., Epstein & Hornstein, 1969; Yao & Siegel, 2021). Also, whilst many studies have found emotional responses such as sympathy to generally predict helping behaviours, some studies report weak or non-significant links (e.g., Zijlmans et al., 2012). A systematic review by Wilner and Smith (2008) found that the evidence for Weiner's attribution theory was inconsistent, reporting at best partial support for the theory. The authors argue that these inconsistencies in support for the theory may in part be explained by methodological issues with included research, specifically within how helping behaviour is defined. For

example, one study included in the review defined helping behaviour as ‘intervening in ways that were less likely to reinforce challenging behaviour’ (Jones & Hastings, 2003), whilst other studies utilised definitions more aligned with likelihood and willingness to help (Rose & Rose, 2005). Other inconsistencies reported were related to the relationship between expressions of willingness to help and actual helping behaviour, and there was minimal evidence to suggest that these two variables were associated (Willner & Smith, 2008).

Perhaps related to this, another methodological factor which may contribute to inconsistencies is that much of the evidence base is built upon hypothetical, self-reported studies (Pekrun & Marsh, 2018), which limits the ecological validity and application of attributional relationships and pathways to real world contexts. Despite this, the research examining whether hypothetical or real-world scenarios are different has also demonstrated inconsistencies. For example, Lucas et al. (2009) reported significant differences within the attributions of teachers between vignettes and real-world scenarios, whilst other studies have not found there to be significant differences between the two (e.g., Willner & Smith, 2008).

7.8.2 Factors Informing Attributions

Some research has examined how different conceptualisations influence attributions, and resultant emotional and behavioural responses. Much of this research has examined the influence of medicalised explanations on stigmatising attitudes towards mental health problems, and some exploring attributions towards physical health (e.g., Roesch & Weiner, 2001). Generally, findings demonstrate that medicalised conceptualisations decrease attributions of controllability an individual is perceived to have over their conditions, thereby reducing blame, and increasing responses such as sympathy and helping (e.g., Kingston et al., 2016; Kvaale et al., 2013; Monterosso et al., 2005). Whilst a reduction in controllability may have some helpful implications, some studies have demonstrated that explanations which conceptualise mental health problems as medical and uncontrollable to the individual, are more likely to increase how dangerous the person is perceived to be (Haslam & Kvaale, 2015; Jorm & Griffiths, 2008; Lebowitz & Appelbaum, 2018; Read et al., 2006).

Conversely, research examining the influence of psychosocial explanations on attributions appears more inconsistent and perhaps more nuanced, with regards to which attributions are most sensitive to change. For example, studies appear to suggest that offering psychosocial explanations which contextualise an individual's behaviour and presentation may reduce attributions of dangerousness (e.g., Haslam & Kvaale, 2015; Walker & Read, 2002) but appear to increase attributions of controllability and personal responsibility (e.g., Kingston et al., 2016; Lincoln et al., 2008). It may be feasible that a reason why psychosocial explanations may increase attributions of controllability is because they offer information about an individual's social context, which is not typically emphasised within more medicalised explanations. A study by Foster and O'Mealey (2022) may substantiate this point. They reported that socioeconomic status was significantly associated with mental illness stigma, and this was mediated by attributions of controllability and personal responsibility. Specifically, higher socioeconomic status individuals are more likely to perceive mental health problems as being causally related to internal and controllable factors, which increases blame (Foster & O'Mealey, 2022). Considering this, it appears that both medicalised and psychosocial conceptualisations can influence and alter attributions towards stigmatised presentations.

Some evidence has shown that familiarity can influence attributions and resultant emotional and behavioural responses. Familiarity has been defined as interpersonal contact with members of a stigmatised group (Couture & Penn, 2003). Much of the evidence base studying the impact of familiarity on attributions and attitudes is towards those experiencing mental illnesses (e.g., Corrigan et al., 2003; Couture & Penn, 2003; Walker & Read, 2002). Familiarity has been found to decrease emotional responses of fear (Corrigan et al., 2003; Link & Cullen, 1986), however there is research to suggest that not all contact reduces stigmatising attitudes. Schulze (2007) found mental health professionals, who have contact with, and provide support to, those experiencing mental illness, were still considered to be displaying stigmatising attitudes. Negative attitudes across staff populations towards individuals experiencing mental ill health is not a new or unknown phenomena and has been widely replicated within the literature (e.g., Ghuloum et al., 2022; Hamed et al., 2025 Mårtensson et al., 2014; Ross & Goldner, 2009).

Attributions have also been shown to be informed by experiences and knowledge of given presentations (e.g., Schimdt & Weiner, 1988). For example, if people possess more information about a condition, they may be less likely to appraise it as being within an individual's control (Kalsy et al., 2007), and this has also been shown to be influenced by the extent of staff's experience (Hastings, 1997). Increased knowledge may support a reduction in blame and increases in sympathy, resulting in increased likelihood of helping-related behaviours (Schimdt & Weiner, 1988). These findings may suggest important implications for the importance of staff education, training, and development, if education can influence attributions (Corrigan et al., 2001). A study by Davies et al. (2016) found a significant increase in staff confidence and changes in stability and controllability attributions of challenging behaviour, following participation in a positive behavioural support training intervention. Support for the utility and value of staff training in positively influencing professionals' attributions has also been replicated in other studies (e.g., Corrigan et al., 2012; McKenzie et al., 2002; Rose et al., 2014). These findings may also offer important insights and implications for staff working with SMD, for example the potential utility for offering staff opportunities for training and development and providing staff with training about the causes and maintaining factors of homelessness, mental health problems, and substance use may serve to recalibrate attributions. For instance, trauma-informed or psychologically informed trainings may support staff to frame behaviours in less blaming terms, which may also have a bearing on helping responses, staff-service-user relationships, and person-centred care within services.

7.8.3 Applying Attributional Models to SMD

Taken together, the literature highlights how attributions are not fixed; they are shaped by knowledge, experiences, and social context. For SMD populations, where stigma and blame are prevalent, the importance of equipping staff with psychologically informed attributional frameworks appears clear. Training and organisational culture play a role in shaping these attributional styles, and in turn, the quality of support offered to individuals facing SMD. To date, available evidence researching SMD as a unified construct is limited, and to the best of the author's knowledge, this is the first study to apply attribution theory to an SMD context. SMD is a construct that incorporates several social disadvantages, and it is important to acknowledge that

across the literature, some domains of SMD have received more research interest and input, than others. For example, a significant proportion of the evidence base has focused on attributions and attitudes towards people experiencing mental health problems (as referred to above) (e.g., Corrigan et al., 2000; Haslam & Kvaale, 2015; Kingston et al., 2016; Kvaale et al., 2013; Sousa et al., 2012; Wainwright & Mojtahedi, 2020). Many of these studies have examined attributions towards voice hearers (Kingston et al., 2016) or diagnostic labels of schizophrenia (e.g., Corrigan et al., 2003; Rüsch et al., 2010; Sousa et al., 2012). Other studies have focused on examining attributions and attitudes towards other psychiatric labels, such as depression and anxiety (e.g., Jorm et al., 2000; Wood et al., 2014).

A study by Cronan et al. (2016) revisited the work of Weiner et al.'s. (1988) seminal research on attributions towards the perceived causes of ten different stigmas to examine how stigmas may group, according to attributions of controllability and stability (several of the examined stigmas are relevant to an SMD context e.g., schizophrenia, depression, drug addiction, abuse survivor). Cronan et al. (2016) also tested whether responsibility attributions (i.e. how responsible an individual is for their condition) influences attributions, emotional responses, and helping behaviours. Findings showed that if individuals are perceived to be responsible for their conditions, controllability attributions are higher, and this was associated with less positive emotion and less helping behaviour. The inverse was also found to be present; lower perceived responsibility tended to lower negative responses. These findings appear to support Weiner (1986) and map onto the 'causal chain' he proposed. Stigmas perceived as controllable attracted higher blame, anger, and reduced helping intentions, consistent with Weiner's hypothesis that attributions of responsibility generate negative affect and more punitive / distancing responses. This attributional style has also been demonstrated in other studies examining attributions, emotional, and behavioural responses towards those experiencing mental health problems (e.g., Corrigan et al., 2003; Corrigan et al., 2007; Obonsawin et al., 2013).

Some research has also applied attribution theory to substance use, particularly attributions towards substance dependence (e.g., Tolfrey et al., 2011; van Boekel et al., 2015) and highlighted the role of perceived controllability in shaping social and professional responses. Earlier influential research by Weiner et al. (1988) found attributions toward drug dependence to be one of the most controllable across the ten

stigmas the study examined, which elicited the least sympathy and highest blame. Substance use may often be judged as highly controllable, which increases blame and anger, and reduces willingness to help (Corrigan et al., 2000; Sattler et al., 2021). Conversely, when framed through medical or 'disease' models that emphasise reduced personal responsibility, attributions appear to shift towards offering increased sympathy and support (Clark, 2022), thus the perceived causes of substance use and language used to describe individuals who engage in these behaviours hold important implications for the way in which substance use and dependence is framed and responded to (Kelly, 2004; Kelly & Westerhoff, 2010).

Some research has suggested that attributions and willingness to help may vary depending on type of substance and gender. A South African study by Sorsdahl et al. (2012) found that participants held equally negative attributions of all presented substances, except for cannabis, which was attributed as significantly less dangerous than alcohol. Respondents were also significantly more likely to offer help to women who use alcohol but were more likely to exhibit coercive responses towards men. However, research by Hatgis et al. (2008) examined attributions of personal responsibility towards substance dependence across a spectrum of different drugs (cannabis, cocaine, heroin, alcohol). Findings revealed that personal responsibility attributions were highest for cannabis use and towards men, compared to women. These findings offer partial support to Hatgis et al. (200) and may imply that responsibility attributions are perhaps in part driven by perceptions of how harmful / addictive a substance is. These studies suggest there may be a range of complex factors influencing the attributions made about substance use, as well as the wider social context and culture of respondents. Attributions which portray individuals who use substances as having greater control and responsibility, have also been shown to reduce the willingness of help-seeking (e.g., Yang et al., 2017), which may have important implications for how services appraise substance use and the accessibility of support.

Attributions of stability may introduce slightly more complexity: whilst substance use is often viewed as chronic and relapsing, this perception can foster therapeutic pessimism and reduce optimism about recovery (Walton et al., 1994). Further, extensions of attribution theory point to the role of dangerousness attributions, with people who use substances frequently perceived as threatening, further reinforcing

avoidance and punitive attitudes (Corrigan, 2000). Together, these findings suggest that how substance use is conceptualised has direct implications for stigma, professional behaviour, and the quality of support provided within SMD contexts.

Attributional research on homelessness is more limited than for mental health or substance use and is predominantly epidemiological in endeavour, but some existing evidence suggests similar patterns in how controllability shapes responses. Research exploring public attitudes has been shown to frame homelessness as the result of personal failings (e.g., laziness, poor choices), which increases blame and punitive intentions, whilst reducing support (Batterham, 2020). Conversely, when homelessness is attributed to structural or uncontrollable factors such as poverty, lack of affordable housing, or systemic disadvantage, people express greater sympathy and willingness to help (Toro et al., 2007). A study by Vázquez et al. (2017) examined attributions about homelessness in Madrid and found respondents who were not homeless themselves were more likely to attribute the causes of homelessness to 'individualistic' factors and to attribute higher blame. This contradicts findings from a U.S study by Toro and McDonell (1992) who reported most respondents apportion blame to society rather than individuals, for homelessness.

Across studies, people appear to attribute the causes of homelessness to multiple factors, suggesting complex attitudes about its causes. Regarding emotional responses towards homelessness e.g., compassion and sympathy, a systematic review by Batterham (2020) revealed sympathy is related to more structural explanations of homelessness, whereas fear or anger towards people experiencing homelessness is connected to more internal attributions for homelessness (such as laziness, criminality, addiction and mental illness) (Barnett et al, 1997). The review also found that, in terms of compassion and support for public rights for people experiencing homelessness, Italy, Germany and Belgium all had higher scores than the U.K. and U.S (Toro et al, 2007). Batterham (2020) suggests however, it is important to acknowledge that most European citizens hold positive attitudes towards people who are homeless (Petit et al, 2019).

The above research discussed attributions towards individual domains of SMD. It is important to note however that to date, available evidence researching SMD as a

unified construct is limited, and to the best of the author's knowledge, this is the first study to apply attribution theory to an SMD context.

7.9 Additional Rationale and Aims

Despite SMD being a relatively new concept, prior research into SMD has increasingly begun to highlight that how the phenomenon is operationalised and understood, whether framed as an outcome of individual pathology, structural inequity, or cumulative disadvantage, may have significant implications for practice and policy (Cockersell, 2018; Bramley et al., 2020). Staff working with individuals experiencing SMD are continuously required to interpret complex behaviours and needs, and these interpretations are likely not neutral. Attribution theory (Heider, 1958; Weiner, 1979) suggests that how causes are understood influences both the emotional responses of practitioners (e.g., anger or sympathy) and their behavioural responses (e.g., supportive engagement, withdrawal or punitive action).

Despite this, there is very limited research examining how different explanatory models of SMD shape frontline workers' responses. Given the high prevalence of trauma and adversity amongst this population, and the well-documented risk of services themselves becoming sites of re-traumatisation (Bloom, 2010; Hopper et al., 2010), it is crucial to understand whether certain framings encourage more compassionate, relational, and effective responses, or conversely, perpetuate stigma and exclusion.

Further, from a more systemic perspective, this line of enquiry is relevant to service design, delivery, staff training, and commissioning. It is likely that services are heavily influenced and driven by commissioning-related pressures and targets, rather than being service-user led. The aforementioned complexities of service provision, and the challenges faced by people experiencing SMD when trying to access services, may leave people feeling that they possess little autonomy in their care and recovery. If staff attributions and responses are shown to differ depending on explanatory framing and the inclusion of different psychological perspectives, this would strengthen the case for embedding psychologically informed models across services. Furthermore, it could reveal barriers within existing approaches (e.g., deficit-based or managerialist framings) that may inadvertently reinforce negative cycles of exclusion and disadvantage.

Ultimately, it is hoped that exploring this question will contribute to theoretical understanding of how attribution processes may be applied within an context of SMD, whilst also generating insights to inform and improve staff training, service and systemic culture, and policy. Findings may highlight adaptations at both service and individual levels, to foster more cohesive, person-centred, and strengths-based support, with the potential to enhance wellbeing and engagement amongst people experiencing SMD.

7.10 Hypotheses

Since this is the first known study to examine the influence of different conceptualisations on staff members attributions and behavioural intentions, the aims were exploratory and there was insufficient evidence to hypothesise any directional or non-directional differences. As such, no specific hypotheses were made.

8. Extended Methods

8.1 Rationale for Mixed Methods Approach

This study sought to address two main aims; one was measured quantitatively; the other was explored using a qualitative approach. Thus, a mixed-methods approach was adopted. Broadly, quantitative methodologies use numerical data and seek to formulate and test hypotheses to explain and predict relationships between variables. Within the context of attribution literature, this can include experimental designs and statistical analyses to examine how people attribute causes to events and behaviours. Conversely, qualitative inquiry is more concerned with an in-depth understanding of phenomena and narratives within their naturalistic setting, seeking to reveal and interpret meanings from data collected in a given context (Ahmad et al., 2019).

Mixed methods designs may provide an enhanced and more holistic understanding of the phenomena of interest, supporting a breadth and depth of both quantitative and qualitative knowledge (Wasti et al., 2022). Since attribution research is typically concerned with subjective experiences but utilising quantifiable methodologies, a mixed methods approach was considered to be the most useful method for the present study. It was also considered that since current literature exploring the attributions and behavioural intentions of staff supporting those experiencing SMD, is very limited, a mixed methods approach could provide a more holistic and contextual perspective.

8.1.1 Epistemological Position

Within attribution literature, research has traditionally tended to be informed by a positivist epistemological position, operationalising attributions as real and measurable underlying mechanisms of social phenomena. In conceptualising attributions in this way, such research has adopted mainly quantitative methodologies. Research exploring attribution in relation to SMD domains, although scant, also follows this approach, focusing largely on collecting quantitative data to express and explain differences in attributions, based on given characteristics of interest. A positivist epistemological position, implementing quantitative methodologies, enables the

researcher to capture a broader range of attributions, on a larger scale, and draw conclusions about the influence of given factors on attribution. However, positivist positions have been criticised for negating the influence of subjectivity within experiences of both the participant, and the researcher (Denzin & Lincoln, 2017). A further important critique is that positivist perspectives tend to inherently objectify constructs and experience, which consequently neglects the subjective and relativist nature of these. For example, subjectivity within individuals' attributions around the causes and controllability of a given characteristics in relation to SMD will likely be somewhat dependent on how participants understand the functionality of such characteristics within a particular context. Whilst quantifying participants' attributions does enable constructs of interest to be empirically and objectively measured, which was important for exploring the impact of different conceptualisations of SMD on staff attributions, from a critical realist stance the current research was also fundamentally concerned with the subjective interpretations and contextual factors that shaped participants attributions and behavioural intentions.

Given the critique of a purely positivist approach limiting reality to what can be measured and explained empirically (Bhaskar, 1998; McEvoy & Richards, 2006), and the lack of acknowledgement regarding the importance of causal mechanisms which may not always be directly observable, a critical realist position was philosophically compatible. Critical realism contends that social reality cannot be de-contextualised (Stylianou & Scott, 2018), and accounts for the idea that social reality occurs within open systems, which incorporate interactions between both internal and external contexts (Danermark, 2019). Critical realism seeks to understand social phenomenon through observable and non-observable events, but also through identifying the causal, underlying mechanisms (the real domain) (Bhaskar, 1975; 1989). An integral aim of attribution theory is also to identify and assign causes to events and behaviour. This could be considered to align with the critical realist goal of measuring an observable reality and seeking to uncover hidden mechanisms that drive such outcomes, whilst also recognising that how this is measured is informed by subjective processes (Patomäki & Wight, 2002). In adopting this perspective, it was considered that attribution could be quantified and measured, whilst also retaining and embracing

the subjectivity of experience which may contribute to the attributions, and emotional and behavioural responses staff gave about Alex

8.2 Design

The study adopted a convergent mixed methods design. An online survey was created and distributed between March 2024 and September 2024 for data collection. Within the quantitative arm, a randomised independent groups design was used. The independent variable was vignette condition, whereby participants were randomly allocated by QuestionPro's randomiser tool to view one of three vignette conceptualisations: (1) Biographical, (2) CBT-informed, or (3) Values-informed. The dependent variable was participant scores on the attribution measure, pertaining to the attributions, emotional and behavioural responses made by staff about Alex. Within the qualitative arm of the study, behavioural intentions of staff, to support Alex were explored. Behavioural intentions were captured using two qualitative, open-ended questions, to explore how staff would support Alex in terms of their actions, and what factors they would consider to be important in doing so.

8.3 Participants

8.3.1 Power Analysis

An a priori power calculation using G*Power 3.1 software was conducted to determine the required sample size. The study was powered for appropriate analysis for the primary aim, which utilised a one-way ANOVA, where parametric assumptions were met, and Kruskal-Wallis test where violated. To ensure adequate power for the proposed statistical analysis, a target sample size of 159 participants was required (approximately 53 per vignette condition, assuming randomisation of participants across vignettes was evenly distributed across the total sample). Sufficient power was determined at $>.80$, with a confidence interval of 95% ($\alpha=.05$), to detect a medium effect size ($d=0.5$) (Cohen, 1988). Rationale for sufficiently powering the study to detect a medium effect size was primarily based on previous research comparing different conceptualisations of mental illness and disadvantage on attributions (Kvaale

et al., 2013), and on discussions with both research supervisors, regarding what size of effect would represent clinically significant implications of the findings for clinical practice. Due to unforeseen and unanticipated challenges with recruitment, the sample size target was not achieved¹⁸.

This was somewhat surprising given that recruitment had been extended, following an ethics amendment, out to both local and national networks, and the researcher had made repeated attempts to contact potential gatekeepers over the course of the recruitment window. It was also later discovered that when examining the survey analytics that subsequent attempts following the ethics amendment and further outreach to national networks had not resulted in an increase of respondents completing the survey. Despite this, due to time constraints around the recruitment window, and the length of time recruitment had been open, it was not possible to further extend the recruitment window beyond that already agreed.

Additionally, following lengthy discussions and reflections with project supervisors regarding what the potential challenges in meeting the recruitment target might have been attributed to, it was decided that further extending the recruitment window would not address these, and hence not likely increase uptake.

8.3.2 Rationale for Inclusion Criteria

The study was open to staff members working in identified gatekeeping organisations, aged 18 years and over, who were currently working in a service user facing role within UK homelessness services. It was felt to be important that participants were currently occupying a role whereby they were directly supporting people experiencing SMD, as the attributions and behavioural intentions of this staff population was of primary interest. Screening criteria also stipulated that all participants were required to have been working within a service-user facing role for a minimum of six months. The researcher and supervisors felt this to be sufficient experience of working with people facing SMD, for staff to have developed an understanding of the typical experiences and needs of this population.

¹⁸ For further information see Extended section 8.4.1

As the vignettes were only made available in English language, participants were also required to be literate in English, and to have access to the internet and an internet-connecting device, to complete the online survey. Given that participants were required to be employed within SMD services, it was felt to be very unlikely that participants would not speak English or have access to the internet, thus it is not anticipated that these criteria would have excluded anybody who met the eligibility criteria.

8.3.3 Exclusion Criteria

Any participant who did not answer “Yes” to any of the three screening questions or questions detailed within the consent form, was not eligible to take part, and thus was excluded from the study. If so, respondents were directed to a page within the survey to inform them that they did not meet inclusion criteria and thanking them for their time and interest in the study.

8.3.4 Sample

Seventy-nine participants were recruited in total. Participants were given the option to also provide qualitative data in addition to quantitative responses, as this was not related specifically to the primary aim of the study and thus was not mandatory to take part. Of the 79 participants who completed the online survey, 70 also provided qualitative data.

8.4 Recruitment

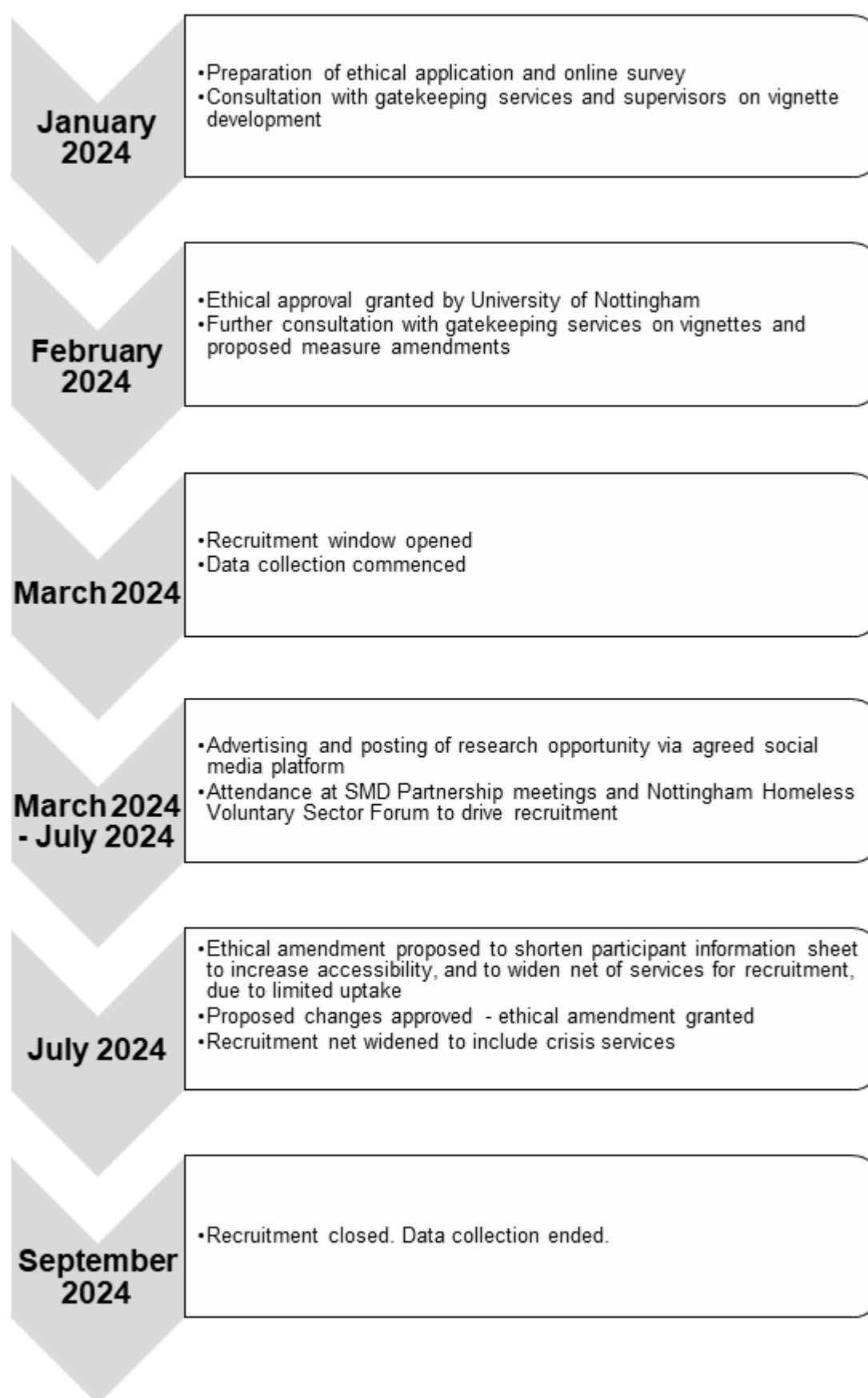
The employed recruitment strategy was two-fold, and utilised both opportunity and snowball sampling strategies. Gatekeeper organisations were sought out and approached for agreement prior to obtaining ethical approval, to ensure any organisation supporting with recruitment would be approved by the University’s ethics committee at the point of ethics application. Gatekeeper organisations included local and eventually nationally based third sector services, supporting those experiencing SMD (Framework, Homeless Link, MEAM, Homeless Psychology Network, The Practice Development Unit), who all promoted the study directly to their staff pool, sending the link out to global organisational email lists, and via advertisement in

monthly staff bulletins. Following ethical approval, study information (including the recruitment poster, participant information sheet, and survey link) was emailed by the researcher and the primary supervisor to nominated staff members within each organisation, for distribution across the service. The researcher also attended several service meetings to begin developing a working alliance and further distribute the research across organisations to support recruitment.

Social media was also used to advertise and promote the study. A professional account on social media platform X was created, and maintained by, the researcher, dedicated to advertising and promoting the study to relevant services and organisations. The study's recruitment poster and survey link were posted on the X account, using relevant hashtags to maximise views and interactions with the post. Previous research has suggested one benefit of utilising social media to facilitate opportunity and snowball sampling strategies is that it can support access to samples which may be unknown or difficult to reach (e.g., Gelinas et al., 2017; Leighton et al., 2021). However, such techniques may make it difficult for sampling error to be accurately determined, thus caution should be applied when considering the overall generalisability and representativeness of the studied population (Sharma, 2017).

To encourage participation, and as compensation for their time and interest in the study, all participants were offered the chance to be entered into a voluntary prize draw. The prize draw was for Amazon vouchers of varying monetary value (1x£50, 2x£25, 4x£10). Participants were asked at the end of the survey if they would like to be entered into the prize draw. If so, they were taken to a separate survey page and prompted to provide their professional email address, which could then be used for randomly selecting the winners. Winners were selected using an online randomiser.

Figure 2. Timeline of recruitment process



8.4.1 Recruitment Challenges and Chosen Solutions

There were unanticipated challenges throughout recruitment, which required reflection, dynamic thinking, and flexibility to navigate and overcome. Prior to recruitment opening, and throughout, despite efforts made by the researcher to develop relationships with services that had agreed to support with recruitment, approximately four months into the recruitment window, it became apparent that insufficient participants had completed the online survey, to satisfy the a priori power calculation. Through checking the analytics function on the survey platform, it was noted that despite many people entering into the survey, a significant proportion of them were exiting at three main stages (prior to completing the measure questions; (1) after the participant information page, (2) following the screening questions page, (3) prior to providing informed consent. Whilst it was reassuring to learn that the screening questions were fulfilling the purpose of filtering out participants who did not meet eligibility criteria, it was apparent that there was significant attrition after participants had read the study information sheet.

To overcome this, it was decided that an ethics amendment would be proposed and submitted to request changes to condense the participant information sheet, to make the information given about the study more inviting and accessible. An amendment was accepted by the UoN ethics committee in July 2024, which in turn did support with increasing participant uptake, however the study remained underpowered at the point of closing the recruitment window in September 2024. Implications of this are discussed further within Extended sections 9 and 10.

In considering what contributed to the challenges with recruitment, and the study subsequently being underpowered, one hypothesis is related to the population of staff the study was sampling from being incredibly stretched and under pressure within their roles, and thus the research subsequently being potentially perceived as another demand. This may have impacted how likely staff were to take part, as participating was not mandatory to their professional role. In reducing the information on the participant information sheet, it was hoped that this would increase the study's accessibility and reduce participant burden. Since the current evidence base for the application of attribution theory and psychological models within the SMD population is scant, staff working in this area may not be familiar with this theoretical framework

and related language used, or with its potential value to their practice. This may have inadvertently deterred or obstructed them from taking part. This hypothesis may be especially important as many of the sample who did take part were from support worker roles, who may be even less likely to be familiar with the relevant evidence base.

8.5 Vignettes

A vignette design was used to enable manipulation of the independent variable. Amongst relevant literature, definitions of vignettes within experimental research contexts, integrate a combination of common concepts. These have tended to include systematically and pragmatically varied descriptions of people, objects, and/or situations, which may represent a combination of characteristics, with the intention of eliciting relevant attitudes, beliefs, ideas and intended behaviours, related to the vignette material (Steiner & Atzmüller, 2017). As vignette methodology enables the researcher a degree of control and manipulation of the variables of interest, and information presented to participants, they are thus a frequently utilised method within attribution research. This may enhance the internal validity and robustness of the research design by endowing the researcher more confidence in concluding cause-effect relationships, in that any differences observed between conditions may be attributable to discrepancies within the vignettes presented (Hughes & Huby, 2002).

Vignettes may also have utility when it is not possible or feasible within the research design to observe actual behaviour(s) which are of interest to the research aim(s). Asking participants to rate their responses in relation to 'Alex', presented within the vignette, rather than appraising generic statements, may also enhance the study's ecological validity as it offers a higher degree of realism in relation to participants' attributions and intended behaviour (Corrigan & Shapiro, 2010). Despite a key aim of vignette designs being to maximise some types of validity, they have attracted some criticism for having lower external validity (e.g., Eifler & Petzold, 2019), as the information presented may not be reflective of wider experiences, for example people experiencing SMD.

As available evidence regarding any effects of gender differences within vignette research has yielded conflicting results, it was deemed important to be cautious, thus

proposing 'Alex' as a gender-neutral figure. Research by Visser et al. (2022) reported findings suggesting that whilst no main effects of gender congruence were observed across vignettes on their outcomes of interest, they did conclude that methodological decisions relating to vignette development should be informed by, and depend on, the study's aims. In recognition of conflicting evidence regarding gender, and as the current research was not specifically interested in any influence of gender differences on attributions and behavioural intentions, vignettes were developed without specifying a pre-determined gender.

8.5.1 Vignette Development

All three vignettes were developed by the researcher. An initial draft of each vignette was reviewed by the primary, secondary, and field supervisors, two of whom have professional experience of working within homelessness services and directly supporting people experiencing SMD, as well as experience of working within both CBT and Values-based approaches. It should be acknowledged however that all three supervisors were Clinical Psychologists, which may thus have influenced the guidance offered around the differing conceptualisations. Once feedback was received, recommended changes were made by the researcher, to ensure the vignettes' fidelity to their respective models. The vignettes were then shared with relevant stakeholders, who were involved in recruitment and working within homelessness services, to ensure their relevancy and representativeness of the SMD population, thus helping to improve their content and face validity. The perspective of a service user experiencing SMD was not sought, as it was important that the vignettes did not reflect the true experience of an individual and were thus purely fictional. However, on reflection, this may have offered a more representative view of lived SMD experience, which could have bolstered validity, and would perhaps have presented an important opportunity for co-production with service-users and individuals with lived experience of SMD.

Whilst efforts were made to ensure that all vignettes were similar in length, naturally those which were informed by one of the psychological models were slightly longer, due to the addition of psychological information elaborating on descriptive details of Alex within the conceptualisation. All vignette lengths were however congruent with current recommendations made within available literature (e.g., Bradbury-Jones et al., 2014; Evans et al., 2015).

Whilst there is currently no universal set of best practice recommendations for developing vignettes for use within mixed-methods research, available literature was consulted with regards to maximising the content and face validity, readability and representativeness of the vignettes. Research by Aguinis and Bradley (2014) outlines a series of recommendations for designing and implementing experimental vignette methodology and offers a synthesis of available evidence in doing so. They highlight the importance of various decision points encountered within vignette research, including the type of vignette and research design, and choosing the level of immersion of participants within the vignette content, to establish an appropriate degree of realism. Aguinis and Bradley (2014) also discuss the importance of choosing the number of vignettes and being specific about the various descriptions and manipulations to the factors and levels which are integral to the research question(s) and aim(s). This was important within the current study as despite each vignette offering the same descriptive information about Alex and their experiences of SMD, the content differed in relation to the psychological understanding of Alex provided.

8.5.2 Vignette Conceptualisations

All three vignettes included the same descriptive overview of Alex and their experiences. This formed the *biographical* vignette, as given below:

Alex has a history of experiences related to severe and multiple disadvantage. Growing up, Alex had difficult and chaotic relationships with their parents and frequently witnessed domestic violence. Alex's physical and emotional needs were often neglected. As a result of domestic violence and neglect, Alex was removed from the family home and taken into foster care. Alex would often flee foster placements and spend periods of time homeless on the streets. Alex does not have any lasting relationships. Alex found education difficult and did not regularly attend school or obtain qualifications. During Alex's time living out on the streets, they became involved with a group of peers and began using various substances.

Alex has historically experienced difficulties with their mental health and frequently struggles with episodes of depression and anxiety. During such

times, Alex has used substances and alcohol excessively. On previous occasions, Alex has had altercations with peers in the hostel they reside at, sometimes leading to aggressive outbursts which have required police involvement. On one occasion, Alex had an altercation with two other residents, having thought the peers were talking about Alex. Alex responded aggressively towards the two peers and the police were required to support staff in managing the incident. Alex also has intermittent contact with the criminal justice system for other behaviours, such as shoplifting.

Building on this, the other two vignettes¹⁹ were developed to incorporate different psychological information, to explore the impact of the differential explanations on attributions and responses given about Alex. The CBT-informed conceptualisation emphasised an understanding of Alex's experiences within the context of cognitions, emotions, and subsequent behaviours. Details given about Alex's experiences, including behaviours, were linked to Alex's historical context which informed the development of core beliefs, rules for living and more current cognitions (e.g., negative automatic thoughts), emphasised to be influencing their emotions and subsequent behaviours. The values-informed vignette framed Alex's current presentation and behaviours within the context of being aligned with their values. Like the CBT-informed conceptualisation, the values-informed vignette emphasised the idea that values are developed as a result of lived experiences, and drawing on the underlying premise of values being core structures which may guide and co-ordinate behaviour (Homer & Kahle, 1988; Paliliunas, 2021).

8.5.3 Vignette Readability

Readability analysis (Klare, 1974) was conducted on all three vignettes. Readability analysis generates two scores: (1) Flesch Easy Reading score, where higher scores indicate improved readability, and (2) an associated Flesch-Kincaid Reading Grade score, with improved readability indicated by a lower score. Flesch Easy Reading and Flesch-Kincaid scores were originally developed in the United States of America, thus the formula and terminology used are primarily representative of an American

¹⁹ See Appendix H for full vignettes.

population. Readability analysis demonstrated that vignette readability was suitable for college grade. Whilst this demonstrates a reasonably high level of reading ability, it is likely that this score was influenced by the inclusion of complex psychological terms and language related to SMD, not as likely to be encountered in everyday material. Although interestingly the biographical conceptualisation had the lowest Flesch Reading Ease score, suggesting this vignette had the lowest ‘readability’. It is likely that vignette readability was also influenced by sentence length, which on reflection could have been shorter. Reading grade was also shown to be consistent across all conditions, which may help to maximise internal validity of vignette content across conditions, even where the conceptualisation was different.

Table 5. Vignette Readability Scores and Flesch-Kincaid Reading Grade

Vignette Conceptualisation	Flesch Easy Reading Score (Flesch-Kincaid Reading Grade)
Biographical	30.9 (13)
CBT	36.5 (13)
Values	38.4 (13)

8.6 Data Collection

Data collection methodologies may span across a continuum ranging from structured, close-ended questionnaires to open-ended interviews. Structured questionnaires offer the advantage of being useful for collecting large datasets and may be more practical and efficient with regards to participant burden, time, and analysis of data (Young, 2015). Previous attribution research has adopted this method to gather a high quantity of responses within a limited timeframe (e.g., Kingston et al., 2016). Where data collection methodologies are narrower in scope, such as that offered by structured questionnaires, there is the potential that data obtained is limited and only directly reflective of the question asked. Consequently, other information which may be of potential interest to an area of investigation (e.g., for contextualising responses), is missed.

More flexible and broader methodologies of collecting data, such as semi-structured or open-ended interviews, may offer the advantage of allowing for greater detail and subjective data to be captured. However, interviews may increase the likelihood of social desirability and investigator bias, which more anonymised methods such as questionnaires may help to eliminate (Bergen & Labonté, 2020; Krumpal, 2013). It was felt by the researcher that attribution and behavioural intentions in the current study could be sensitive to confounding influences such as perceived social desirability, as participants were staff members currently working with individuals experiencing SMD. Thus, when designing the current study, this was considered, along with the relative advantages and limitations of both data collections methodologies outlined above.

Subsequently, this research sought to use an online questionnaire. Two types of questionnaires were used for collection of data: structured and unstructured. To measure staffs' attributions about Alex, a structured questionnaire was adopted. Behavioural intention was examined using two open-ended questions, exploring what actions participants would take to support Alex, and what factors they would consider important in doing so. The two questions prompted qualitative responses, inviting participants to share more idiographic details about their behavioural intentions. As all responses were anonymous, in adopting this method of data collection, it was envisaged that social desirability and investigator bias would be reduced throughout, and participants would feel more able to give honest responses, reflective of their true judgments. This design also permitted a greater number of participant responses to be collected within the study's limited recruitment timeframe.

8.7 Measures

8.7.1 Demographic Data

Demographic information was collected from all participants, across four socio-demographic variables: (1) gender, (2) age, (3) professional background, and (4) number of years of experience working within the SMD sector. For all demographic questions, participants were given the option of choosing 'prefer not to say,' if they did not wish to provide this information. Categorical ranges were used for participants to indicate which option best described them across all four questions, and previous literature was used where possible, for example for age, to inform the development of

meaningful age ranges (Geifman et al., 2013). Whilst demographic data was not used as part of any of the statistical analyses, or directly necessary to address either research aim, it was considered important to facilitate in describing the sample and contextualising the attribution and behavioural intentions data.

8.7.2 Adapted Attribution Questionnaire

This study used an adapted version of Corrigan et al.'s (2003) attribution questionnaire (AQ-27), to measure staffs' attributions about Alex and their emotional and behavioural responses. Corrigan et al.'s (2003) original measure was developed to measure stigma associated with attributions made about adults with Schizophrenia but has been widely used within the broader attribution literature. The measure items are grouped into nine subscales, which tap into the causal attribution dimensions central to Weiner's (1979) attribution theory; locus of internality, controllability, and stability/globality. These constructs are measured via the domains of 'blame' and 'dangerousness'. The AQ-27 also measures associated emotional responses ('anger', 'fear', 'pity'), and behavioural responses ('helping', 'avoidance', 'coercion', 'segregation'). Each item is presented as either a statement or a question about an individual's thoughts, feelings, or a hypothetical decision they might make (e.g., "if I were an employer, I would interview Alex for a job"). Items are scored using a nine-point Likert scale. Higher factor scores represent greater endorsement of the corresponding attribution or response. Statements relating to the 'avoidance' subscale are reversed scored. In measuring causal attributions and associated emotional and behavioural responses, the measure is grounded within Weiner's (1979) attribution theory, to examine how people explain the causes of a given presentation and how these explanations influence emotional and behavioural responses.

Research has generally supported the reliability and validity of the AQ-27 (Fridberg & Ahmed, 2013). Field (2018) suggests an alpha score of .7 or more indicates good reliability. Cronbach's alpha scores demonstrate good internal consistency across subscales, ranging from $\alpha = .68$ – $\alpha = .96$ (Corrigan et al., 2004; Kingston et al., 2016). Some research has found internal consistency of the 'pity' subscale was improved by separating 'pity' from the other two components measured within that domain ('sympathy' and 'concern') ($\alpha = .68$ to $\alpha = .75$) (Buttery et al., 2020; Kingston et al., 2016). The current study reported a Cronbach's alpha score of $\alpha = .63$ with 'pity'

domain items amalgamated, and $\alpha = .70$ when 'pity' was separated from 'sympathy/concern', suggesting this improved the internal consistency of the measure in this study too; a finding which is in line with previous research. There is however some debate regarding the factor structure of the AQ-27, with some research supporting six factors (e.g., Brown 2008) versus nine factors (e.g., Corrigan et al., 2003; Corrigan, 2012).

Whilst there is to the best of the researcher's knowledge, currently no research using the AQ-27 to examine the attributions and emotional and behavioural responses of staff towards those experiencing SMD, it was deemed that there is considerable overlap and coexistence between the population the measure was developed from (mental illness and stigma) and those experiencing SMD and associated exclusion / stigmatisation. A shorter version of the AQ-27, (AQ-9), was also considered in attempting to balance efficacy and construct validity of the chosen measure with brevity and participant burden, however the AQ-27 was considered to be more comprehensive in incorporating constructs of attribution, emotional and behavioural responses. This was important as it was the only standardised measure used within the current study.

As there is no specific measure of attribution in relation to an SMD context and population, minor adaptations were made, including changing the given name in the original measure from 'Harry' to 'Alex'. Minor amendments were also made to the language of four questions on the measure, where the language used was not applicable to the current study e.g., terminology specifically related to psychiatric settings, and to help ensure their representatives of all domains of SMD. For example, the statement *"if I were in charge of Harry's treatment, I would force them to live in a group home"* was amended to instead read *"if I were in charge of Alex's treatment, I would force them to live in a supported living service with others"*. Three out of four of the amended questions corresponded to the 'segregation' domain, and one corresponded to the 'coercion' domain. This may offer support for the rationale of amendments only being necessary to terminology and language to ensure representativeness to an SMD population, as opposed to making any changes to the overall underlying factor structure of the measure. To help ensure content and face validity, consultation was conducted with homelessness services involved in recruitment and three Clinical Psychologists, two of which have experience in working

within the field of SMD, to obtain feedback on measure adaptations, and to help ensure language was relevant to, and representative of an SMD context.

8.7.3 Qualitative Questions Exploring Behavioural Intention

Several theoretical accounts have attempted to conceptualise the relationship between behavioural intention and behavioural outcome e.g., theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), and the theory of planned behaviour (Ajzen, 1991; Ajzen & Madden, 1986), positioning intention as playing an integral role in predicting behavioural outcomes. Corrigan et al. (2003) suggested that behavioural intention is a prerequisite to a behavioural outcome and demonstrated an association between scores on a behavioural outcome measure and actual helping behaviour (Corrigan et al., 2004), which has since been replicated in other attribution studies (Kingston et al., 2016). In these studies, however, the association between behavioural intention and behavioural outcome was found to be small. Considering this, the researcher felt that more open-ended means of exploring behavioural intention and outcome, could be helpful in contextualising the scores on the AQ-27, and eliciting idiographic and nuanced information relating to participants' appraisal of what factors may be important when supporting Alex.

The two questions to explore behavioural intention were developed by the researcher and the primary supervisor and were informed by the ideas discussed above (i.e., to ensure both intention and an actual behavioural outcome could be elicited). Along with vignettes, these questions were also subject to feedback from relevant stakeholders working in SMD services, to ensure they were accessible and reflective of the constructs of interest.

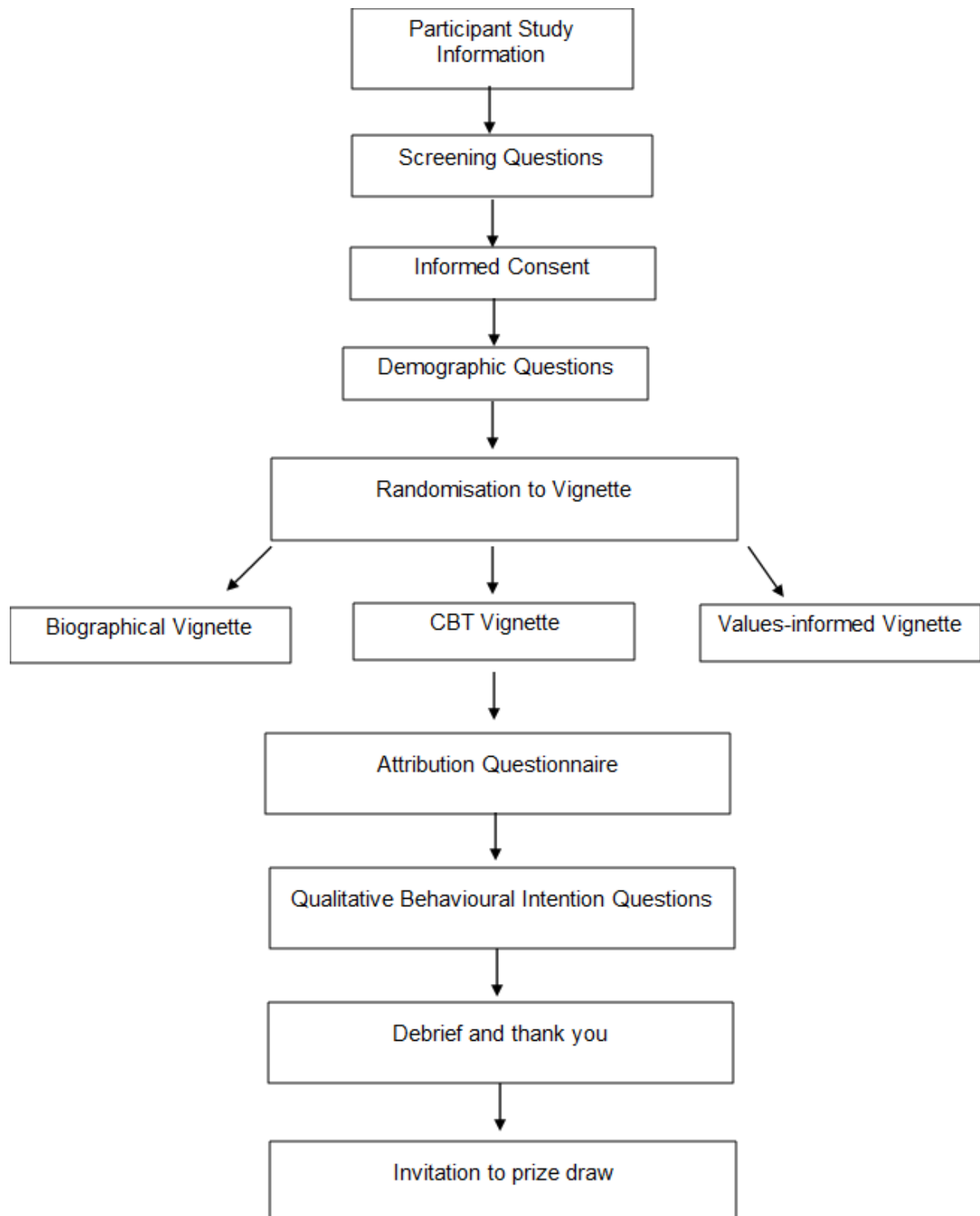
8.8 Extended Procedure

Figure 3 depicts the study procedure for all participants during data collection. Upon launching the online questionnaire, participants were immediately taken to the participant information page. All participants were asked to read this carefully and indicate by ticking a box at the bottom of the page once done so. Following this, participants were asked to answer three screening questions to assess eligibility to take part. If participants met inclusion criteria, they were automatically directed to the

page to provide informed consent to take part. Those who did not meet inclusion criteria, were taken to an exit screen and thanked for their interest and time.

If informed consent was given, participants were asked to answer five demographic questions to help the researcher describe the sample and provide context within the analysis. Participants were then randomly allocated to one of three vignette conditions, where they were asked to read the information presented about a fictional character, Alex. Participants were then asked to provide ratings for each of the statements stipulated by the attribution measure and answer two qualitative questions. At the end of the survey, participants were shown a debrief message and thanked for their time and participation. They were also asked to indicate if they wished to be added in to a voluntary prize draw for the chance to win Amazon vouchers. If 'Yes,' participants were taken to a link to a separate online 'QuestionPro' survey and asked to provide an email address for contact, if successful in the prize draw. Those who indicated 'No' were directed to the end of study page.

Figure 3. Flow diagram depicting study procedure



8.9 Ethical Considerations

The study was conducted in accordance with the ethical principles which have their origins in the Declaration of Helsinki (World Medical Association, 2013) and the principles of Good Clinical Practice. Ethical approval for the study was granted by the University of Nottingham's Division of Psychiatry and Applied Psychology research ethics committee in February 2024²⁰. An amendment was submitted and subsequently approved in July 2024. The purpose of the amendment was to support continued recruitment to the study, due to unforeseen limited uptake of participants. The amendment involved reducing the amount of information presented within the participant information sheet to improve accessibility and readability, and to change the order in which the survey flowed; specifically requesting to ask participants to answer the screening questions prior to providing informed consent.

8.9.1 Privacy and Confidentiality

Ensuring the rights and privacy of participants was a priority throughout the research. All data was collected and stored securely in accordance with General Data Protection Regulations (GDPR, 2018) and University of Nottingham regulations (Research and Data Management Policy). Access to the information was restricted to the researcher and any relevant regulatory authorities. Survey data was initially kept secure within the password protected QuestionPro online survey platform, only accessible by the researcher. Once recruitment had closed, all data was downloaded and exported into Microsoft Excel and SPSS files for the purpose of analysis. All study data, including databases, was stored within the password protected UoN OneDrive. As all data provided by participants was non-identifiable (i.e., participants were not requested to provide their name or any other potentially identifiable information throughout), participant anonymity and confidentiality was ensured. Basic demographic information was requested to support in contextualising data collecting in relation to the study's aims, however this is also anonymous, and participants were given the option to select

²⁰ See Appendix B and B1.1 for proof of ethical approval and amendment.

'prefer not to say'. All data and documents pertaining to the research will be retained for a period of seven years, in accordance with University's storage policy.

8.9.2 Informed Consent

All efforts were made by the researcher to ensure participants were provided with all necessary information about the research (i.e., within the Participant Information Sheet)²¹, prior to giving informed consent. Participants were also provided with the researcher's University of Nottingham contact details, should they have any questions regarding the research. The participant information sheet was also shared with research supervisors and stakeholders within gatekeeping organisations; to help ensure it was appropriate and accessible for prospective staff working with service-users. Where the research was advertised on social media, a brief summary and the study poster²² were provided to highlight key information relevant to taking part.

It was decided collectively by the researcher and both research supervisors that participants' eligibility to take part should be assessed via the agreed screening questions, prior to asking for informed consent. This was felt appropriate so that participants were not being asked to provide informed consent before it had been established if they met eligibility criteria, to help ensure only data was collected from those who could meet the study's inclusion criteria. Participants were made aware that if they did not meet the study's inclusion criteria, any data provided from the three screening questions, would be immediately destroyed. All participants that satisfied eligibility criteria were required to complete the online consent form, built into the study survey, before being able to access the rest of the survey questions.

8.9.3 Participant Wellbeing

It was not expected that the study was likely to cause or contribute to emotional distress for participants. It was however acknowledged by the researcher that the experience of reading a vignette describing difficult life experiences of Alex, and/or the conceptualisations of these could evoke difficult experiences for some individuals (perhaps due to their own personal experiences, as often professionals working in

²¹ See Appendix C and C1.1 for Participant Information Sheets.

²² See Appendix F for study recruitment poster.

supporting roles in such services may have their own lived experience aligning with that of service-users). In consideration of this, vignettes were read by all three supervisors, as well as relevant stakeholders within gatekeeping organisations, to help ensure their content was appropriate. All advertising social media posts were also made clear and explicit about the purpose and interests of the research, and what was required by participants. Participants were also shown a debrief page at the end of the survey, which detailed the purpose and aims of the research, and provided contact details of organisations where further information about SMD could be obtained (Framework, Homeless Link, Making Every Adult Matter). The participant information sheet and survey debrief page also included the researcher's University of Nottingham contact email address, should participants have any questions or queries relating to the research.

8.10 Quantitative Analysis

8.10.1 Primary aim

ANOVA Assumptions and considerations

ANOVAs are widely considered to be robust parametric tests (Field, 2018; Schmider et al., 2010). Despite this, it is an integral part of the analytic process to check parametric assumptions have not been violated. The following assumptions were checked prior to analysis using ANOVA:

1. *Normally distributed data*: this was checked using the Kolmogorov-Smirnov test of normality, and by assessing the values of skewness and kurtosis.
2. *Homogeneity of variance*: that samples are obtained from populations where there are equal variances. This was tested using Levene's test of equal variances.
3. *Independence*: that observations between groups are independent, as such the groups do not influence each other.
4. *Interval data*: data within the dependent variable (attributions) should be measured at least at the interval level of measurement (i.e. measured by a continuous scale, rather than nominal / categorical).

Where data is found to violate the above assumptions, non-parametric alternatives are indicated. In this instance, the Kruskal-Wallis test.

8.11 Choosing a Qualitative Methodology

Since the function of the secondary aim was to obtain a condensed and broad description of participants' behavioural intentions regarding how they may support Alex, a qualitative content analysis was considered the more appropriate qualitative approach. Qualitative content analysis constitutes a systematic research approach to describe and interpret textual data, whereby through analysis, categories and patterns are developed (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Due to its systematic and flexible approach, content analysis is a frequently utilised methodology within health and social research.

The decision to use content analysis was informed by several considerations. The second research aim was not to seek or elicit an in-depth narrative, but rather to describe and distil participants' ideas, meanings, and intentions into fewer content-related categories, which could give context and nuance to their behavioural intentions and allow for comparisons between conceptualisation groups. Also, content analysis may offer an important benefit of helping to describe the data, whilst remaining content-sensitive (Krippendorff, 1980).

8.12 Qualitative Analysis

Qualitative analysis was informed and underpinned by widely renowned guidance for undertaking qualitative content analysis; Elo and Kyngäs's (2008) guidelines for qualitative content analysis process (Elo & Kyngäs, 2008) and Hsieh & Shannon (2005). Within Elo and Kyngäs's (2008) framework, three main stages are proposed: *preparation, organising, reporting*.

Table 6. Stages of Qualitative Content Analysis (Elo & Kyngäs, 2008)

Phase of Analysis	Process Description
<i>Preparation phase</i>	1. Begins by selecting the unit of analysis. 2. Making sense of the 'whole data'. 3. Choosing mode of analysis e.g., inductive or deductive.
<i>Organising phase</i>	1. Open coding 2. Grouping 3. Categorisation 4. Coding Sheet 5. Abstraction
<i>Reporting the analysing process and results</i>	Main and sub-categories are reported in sufficient detail, along with detail and transparency about the analytic process.

Preparation: Elo and Kyngäs (2008) stipulate that the first stage of any qualitative content analysis is the preparation phase. This occurs prior to any data analysis and involves deciding on the unit of coding the analysis will adhere to, and the researcher familiarising themselves with the data. Within the current study, because responses to the behavioural intention questions were brief, the unit of analysis was agreed to be individual sentences, which would later be distilled to form initial codes. The next step is for the researcher to begin familiarising themselves with the data and making initial sense of units of analysis. This was done by reading over full participant responses for each question for each conceptualisation group, after exporting all data from the survey platform into a word document. The researcher then continued to immerse themselves in the data by re-reading participant responses, before exporting into an Excel spreadsheet for each group. Initial impressions and reflections were noted within the reflective diary and discussed in supervision. Table 9 below illustrates this for the CBT group.

Table 7. Extract from Reflective Journal for Preliminary Analysis of CBT Group

Initial Reflections	Further Impressions
Heightened emphasis on risk	Participants appear to be thinking in more 'extreme' ways about risk (risk to themselves from Alex mostly)
Placing of the challenge / Alex's presentation	Where does CBT encourage understanding of risk? Where is the challenge / 'problem' placed compared to how other models might appraise this?
Conflict between where this fits with referencing the past	Some participants seem to be drawing on a psychological understanding of Alex e.g., referencing their life history and survival, but then perhaps attributing their presentation to something within them, rather than outside context?

Since extant research is scarce with regards to the attributions and behavioural intentions of staff supporting those experiencing SMD, analysis was inductive, to allow for greater openness within participant data and interpretation, which is recommended where knowledge is scant or fragmented (Lauri & Kyngäs, 2005).

Organising: The first step within the organising phase is open coding. The primary researcher made notes and documented reflections in the margins of each line of data. Words or phrases which captured key concepts were also highlighted. Given that an integral part of the analysis was to explore emerging categories across the three groups, and the researcher's central position within the analysis, it was important to discuss and reflect on this in supervision, where the initial codes could be checked for accuracy by the primary supervisor.

Following open coding, main categories were developed by grouping similar codes into subcategories²³. From this, main categories can be created via a process known as abstraction. Abstraction is a methodological tool used in qualitative content analysis, defined as a process of moving from 'lower' elements to a 'higher' pattern of conceptual labels (Lindgren et al., 2020). Specifically, the creation of main categories, from subcategories and before that, initial codes.

²³ See Appendix O for examples of initial coding relevant to the 'organising' stage.

Reporting: Involves describing the analytic process as transparently as possible and presenting the categories in a clear and meaningful format. Illustrative quotations are also given to substantiate the researcher's interpretations. Reporting the results aims to move beyond describing the data, to evidencing a narrative, that is grounded in the data, that attempts to answer the research question/aim. Following this, the results are discussed and made sense of within the wider context of existing literature and knowledge.

8.12.1 Quality Monitoring and Reflexivity

Unlike quantitative research, evidencing benchmarks of objectivity and replicability are not necessarily criteria for operationalising quality in qualitative research. However, qualitative research is also required to be subjected to a degree of quality appraisal and to evidence scientific rigour and credibility throughout the research process. Quality monitoring strategies typically involve assessing credibility, trustworthiness, and reflexivity to evidence rigour (Berger, 2015). Thus, several steps were taken throughout the research process to support the scientific rigour of the study. Adhering to mixed methods and quality standards, the study used GRAMMS checklist (O'Cathain et al., 2008), to support self-monitoring and quality appraisal of reporting. This checklist was chosen because it provides reporting guidelines for mixed-methods studies in healthcare research (O'Cathain et al., 2008).

According to Spencer and Ritchie (2012), credibility refers to being transparent regarding how findings were reached and their defensibility. To evidence this, example workbooks are given to demonstrate initial coding and development of main categories by grouping together and assimilating similar codes from the raw data. The primary research supervisor also supported the assurance of credibility by checking over initial codes and subsequent main categories.

Regular supervision was also an important strategy used to help ensure reflexivity and quality of the research. Supervision occurred regularly between the researcher and the primary and secondary research supervisors. Within the initial stages of the research, the field supervisor also attended supervisions to support with the development of the project and offer field expertise for conducting research within an SMD population. Supervision logs were completed to give a detailed summary of each

meeting and were stored at UoN. A reflexive journal was also created and maintained by the researcher to document and reflect on important discussions and making sense of the data in the wider context. This was also important for the primary researcher to reflect on and make note of any countertransference in relation to the data and to keep track of decisions made throughout.

8.13 Disseminating Results

It is intended that findings will be shared and disseminated to maximise the impact of the research and help to ensure findings can be used and incorporated by staff working in SMD services, other professionals, and organisations, to support those experiencing SMD. It is also hoped that the current findings will be useful for informing future relevant research. It is also anticipated that the journal paper will be submitted for publication in a peer-reviewed journal.

Of the local and national services that were involved directly in supporting recruitment, some services (Homeless Link, Practice Development Unit, Framework) have requested to receive a summarised copy of the findings, which will be shared via the creation of a reader-friendly report by the researcher.

9. Extended Results

9.1 Survey Completion & Missing Data

Estimated sample size based on an a priori power calculation prior to recruitment commencing, stipulated that 159 participants would be required to achieve sufficient power at $>.80$, with a confidence interval of 95% ($\alpha=.05$), to detect a medium effect size ($d=0.5$) (Cohen, 1988). Based on this, the study could be said to be underpowered, since only 79 participants completed the survey. Upon reflection, there may be several contributing factors to this outcome. Firstly, attribution research and enquiry within the SMD field is only within its infancy and existing literature is scant. This will inevitably influence how attribution theory may be applied within clinical practice, when thinking about individuals experiencing SMD. It is likely that staff working within SMD services are not familiar with attribution theory, nor with its potential utility and value in applying it to this group. This may also help to explain why only 127 people accessed the survey overall. In response to the limited uptake of the survey, an ethical application was submitted in July 2024 to make an amendment to support its accessibility and reduce the amount of time taken to complete it. Despite this, it may be that some participants still experienced the initial pages of participants information, screening and consent items as uninviting, and lengthy.

One hundred and twenty-seven people accessed, or began completing the online survey, however of this number, only 79 (62.2%) completed the survey in full. Attrition at this stage was due to a combination of factors; 13 individuals did not meet inclusion criteria (10.2%), (assessed via three screening questions), 22 individuals did not give informed consent to take part (11.4%), and 13 people exited the survey before completion (14.1%).

For questions relating to the quantitative aim of the analysis, the survey required participants to complete all questions before moving on to the next section. Thus, there was no missing data of relevance to the quantitative aims of the study, and no requirement to exclude missing cases from the analysis. The two questions relating to the secondary aim were both 'optional', meaning participants could choose whether they provided responses to either one or both questions. Only 9 participants chose not to provide answers to these questions; however, the data they contributed to the

quantitative analysis was still included. Interestingly, of the 9 participants who chose not to provide any qualitative data, 5 (55.6%) were from the CBT group. The remaining 4 participants were split equally across the biographical and values groups.

Of the 79 participants who completed the survey, the average time taken was calculated to be 20.6 minutes. The time it would take participants to complete the survey was an important consideration as the research was mindful of how busy staff working within homelessness services would likely be, thus tried to make sure the survey was perceived as interesting and meaningful to their work, but also that it could be completed meaningfully in as little time as possible.

9.2 Extended Sample Characteristics

Available evidence exploring the demographic makeup of professionals working within the SMD sector is scant, however there is consistent evidence which shows that certain demographic characteristics may be overrepresented within certain professional contexts related to SMD. For example, women are consistently found to be overrepresented, compared to males, working within health and social care-related contexts (e.g., Francis-Devine, Zaidi, & Murray, 2025), where they may provide direct care to individuals experiencing aspects of SMD e.g., mental health and substance use problems. Whilst examining the impact of population demographics of professionals working within the SMD sector was not an aim of the study, it offers an interesting comparison with the current sample, suggesting the current sample is reflective of the wider population demographics in terms of gender and professional background.

9.2.1 Gender

All participants except one indicated the gender they identified with. The total sample consisted of 23 known males (29%) and 55 known females (69%), with 1 (1%) participant indicating 'prefer not to say'.

9.2.2 Age

Age responses were coded in ranges, specified in increments of 10-year age groups, spanning from 19 years to 60+ years. It was felt that the category '60+' was more suitable than further ranges to incorporate participants over the age of 60, due to most participants likely falling below that age, and to account for potential retirement. All participants indicated which age group best described them, with 19-29 being the most common age range (29%), and 60+ (7%) being the least.

9.2.3 Professional Background

Professional background was coded as: 'Nursing / Support Worker' (23%), 'Psychology / Psychotherapy' (15%), 'Occupational Therapy' (1%), 'Social Work' (6%), 'Other Allied HCP' (18%), and 'None' (35%). Interestingly, the most common category identified with was that which did not specify a professional background / qualification ('None'). This may not be surprising as many support staff who work in homelessness services are not required to have a professional qualification and so may not perceive themselves as aligning with a particular professional background. There may also have been other roles which are not given as discreet categories within this question, which may help to explain why 18% of participants indicated 'Other Allied HCP'. Participants were also given the option of 'prefer not to say' and 1 (1%) participant chose this.

9.2.4 Professional Experience (years)

Eligibility criteria stipulated that participants were required to have at least 6-months experience of directly supporting people accessing homelessness services, to take part. Almost half of all participants had between 2-4 years (40%), and only 6% had between 6-months and 1 year. 34% of participants described themselves as having over 10 years professional experience.

9.3 Extended Quantitative Results

The journal paper provides a comprehensive overview of the quantitative results pertaining to the primary aim. Further detail is given below with regards to data

collation and cleaning, preliminary analysis (including further information about ANOVA and assumption testing), assessing and checking randomisation across groups, and further detail on quantitative findings.

9.3.1 Data Collation & Cleaning

All raw data was downloaded from the online survey platform, QuestionPro, into an Excel spreadsheet. All versions were saved, and the history of each subsequent version detailing the cleaning process was documented in a password protected log, created by the researcher. Data cleaning occurred in Excel and consisted of removal of participants who had not completed all questions relating to the primary aim. For example, where QuestionPro had pulled through responses from the screening questions for people who did not meet inclusion criteria, this data was deleted as it could not be utilised within the analysis. Following cleaning, the Excel spreadsheet was converted into an SPSS dataset for the purposes of analysis.

9.3.2 Preliminary Analysis

Preliminary analysis, data considerations (including checking assumptions for parametric testing), and testing procedures were all conducted in accordance with guidance and recommendations taken from Field (2018) and Pallant (2020).

9.4 Analysis of Variance (ANOVA)

Analysis of Variance (ANOVA) is described as a linear model, used to compare the means of three or more groups, to examine whether there are differences between or within them. Since the primary aim was to examine whether there are any significant differences between groups, ANOVA was considered an appropriate choice of parametric test. In assessing for differences, ANOVA utilises group means to predict scores, rather than the overall mean. ANOVAs produce an *F*-statistic, which is used to express the ratio of systematic (model) to unsystematic (error) variance within the data. ANOVA is considered an omnibus test, meaning it assesses for overall differences, but it does not specify where differences, if any, occur. ANOVAs are

generally considered to be robust tests (e.g., Field, 2018; Glass et al., 1972), however it is important to assess assumptions for ANOVA, and where assumptions are violated, adjustments to the F -statistic are required (e.g., Brown-Forsythe F or Welch's F), or consideration of the use of a non-parametric alternative. Within conditions of non-normality e.g., skewed or kurtotic samples, the F -statistic is still considered to be robust against likelihood of Type I error (Schmeider et al., 2010; Knief & Forstmeier, 2021), meaning the Type I error rate remains close to the specified alpha level. Thus, an ANOVA was conducted to examine differences between groups on all dependent variables that did not violate the normality assumption.

9.4.1 Normality

Normality was assessed in three different ways: (1) statistical test of normality, (2) calculating z-values based on skewness and kurtosis statistics, (3) visually assessing the distribution of the data via histograms. To assess normality statistically, the Kolmogorov-Smirnov test was used.

Some research suggests the Kolmogorov-Smirnov test is better suited in samples where $n > 50$. All variables except for 'blame' and 'avoidance' produced significant results. As such, z-values were calculated by dividing skewness and kurtosis statistics by their relative standard errors. Further information can be found within the Preliminary Analysis Tables in Appendix K. For medium sized samples ($n < 50$), a z-score of + or – 3.29 indicates a deviation from normality (Kim, 2013). Based on this, five variables fell outside the parameters of normality: 'anger' (positive skew and leptokurtic), 'help' (negative skew and leptokurtic), 'fear' (positive skew and leptokurtic), 'segregation' (positive skew and leptokurtic), 'coercion' (positive skew), thus were analysed using Kruskal-Wallis tests as a non-parametric equivalent to ANOVA. Normality was also assessed visually by examining histograms for a bell curve shape (see Appendix L).

9.4.2 Homogeneity of Variance

Parametric tests assume that groups have equal variances (Pallant, 2020). The three groups were reasonably similar in terms of sample size (Biographical $n = 26$, CBT $n = 24$, Values $n = 29$). Levene's test was conducted to assess the assumption of

homogeneity of variance. Levene's indicated that this assumption had been satisfied, and homogeneity of variances was achieved. See Appendix K, Table 12 for reported Levene's statistics and the relative significance for each of the dependent variables.

9.4.3 Randomisation of Groups

A one-way between-groups ANOVA was conducted to assess for differences in mean scores between vignette groups and demographic variables: (a) 'gender' $F(2, 76) = 2.38, p = .099$, (b) 'age' $F(2, 76) = 1.01, p = .370$, (c) 'professional background' $F(2, 76) = .92, p = .402$, and (d) 'number of years professional experience' $F(2, 76) = .28, p = .758$. No significant differences were found between the groups; thus, randomisation was successful. This is important as it suggests that the differences found across variables were therefore not due to any unforeseen biases within group allocations.

9.5 Further Detail of Quantitative Findings

The journal paper provides a comprehensive summary of all the significant differences found between groups, and necessary post-hoc analyses. For several of the variables examined by the measure, the one-way ANOVA did not find any statistically significant differences between conceptualisation groups. ANOVA revealed there were no significant differences between conceptualisation group for the attribution variable 'blame' $F(2, 76) = .153, p = .858$. This was also the case for the emotional response variables; 'pity', and 'sympathy / concern', and the behavioural response variable; 'avoidance'. Despite ANOVA being regarded as a robust test (e.g., Field, 2013; Glass et al., 1972), it is important to consider the influence of statistical power on the results where a non-significant difference was obtained between groups. Since the study could be considered to be underpowered, it is important to consider that this may have influenced how likely the analysis would have been to detect a significant difference, if one exists, across these variables.

Where parametric assumptions were violated, Kruskal-Wallis tests were conducted to assess for differences between groups. For the variables 'anger', 'fear', 'help', 'segregation', and 'coercion', no statistically significant differences were found, which again, may have been influenced by the study achieving limited power within the

sample to detect a significant result, if one exists. Interestingly, despite the sample not achieving full statistical power, and requiring the use of a non-parametric alternative for some variables, the Kruskal-Wallis test conducted to assess for differences between groups across the emotional response variable 'fear', did reveal a significant difference. This was found via post-hoc analysis to be between both the CBT and biographical conceptualisation groups, and between the CBT and values group. The effect size achieved was $\eta^2 = .09$, which constitutes a moderate effect (Cohen, 1988), suggesting that despite not achieving full power, the significant difference was large enough to be detected.

9.6 Extended Qualitative Results

This section further evidences and describes key findings for each conceptualisation group, expanding on what is reported within the journal paper. The main categories, key points, and illustrative quotations are reported in Tables 8-10, with further detail given in narrative below, to illustrate and substantiate the main categories for each group, developed within the analysis.

9.6.1 Further Detail on Main Categories for the Biographical Conceptualisation Group

Table 8. Main categories, key points, and example quotes for the Biographical group

Main category	Key points	Example quotes
Recognising the impact of the past on the present	- Considering the influence of Alex's past on their engagement, and ability to trust professionals	<i>"Important to consider Alex's past trauma and aim to build a trusting relationship" (P²⁴47)</i>
		<i>"May take a long time for Alex to build trust" (P58)</i>
		<i>"Explore if Alex has been let down by professionals and take in to account their past experiences" (P25)</i>
		<i>"Alex probably has little or no trust in services" (P55)</i>
	- Working with Alex in a trauma-informed and psychologically informed ways	<i>"Give Alex time and space to feel safe" (P58)</i>
		<i>"Expect to work with Alex in various emotional states" (P58)</i>
		<i>"Understanding Alex's ambivalence to change" (P68)</i>
	- Understanding Alex's current presentation as an adaptation to trauma	<i>"Anger and threats are part of how Alex is surviving" (P58)</i>
		<i>"Alex likely has good reasons not to trust systems" (P58)</i>
		<i>"Show Alex there are other ways of feeling fulfilled" (P14)</i>

²⁴ P refers to Participant.

Main category	Key points	Example quotes
Promoting engagement and autonomy	- Encouraging engagement by understanding and advocating for Alex's needs	<i>"Having professionals that understand what would be in Alex's best interests" (P39)</i> <i>"Start by getting to know Alex by listening, hearing what is going on in their life" (P47)</i> <i>"Alex appears to be living 'disconnected' from mainstream society" (P58)</i> <i>"Encourage Alex to make informed choices" (P52)</i>
	- Offering support via a non-judgmental stance to encourage autonomy	<i>"Advocating at appointments with Alex" (P47)</i> <i>"Support Alex without judgment" (P17)</i> <i>"Being non-judgmental of struggles Alex may experience on their journey to recovery" (P33)</i> <i>"Advise and encourage, but don't force anything" (P44)</i> <i>"Promote autonomy 'do with' not 'do for'" (P68)</i>
	- Facilitating progress to support change	<i>"Facilitation of opportunities to activate a model of change" (P65)</i> <i>"Re-establishing hope that Alex can change their behaviours" (P17)</i> <i>"Supporting Alex to have a voice in the system" (P61)</i>

Main category	Key points	Example quotes
		<i>"Allow Alex to understand and make decisions for themselves, making them feel they have agency and control over their life to change it" (P5)</i>
Holistic and multi-agency approach to intervention	- Different services for different intervention needs	<i>"Multi-agency meeting to discuss concerns and devise a care package for mental health, drug addiction, housing, education, employment" (P73)</i> <i>"Seeking appropriate supported accommodation" (P76)</i> <i>"Together we could access support from the GP and substance use services" (P47)</i>
	- Encouraging interventions that Alex views as important	<i>"Conversations with Alex about what they want in terms of mental health and drug rehabilitation" (P78)</i>
	- Joined up working with agencies to support Alex	<i>"Working closely with other agencies to work towards a holistic approach" (P17)</i> <i>"Liaising with Alex's professional network" (P22)</i> <i>"Gather all professionals involved to get a clear picture of Alex's needs and plan the best course of action to support them to access support" (P25)</i>
	- Considering power dynamics in service delivery	<i>"Services taking responsibility for their parts in understanding Alex's situation" (P27)</i>

Main category	Key points	Example quotes
		<i>"Consider power dynamics created within systems and how to support Alex to have a voice" (P61)</i>
Flexible approach with Alex at the center	- Person-centered and flexible approach	<i>"Using person-centered approaches" (P8)</i>
		<i>"Beneficial to catch them on an as and when basis" (P14)</i>
		<i>"Always go at Alex's pace" (P47)</i>
		<i>"Use their language and don't overcomplicate" (P68)</i>
	- Recognising Alex's expert role in their own experience	<i>"We should assume Alex can lead us and is best place to do so" (P58)</i>
		<i>"Working to Alex's agenda" (P58)</i>
	- Working alongside Alex to develop therapeutic rapport and trust	<i>"Get to know them, develop a therapeutic relationship and build trust" (P36)</i>
		<i>"Reminding Alex, we can be in this together" (P47)</i>
		<i>"Understanding and support starts with stability and security" (P73)</i>
Considering risk and safety	- Importance of staff looking after their own wellbeing, as a means of managing risk	<i>"Staff need to look after their own wellbeing when interacting with Alex" (P8)</i>
		<i>"Consider personal safety" (P52)</i>

Main category	Key points	Example quotes
	- Considering the influence of different factors on risk - Understanding risk within Alex's context	<i>"Stop support sessions if Alex is under the influence of substances" (P2)</i> <i>"How does accommodation create risk for Alex?" (P61)</i> <i>"We wouldn't be unduly worried if Alex presented with anger or threats, that appears to be part of their way of surviving" (P58)</i> <i>"Dispel myths of danger" (P61)</i>

The biographical group emphasised how Alex's presentation and challenges are embedded within their life context and history. Participants consistently viewed Alex's presentation and behaviours as a direct adaptation to earlier contexts of trauma and adversity. Despite not receiving any psychological information within the vignette, they tended to encourage a trauma-informed and psychologically minded approach to building a therapeutic relationship, with recognition that engagement may be slow and not always linear. As one participant acknowledges it's *"important to consider Alex's past trauma and aim to build a trusting relationship"* (P²⁵47), highlighting how early experiences may impact Alex's current engagement and trust. Other participants stated, *"Alex probably has little or no trust in services"* (P55) and *"survival methods involve negative behaviours"* (P58), emphasising the idea of functional contextualism; that Alex's behaviour, whilst potentially challenging, makes sense within their context.

For this group, ideas around engagement and autonomy, which focused on listening to Alex and advocating for their needs without judgment, were also important. When thinking about what factors would be important to consider when offering support to Alex, the biographical group placed importance on creating conditions for Alex to feel empowered, highlighted by one participant: *"encourage Alex to make informed choices"* (P52), and another: *"promote autonomy 'do with' not 'do for'"* (P68). Support was also framed as relational and respectful, rather than directive: *"advise and encourage, but don't force anything"* (P44).

A holistic and multiagency approach was also emphasised, to respond to and support Alex with a range of challenges with mental health, substance use, housing and employment / financial needs. The biographical group thought about services as agencies which need to collaborate to develop a comprehensive picture of Alex's needs. One participant noted *"multi-agency meeting to discuss concerns and devise a care package for mental health, drug addiction, housing, education, employment"* (P73), whilst another emphasised the importance of choice *"working with Alex to address the changes they want"* (P17). Participants also recognised and considered power in service delivery, noting the importance of: *"considering power dynamics created within systems and how to support Alex to have a voice"* (P61) and *"services taking responsibility for their parts in understanding Alex's situation"* (P27).

²⁵ P refers to Participant

Flexibility and a person-centred approach were also central to the biographical groups' stance. Alex was viewed as the expert in their own life, with professionals encouraged to adapt to Alex's needs, rather than impose. This is evidenced in the quote "*we should assume Alex can lead us and is best placed to do so*" (P58). This emphasises working collaboratively with Alex, whilst building rapport through continuity and presentness, as evidenced by: "*reminding Alex we can be in this together*" (P47).

Risk and safety were also approached contextually, with participants recognising that Alex's past trauma would likely be influencing their current presentation. One participant stated, "*we wouldn't be unduly worried if Alex presented with anger or threats, that appears to be part of their way of surviving*" (P58). Staff safety and wellbeing were acknowledged e.g., establishing clear boundaries and considering the influence of substances on presentation, however this tended to be balanced with an understanding and framing of risk through Alex's lived experiences and context.

9.6.2 Further Detail on Main Categories for the CBT Conceptualisation Group

Table 9. Main categories, key points, and example quotes for the CBT group

Main category	Key points	Example quotes
Influence of the past on the present	- Considering the impact of Alex's previous experiences of trauma, neglect, feeling unsafe, on how Alex is presenting in the here and now	<i>"Address Alex's trauma from childhood as their behaviour stems from childhood and instability" (P74)</i>
	- Link between Alex's history and lived experiences, and their current perspective	<i>"Consider past trauma as a reason for their behaviour and beliefs" (P74)</i>
	- Educating others about Alex's background and how this links to their presentation	<i>"Being mindful of the past but also going in with a fresh start" (P62)</i> <i>"Educate others about Alex's background and the reasons they behave this way" (P59)</i>
Importance of the therapeutic relationship	- Relationship needs to be developed first before other interventions can be explored	<i>"Develop rapport and trust first" (P50)</i>
	- Building trust and sense of safety takes time and consistency	<i>"Building a trusting and consistent professional relationship to sense of foster security" (P37)</i> <i>"Lack of trust [in people] which will need to be built up over time" (P74)</i> <i>"Alex needs consistency and to know they are fully supported before they can progress" (P79)</i>

Main category	Key points	Example quotes
Different difficulties will require different interventions	- Different agencies will meet different needs	<i>"Recognising Alex has multiple issues co-occurring which require different interventions" (P31)</i> <i>"Encourage Alex to engage with interventions or services to support different problems" (P50)</i>
	- The order that interventions are offered is important e.g., meeting basic needs before addressing trust	<i>"Ensuring benefits and accommodation is in place first, ensuring Alex has sufficient food and clean clothes, then help Alex to address their trust issues" (P3)</i> <i>"Meeting safety, emotional and physical needs for Alex" (P50)</i>
	- Different services working together in a collaborative way	<i>"Importance of services working with Alex in a joined-up way" (P31)</i> <i>"Ensure all support staff communicate in multi-agency meetings to ensure Alex is getting necessary support" (P74)</i>
Prioritising risk and safety	- Frequent and thorough assessment of different risks	<i>"Regularly assess risk" (P11)</i> <i>"We need to be careful to assess risk" (P48)</i> <i>"What is Alex not telling us" (P23)</i>
		<i>"Establishing boundaries with Alex and risk to others" (P62)</i> <i>"If staff lone work, they must be able to call for help" (P74)</i>
		<i>"Staff to have an escape route if Alex were to become aggressive" (P74)</i>
	- Establishing appropriate boundaries and prioritising staff safety	

Main category	Key points	Example quotes
	- Considering different factors which may influence risk	<i>"Alex's risk to others is higher when under the influence" (P48)</i> <i>"On paper, Alex looks like a risk" (P79)</i>
Tools to navigate conflict differently	- Equipping Alex with different tools to relate to and manage conflict differently	<i>"Giving Alex alternative strategies to manage conflict" (P23)</i> <i>"Inviting Alex to see another perspective" (P23)</i> <i>"Building skills for maintaining recovery and wellbeing" (P48)</i> <i>"I would look at things that could build confidence" (P11)</i>
How staff understand Alex's difficulties influences how they respond	- Different understandings of Alex's position and behaviour - Different understandings of resistance and engagement influences staffs' stance towards engaging and working with Alex	<i>"Substances used as a coping mechanism" (P74)</i> <i>"Others may be judgmental towards Alex due to their choices" (P79)</i> <i>"Empathy in place of sympathy" (P6)</i> <i>"Not forcing Alex into services or scenarios they are not comfortable in" (P31)</i> <i>"Try to get Alex to agree to engaging with mental health services" (P45)</i> <i>"Encourage Alex to engage with interventions or services to manage problems" (P50)</i> <i>"Make them understand the importance of treatment and how it would help" (P6)</i>

Whilst the CBT group also acknowledged the impact of Alex's historical context on their present difficulties, they were more likely to frame it primarily through a lens which is congruent with a CBT approach. For example, there was clear recognition that Alex's trauma history informed and influenced their current beliefs and behaviours. One participant noted that they would *"consider past trauma as a reason for their [Alex's] beliefs and behaviours"* (P74).

The therapeutic relationship was described and appraised by the CBT group as a necessary foundation for intervention and working to support Alex. Participants described *"lack of trust which will need to be built up over time"* (P74) and *"Alex needs consistency and to know they are fully supported before they can progress"* (P79), reflecting the group's recognition of the importance of relationship development before other interventions may be effective. A trusting therapeutic alliance was viewed as one of the most important ingredients and a foundation for supporting Alex to make change. This makes sense within the context of collaborative empiricism, encouraged as integral by a CBT approach.

Participants also viewed the challenges and difficulties Alex presented with as requiring specific interventions from relevant agencies, with some acknowledgment that these needed to be offered in a staged and sequenced way, to maximise Alex's engagement, as evidenced in quotes such as *"recognising that Alex has multiple issues co-occurring which require different interventions"* (P31) and *"ensuring benefits and accommodation is in place first, ensuring Alex has sufficient food and clean clothes, then help Alex to address their trust issues"* (P3). Participants also acknowledged that care and support should be joined up, with different services communicating and working collaboratively.

A prominent theme within the CBT group focused on emphasising the importance of regularly assessing and managing risk; mainly the risk Alex may pose to staff and others, and how to manage this appropriately. Participants emphasised structured and thorough assessments of risk, noting *"regularly assessing risk"* (P11) and *"we need to be careful to assess risk"* (P48) as essential in practice. Participants also appeared to demonstrate an orientation towards proactive safety planning and establishing boundaries when supporting Alex e.g., *"if staff lone work, they must be able to call for help"* (P74) and *"staff to have an escape route if Alex became aggressive"* (P74), to

mitigate risk and enhance safety. Participants did however also acknowledge the impact of other factors which may potentially influence Alex's risk e.g., using substances, stating *"Alex's risk to others is higher when under the influence"* (P48), and holding this in mind when supporting Alex, suggesting an acknowledgement of how difficulties may coexist and interlink.

Participants also focused on helping Alex develop coping strategies and behavioural skills to find alternative ways to navigate and resolve interpersonal challenges. Aligning with a CBT approach, participants talked about *"inviting Alex to see another perspective"* (P23), *"giving Alex alternative strategies to manage conflict"* (P23) and *"I would look at things that could build confidence"* (P11), viewing this as integral to relapse prevention and recovery.

Lastly, participants noted that the way staff understood Alex's behaviours were considered to influence how staff would then respond to, and engage with, Alex. Participants talked about advocating with an empathic stance rather than sympathetic, towards Alex's position, without judgment, and different ways of understanding resistance, as being important in influencing how they may work with Alex. One participant noted *"not forcing Alex into services or scenarios they are not comfortable in"* (P31). Another also talked about empowering Alex in *"considering what Alex can do for themselves"* (P23).

9.6.3 Further Detail on Main Categories for the Values Conceptualisation Group

Table 10. Main categories, key points, and example quotes for the Values group

Main category	Key points	Example quotes
Understanding the connection between environment and behaviour	- The environment is an important factor for influencing Alex's presentation and behaviour	<i>"The environment as a trigger" (P12)</i>
		<i>"Understanding the influence of environment on behaviour" (P9)</i>
	- Historical environments and experiences play an important role in present and future experiences and in how staff understand Alex	<i>"Important to consider past trauma is likely having a significant impact on their current behaviour" (P60)</i>
		<i>"Trauma is at the front of my mind when supporting Alex" (P29)</i>
		<i>"Keep in mind the journey they have had to get to where they are" (P16)</i> <i>"Behaviour as a result of circumstances, not them inherently as a person" (P9)</i>
Importance of the therapeutic relationship	- The therapeutic relationship supports development of safety and trust, which in turn supports engagement	<i>"Relationship supports feelings of safety" (P64)</i>
		<i>"Long-term positive engagement needs to be based on a safe working relationship" (P32)</i>
		<i>"A trusting relationship helps work towards goals" (P64)</i>
	- Developing and establishing safety for Alex needs to happen first	<i>"Help Alex feel safe and then try and access their needs" (P26)</i>
		<i>"Walking with Alex through the steps forward" (P46)</i>

Main category	Key points	Example quotes
	-Being alongside Alex in the context of the therapeutic relationship supports recovery	<i>"Support staff being present and involved" (P9)</i>
Stance towards support is on a continuum	- Different staff exhibited different stances around how they would support Alex, ranging from promoting choice and empowerment to being more forceful.	<i>"Empowering Alex to make informed decisions" (P43)</i> <i>"Encouraging Alex to think of their future and what they want" (P29)</i> <i>"Push Alex towards meaningful activities and away from negative peers" (P9)</i>
Empathising with Alex's position	- Considering Alex's readiness to enact change and importance of prioritising Alex's position - Past experiences may hinder engagement - Placing Alex at the center of their care and recovery and promoting choice	<i>"Long-term positive engagement needs to be on Alex's terms" (P32)</i> <i>"[Interventions] more likely to be effective when Alex is ready to engage" (P32)</i> <i>"Be aware Alex may not be open to recovery process, or that they may have relapse" (P60)</i> <i>"Important to consider past trauma is likely having a significant impact on Alex's current behaviours" (P60)</i> <i>"Previous negative experiences might make engagement difficult" (P35)</i> <i>"Keep in mind the impact of their background on their engagement" (P43)</i> <i>"Ensuring Alex is at the heart of every decision" (P51)</i> <i>"Take a person-centered approach, so primarily led by Alex's wishes" (P12)</i>

Main category	Key points	Example quotes
		<i>"Take a lead from them on what feels like a priority" (P32)</i> <i>"Giving them choices to make decisions about their recovery" (P66)</i>
Flexibility in responding to Alex	- Recovery is not linear and the importance of working with Alex at their pace - Acknowledging and responding in line with Alex's values	<i>"Giving Alex lots of opportunities to break the cycle" (P9)</i> <i>"It will take time to make meaningful change" (P26)</i> <i>"Being aware Alex may have relapses...allowing them to go through the recovery process" (P60)</i> <i>"Keeping Alex's values in the forefront" (P43)</i> <i>"Considering Alex's strong sense of justice when working with them" (P21)</i> <i>"Being mindful of Alex's values and how this can influence how Alex may interpret my [staff] behaviours" (P38)</i>
Multiple agencies collaborating to meet Alex's needs	- Working with Alex and services holistically to access different services for different needs - Needs should be considered and met in a hierarchy	<i>"Holistic approach to supporting Alex" (P51)</i> <i>"Involving multiple agencies to support Alex" (P66)</i> <i>"Asking everyone involved with Alex to come together" (P67)</i> <i>"Multi-disciplinary team support is best" (P75)</i> <i>"Ensure Alex's physical needs are met first" (P64)</i> <i>"Once Alex has been supported with life skills and had a period of stability, then move onto wider community" (P77)</i>

The values group framed their understanding of Alex, and how they would support them, through more of a humanistic and justice-oriented lens, which is interesting considering the values vignette described Alex as valuing justice. This group placed strong emphasis on dignity, empathy, and the role of Alex's environment (referring to both past and present) in terms of shaping their presentation and behaviour. Participants viewed Alex's difficulties not as intrinsic deficits, but rather as adaptations to their context: *"behaviour as a result of circumstances, not them inherently as a person"* (P9) and *"behaviour is not a result of Alex as a person"* and *"keep Alex's journey in mind to get to where they are"* (P16). Trauma and systemic disadvantage were at the forefront in terms of what this group considered important in supporting Alex, and behaviour was understood as being deeply influenced by past and present environments: *"understanding the environment as a trigger"*.

The values group viewed the therapeutic relationship as a space where safety, recovery, engagement, and hope could emerge, with one participant noting that the *"relationship supports feelings of safety"* (P64) and another reflecting *"walking with Alex as they take steps forward [in recovery]"* (P46). This exemplifies how support was understood as a process of being present and alongside Alex, where trust and emotional safety are prerequisites to therapeutic progress.

Participants identified with a continuum of stances when supporting Alex, ranging from empowerment and choice to more directive strategies. Whilst some participants emphasised the importance of encouraging action: *"push Alex towards meaningful activities and away from negative peers"* (P9), the prevailing stance was one of empowerment, acceptance, and respecting Alex's readiness: *"empowering Alex to make their own decisions"* (P43) and *"long-term positive engagement needs to be on Alex's terms"* (P32).

Empathy was also appraised as important to working effectively with Alex. Participants consistently acknowledged that past experiences could hinder engagement and advocated for a person-centred and choice driven approach. One participant reflected *"ensuring Alex is at the heart of every decision"* (P51) and another *"give Alex choices about their recovery"* (P66). This stance reflects a values-based commitment to promoting autonomy, justice, and respect for Alex. Another participant talked about

the importance of considering Alex's readiness to enact change, reflecting *"be aware Alex may not be open to recovery"* (P60).

Flexibility was not only seen as an ethical necessity by this group, but they also recognised the importance of responding in alignment with Alex's values, and how service-user and staff values may interact, noting *"being mindful of Alex's values and how this can influence how Alex may interpret my [staff] behaviour"* (P38). Participants also recognised that recovery is not linear, acknowledging setbacks as part of the process. Participants reflected: *"it will take time to make meaningful change"* (P26) and *"giving Alex lots of opportunities to break the cycle"* (P9), demonstrating an appreciation of the importance of responsiveness and humility in their approach.

Lastly, the values group emphasised collaborative, multi-agency working that advocated for Alex's voice and priorities. Participants strived for a hierarchical approach to understanding and meeting Alex's needs, starting with basic physical needs, proceeded by psychological and wider social support: *"ensure Alex's physical needs are met first"* (P64) and *"once Alex has been supported with life skills and had a period of stability, then move onto wider community"* (P77). Importantly, the values group consistently framed service provision with a justice-informed lens, ensuring that Alex is not viewed as the 'problem', but rather as someone to walk alongside and empower within staffs' approach to providing support.

9.7 Connecting key quantitative and qualitative findings across groups

Further to the journal paper, additional detail is given below to synthesise the quantitative and qualitative findings.

9.7.1 *Attributions*

Quantitative findings revealed a statistically significant difference in attributions of 'dangerousness', with participants in the CBT group endorsing attributions relating to dangerousness more highly, compared to both the biographical and values groups. These heightened perceptions of threat and danger were further reflected within the qualitative data and subsequent main categories developed for the CBT group, which consistently prioritised thorough and frequent assessment and management of Alex's risk, the establishment of boundaries, and staff safety protocols for working with Alex. There was a clear and paramount focus on managing risk proactively and finding ways to safeguard staff, suggesting a heightened sense of perceived danger that mirrored the quantitative findings across the 'dangerousness' domain.

In contrast, whilst scores for the 'blame' domain did not appear to differ significantly across the three groups, participants within the CBT group endorsed attributions of 'blame' most highly, compared to the other two groups ($M = 9.25$, $SD = 3.33$). Interestingly, the lowest mean score was reported for the biographical group ($M = 8.77$, $SD = 3.17$), and the corresponding qualitative categories focused on non-judgment, trauma-informed, and psychologically driven approaches to recognise Alex's behaviour as an adaptation to past harm. Similarly, the values group framed Alex's behaviour within the context of environmental and systemic injustice, endorsing an understanding of Alex's presentation that de-emphasised individual culpability. This alignment between lower dangerousness and blame scores and the qualitative emphasis on Alex's context, highlights a more person-centred and systemic understanding across the biographical and values groups.

9.7.2 *Emotional Responses*

Quantitative findings revealed significantly higher levels of 'fear' endorsed by participants within the CBT group, compared to the other two groups, which was also

mirrored within the qualitative emphasis on managing risk and safety, particularly towards staff. Fear was not just expressed emotionally but operationalised through rigid boundaries and contingency planning by the CBT group. In contrast, the values group's mean rank score for the 'fear' domain was the lowest of the three groups (34.98), and the qualitative data reflected this with a focus on empathy, flexibility, and understanding Alex's position through a systemic frame. Rather than understanding Alex as threatening, participants in the values group appeared more able to frame Alex's behaviour and presentation as a response to trauma, injustice, and unmet needs and values.

Whilst not reaching statistical significance, emotional response domains of 'pity' and 'sympathy/concern' were statistically similar across the three groups. Qualitative categories however drew upon subtle distinctions in the tone and emotive stance of the groups. The values group tended to lean towards expressions of empowerment and being alongside Alex, whilst in contrast, the CBT and biographical participants conveyed expressions of concern for Alex with a more hierarchical tone, often grounded in trying to understand Alex's position, and perhaps offer a sympathetic approach, rather than an empathetic understanding. Interestingly however, the CBT group endorsed items related to sympathy and concern the least across the measure.

Although there were no statistically significant differences found between groups for the 'anger' domain, interestingly, the mean rank score was the highest for the CBT group (43.00), compared to the biographical (42.08), and the values group (35.66) was the lowest. Whilst qualitative data does not explicitly reference the emergence of anger as an emotional response towards Alex, there are perhaps some subtle and indirect ways that anger could be interpreted or may have been reflected or diffused in participants' responses. For example, a significant emphasis on risk was made within the CBT group, which may be suggestive of a perception of Alex as an individual who could elicit strong emotional responses such as threat, frustration or vigilance. Participants within the biographical group often referred to anger (located within Alex) as a survival strategy, or as adaptive behaviour developed to navigate difficult early contexts. In understanding the origins of Alex's behaviour, staff may be able to mitigate or minimise their anger, if any, towards Alex. The values group scored the lowest mean rank (35.66), tending to prioritise empathy and flexibility, appearing to be most able to

cognitively and emotionally distance themselves from anger by understanding Alex through empathetic and contextual lenses.

9.7.3 Behavioural Responses

Across all four behavioural response domains ('help', 'segregation', 'coercion', and 'avoidance'), there were no statistically significant differences found within the quantitative data. Interestingly, whilst the biographical group had the highest mean rank score for 'avoidance' (13.38), the CBT group had the lowest 'help' mean rank score (37.90), and the highest mean rank scores for 'segregation' (46.73), and 'coercion' (42.46). Despite no statistically significant differences between groups, qualitative findings uncovered more nuanced differences in terms of how support was understood, operationalised, and proposed across the three groups. For example, categories which emerged from the biographical group revealed ideas of advocacy, building trust, and trauma-informed care, frequently framed through a lens of promoting relational safety and understanding Alex's trauma. The CBT group's responses around behavioural support tended to be more goal-oriented with an emphasis on building skills, conflict resolution, and encouraging compliance with service engagement. In contrast, the values group appeared more likely to frame their approach to offer support to Alex in a values-driven, collaborative, and empowering way. However, whilst some participants within the values group framed support via a more directive and potentially forceful stance e.g., the main category describing the continuum of responses of how support may be offered to Alex, the mean rank score for the values group was the lowest on the 'coercion' domain.

10. Extended Discussion

The current study's aims were twofold. The primary aim was to examine whether offering different understandings of SMD to staff working in homelessness services influenced their attributions, and emotional and behavioural responses. The secondary aim was to qualitatively explore staffs' behavioural intentions to offer support to the character described within the vignette. Within this chapter, further discussion is offered in relation to the points raised within the journal paper, integrating the findings from both the primary and secondary aims, where appropriate, to further contextualise findings. Further discussion is also offered in relation to implications for clinical practice, the study's strengths and limitations, and future research directions are also identified.

10.1 Extended Discussion of Preliminary Analysis

Previous attribution research utilising the AQ-27 has demonstrated that the emotional response domain 'pity' was likely capturing and measuring two distinct and separate emotional responses; 'pity' and 'sympathy/concern' (e.g., Buttery et al., 2020; Kingston et al., 2016). Prior to the main analysis of quantitative data, this was tested with the current data via reliability analysis. Preliminary analysis demonstrated findings that were in accordance with previous research, demonstrating an improvement in internal consistency of the AQ-27 measure when emotional response domains of 'pity' and 'sympathy/concern' were separated out²⁷. This was evidenced by an increased Cronbach's alpha score for the measure (from $\alpha = .63$ to $\alpha = .70$) upon separating out 'pity' from 'sympathy/concern'. Field (2013) suggests that an alpha score below .7 demonstrates poor internal consistency, suggesting that by separating out these constructs, internal reliability was improved. This may indicate that the current sample perceived a difference or incongruency between the two emotional responses and may be partially attributable to the age of the AQ-27 measure, and potential changes to the connotations of 'pity' overtime, meaning it may no longer be as closely semantically linked with feelings of sympathy. Batson et al (1997) make a distinction between 'pity' (associated with passivity and condescension) and 'empathic concern'

²⁷ Please refer to Extended Methods section 8.7.2 for full details.

(linked to more active support and solidarity), which was further supported in other more recent research (e.g., Kingston et al., 2016). This, however, requires further exploration.

10.2 Extended Discussion of Main Findings Related to Primary Aim

10.2.1 Attributions

Quantitative analysis demonstrated that attributions of ‘dangerousness’ are sensitive to different conceptualisations of SMD. Participants exposed to the CBT-informed conceptualisation endorsed attributions relating to ‘dangerousness’ significantly more, compared to participants in both the biographical and values groups. These attributional judgments appear to also be reflected within the qualitative data. These findings appear to be aligned with previous research, which has considered attributions of dangerousness to be an identifiable factor in stigma towards certain groups, with much of this evidence being in relation to a mental health context (e.g., Angermeyer & Matschinger, 2003; Corrigan et al., 2003). To relate to the construct of SMD, research examining attributions of dangerousness tends to focus on how individuals perceive the likelihood of future behaviour, with much current research conducted within the context of mental health and criminal justice system involvement. For example, examining how attributions about mental illness impact perceptions of dangerousness and subsequent behavioural responses (Wainwright & Mojtahedi, 2020). Whilst Weiner’s (1979) attributional model stipulates that attributional beliefs about the causes of behaviour play an important role in influencing associated emotional and behavioural responses (Weiner, 1979; 1986), some research has found that the effects of appraisals of dangerousness on helping responses are unmediated by beliefs about personal responsibility (e.g., Corrigan et al., 2003). Instead, research has suggested that much of the dangerousness effects instead operate by increasing fear, which in turn affects the presence of a particular behavioural outcome (e.g., avoidance, coercion), without a mediating cognitive attribution. This has previously been coined the ‘danger appraisal hypothesis’ (Edwards & Endler, 1989; Paterson & Neufeld, 1987), stipulating that danger in particular, is a key perception that leads to fear, and avoidance (Corrigan et al., 2003). Several studies have demonstrated a relationship between beliefs of dangerousness regarding individuals with mental

illness, and a subsequent emotional response of fear (e.g., Angermeyer & Matschinger, 1996; Levey & Howells, 1995). It is important to note however, that this relationship has primarily been evidenced within the context of mental illness, which is only one facet represented within the construct of SMD.

Within the current study, quantitative findings did not demonstrate a significant difference regarding a behavioural outcome of avoidance, however differences between the three groups are more nuanced within the qualitative findings. As the CBT group emphasised risk, safety, and importance of implementing protocols for managing this, whilst not explicitly 'avoidance', this could be interpreted as this group placing more focus on behaviours and strategies which are distancing from the individual. For example, one participant talked about the importance of having an escape route and another about being able to call for help. To establish whether CBT-informed conceptualisations do have an inflating influence on dangerousness attributions towards individuals experiencing SMD, further replicable research is needed. Future research may also be strengthened if additional measures of dangerousness attributions are implemented, since some studies have suggested that this construct may be poorly measured within a single measure (e.g., Jorm et al., 2012), as was the case in the current study. Although not discussed within the journal paper, the 'fundamental attribution error' (FAE) (Ross, 1977) may offer further explanation and context around why the CBT groups' attributions of dangerousness and blame were found to be the highest. The fundamental attribution error is a well-established theory that frames the tendency for individuals to overemphasise internal, dispositional causes of another's behaviour whilst underestimating situational or contextual factors. Previous research has tested the boundaries of this putatively widespread pattern, and it is widely acknowledged that the classic attribution effects stipulated by the FAE are contextually bound (e.g., Scopelliti et al., 2018; Niemi et al., 2023).

Within the current study, increased dangerousness and blame attributions observed within the CBT group may reflect this bias, given CBT's emphasis on individual cognitions and behaviours as the locus of change. By foregrounding internal processes, CBT-informed conceptualisations may have inadvertently encouraged staff to interpret Alex's behaviour as being attributable to personal dispositions, thereby amplifying perceptions of controllability, responsibility, and risk. Contrastingly,

as acknowledged within the journal, the values group endorsed dangerousness attributions the least, and this difference was statistically significant. Qualitative findings also showed that the values group placed the least amount of emphasis on risk and were more likely to attribute Alex's behaviour to being a result of circumstances, rather than attributing it to "*Alex as a person*". This may have exerted somewhat of a 'corrective' influence on the FAE by explicitly highlighting Alex's behaviour in relation to the systemic context, and humanising Alex through the articulation of their personal values. This reframing may have helped staff to attribute behaviour to external or situational factors, thereby reducing perceptions of dangerousness and fostering more sympathetic and collaborative responses.

Some evidence has suggested that when people perceive shared or understandable values, they are more likely to attribute benevolent intent, rather than threat, which may reduce the likelihood that behaviour is interpreted as dangerous (e.g., Ye et al., 2024). Whilst Ye et al's. (2024) study was not conducted within the context of SMD, it may offer an important insight into the potential of values to humanise an individual, and their behaviour. When staff are given information about a person's values and what matters to them, this may help to provide meaning and context to their presentation, which staff may otherwise be more likely to perceive as challenging or difficult. Research directly tying values disclosures to changes within attributions is scant, and even more so within an SMD context, however there is some relevant evidence from parallel literature, which may offer support for this. For example, research exploring moral and social psychology has found that values-oriented language can shift moral judgments and social behaviour (Feather, 1988; Niemi et al., 2023). Whilst not explicitly about SMD or dangerousness / blame attributions, these studies may indicate that values-laden information can shape and influence peoples' perceptions and responses, and this suggestion could have important implications for other contexts such as SMD.

10.2.2 Emotional Responses

As discussed within the journal paper, it may be regarded as intuitive that if attributions of dangerousness are higher, emotional responses of fear will follow suit. Whilst the current study did not examine a correlational or mediating relationship between attributions and emotional responses, the findings demonstrated could be understood

as being in accordance with attribution theory regarding heightened attributions of dangerousness and blame increasing emotional responses of fear and anger. The only significant difference between groups across emotional domains was found for 'fear', which was endorsed the most by CBT participants, and least strongly for the values group. This pattern is particularly important because emotional responses, such as fear, are theorised to directly influence behavioural intentions (Weiner, 1986). According to attribution theory, when behaviour is attributed to internal, controllable, and stable causes, negative emotional responses such as fear or anger are more likely, whereas external and uncontrollable attributions are more likely to elicit emotional responses such as sympathy or concern (Weiner, 1982).

A study by Barnett et al. (1997) found sympathy is related to more structural explanations of homelessness (i.e. externalising attributions), whereas fear or anger towards people experiencing homelessness is connected to more internal attributions for homelessness that are focused on dispositional aspects of the individual (such as laziness, criminality, addiction and mental illness). This may offer insights into the current study's findings; the CBT-informed conceptualisation may have led participants to perceive Alex as more unpredictable and threatening, thereby potentially reinforcing fear. This is consistent with qualitative accounts from the CBT group, which highlighted heightened attention to risk, staff safety, and rigid boundary-setting, suggesting that fear may have shaped participants' interpretations and subsequent intended behavioural responses. Fear has been shown to predict greater endorsement of coercive measures, segregation, and boundary-setting (Corrigan et al., 2003), which can undermine engagement and trust. Within SMD services, where many individuals have experienced coercion or systemic neglect, fear-driven responses may perpetuate cycles of disempowerment, heighten mistrust of services, and contribute to service user disengagement.

By contrast, participants in the values group endorsed fear items the least. Since values are typically viewed as organising principles or determinants of attitudes, beliefs, and behaviours (Hitlin & Piliavin, 2004; Schwartz et al., 2010), and there is recognition that values development is informed by a range of influences an individual is exposed to (Ponizovskiy et al., 2019; Schwartz & Bilsky, 1990), this may help to explain why values-based explanations may externalise, humanise and contextualise a person. The values conceptualisation may have encouraged participants to

understand Alex's presentation as being attributable to understandable and relatable human experience, which may have reduced 'othering' and attenuate perceptions of threat. Research in moral psychology supports this interpretation, showing that value-framing fosters identification, empathy, and trust (Ye et al., 2024). In this sense, a values-based conceptualisation may act as a buffer against the fear response, helping staff to interpret behaviour as functional and contextual, rather than inherently dangerous and to be feared.

Taken together, these findings may highlight the importance of emotional responses, particularly fear, in shaping staff reactions to those experiencing SMD. Elevated fear in the CBT group suggests that even clinically sophisticated frameworks may inadvertently foster risk-averse or defensive responses, whereas incorporating values-based framings may help to mitigate fear by facilitating identification with the other and reducing perceived threat. In practice, this suggests that how SMD is explained to staff is not neutral: different explanatory lenses can elicit markedly different affective responses. Future research should further explore this tentative relationship.

10.3 Extended Discussion of Behavioural Responses and Main Findings Related to Secondary Aim

Further discussion regarding quantitative findings of behavioural responses measured within the primary aim, and qualitative findings captured in relation to the secondary aim (behavioural intentions) is provided below.

There were no significant differences found between groups across any of the behavioural response domains ('help', 'segregation', 'coercion', 'avoidance'). Although the differences were not statistically significant, it is perhaps noteworthy that the values group endorsed the 'help' domain the most, whereas the CBT group endorsed items on this domain the least, as reflected by group mean scores. Several hypotheses might account for this, and the qualitative findings offer further nuance to characterise quantitative differences. Firstly, as considered within the attributions discussion, there are differences between these modalities in terms of the extent to which they may focus on 'individual responsibility', and where they locate causality and responsibility for change. CBT frameworks may be more apparent in locating the onus of change primarily within an individual, emphasising cognitive and behavioural modification. This may lead practitioners to view service users as being responsible for their own

improvement, subtly shifting the stance from “how can I help this person?”, to “how can I influence this person to help themselves?”. Qualitative findings seemed to reflect this, with CBT participants often describing directive, risk-oriented or boundary focused support, which although framed as ‘help’, may carry a well-intentioned, but subtly coercive undertone within the therapeutic context (Valenti & Giacco, 2022). This framing could have reduced self-reported ‘help’ responses because what is offered is less about collaborative support and more about risk mitigation and behavioural modification. Interestingly, as alluded to within the extended introduction, these may be reflective of typical and frequently used markers of clinical change within services, including those which offer support to people facing SMD.

In contrast, the values-informed conceptualisation may have engendered responses that fostered humanisation; seeing Alex as a person with goals and motivations, which has been linked to increased helping behaviour (Buckley et al., 2021; Haslam, 2006). There may also have been ambiguity in terms of how help was defined across the three groups. For instance, qualitative findings demonstrated that each group may have conceptualised ‘help’ somewhat differently. Although the qualitative data was limited in terms of depth, it may offer some important nuances. The CBT group seemed to think about help as being about behaviour change, boundary setting, active engagement and risk management. Their focus on more directive and risk-reducing responses may also help to account for why this group endorsed items on both the ‘coercion’ and ‘segregation’ domains the most too. Perhaps surprisingly, the biographical group focused their understanding of help around trauma-informed perceptions, despite no psychological information being offered within this conceptualisation, reducing judgment and acknowledging behaviour as survival adaptations (which could be understood as supportive but less action-focused). The values group framed help as being about co-production, collaboration, autonomy-focused, and attunement to Alex’s values and what is important to them, which may have served to humanise Alex through understanding relatable shared meanings.

According to Weiner’s (1979) attribution theory, emotional responses such as anger or fear proposedly reduce prosocial behavioural responses such as helping, whereas emotional responses such as sympathy, are said to increase helping. Whilst this study did not assess a mediating role of emotions on behavioural responses within an SMD context, it may be unsurprising that the CBT group endorsed helping responses the

least since their fear scores were the highest. By contrast, the values group scored the lowest on fear and highest on helping. Further context for this may be offered by Haslam's (2006) dehumanisation theory, which is an influential framework for understanding how and why people may deny others humanity. The framework hypothesises two forms of dehumanisation; (1) animalisation; whereby uniquely human traits are denied to the other, or (2) mechanistic; denial of another's human nature e.g., warmth, emotional responsiveness, or individuality (Haslam, 2006). Dehumanisation has been evidenced within the literature to reduce important human characteristics such as empathy that are likely involved in influencing helping behaviour (Haslam, 2024; Hoogendoorn & Rodriguez, 2023) and may contribute to the perceived justification of neglect and punishment (Locke, 2009). This may be particularly prominent within stigmatised groups (Fontesse et al., 2021) and may reinforce systemic disadvantage.

People facing SMD are more likely to experience stigmatisation, thus may by default be considered more vulnerable to the impact of psychological processes in others, such as dehumanisation. A conceptualisation of SMD which frames Alex's presentation as being a result of internal cognitions and behaviours may risk increasing 'mechanistic' dehumanisation and reducing helping responses. This could offer some insight into why fear was highest for the CBT group, and lowest for the values group. Some research within a mental health context has found that processes of dehumanisation may also legitimise coercive practices amongst staff (e.g., Jina-Pettersen, 2022; Newton-Holmes & Mullen, 2011), which again may help to explain the highest coercion scores being observed within the CBT group. This attribution may invite more directive responses, as seen within the qualitative findings for the CBT group, rather than collaborative ones. Haslam (2006) also hypothesises that dehumanisation leads to social distancing i.e. if an individual is perceived as dangerous, then they may be viewed as less fit for inclusion in normal social life (Haslam, 2006). This may be in accordance with this study's attribution findings of increased endorsement of dangerousness by CBT participants. Values-based understandings may instead work to restore human traits, countering dehumanisation, by framing Alex's behaviour as a pursuit of meaningful goals, referring to their motivations and subjectivity as relatable and human.

As briefly alluded to within the journal paper, it is important to acknowledge the discrepancy between behavioural intentions and actual behavioural responses, also known as the intention-behaviour gap (Sheeran, 2002). Despite research suggesting that behavioural intentions are often good predictors of actual behaviour (e.g., Link et al., 2004; Webb & Sheeran, 2006), these scales attempt to infer actual behaviour from reported intentions, which may be problematic (Link et al., 2004). Whilst this study aimed to capture both behavioural intentions and responses, it did not explicitly examine whether intentions were correlated with actual behavioural responses or observable behaviour, and thus this could be a limitation which future research could address.

Other theories which are not discussed within the journal paper, may also be useful for offering a theoretical framework, which recognises the difference between behavioural intention and actual behavioural response. The Theory of Planned Behaviour (TPB) (Ajzen, 1991) is a widely used model within the literature for predicting and understanding health-related intentions and behaviour (Godin et al., 2005). It hypothesises how behavioural attitudes and intentions translate into observable behaviours and is theorised as an extension of the Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975). The TPB posits that behavioural intention is determined by components of; personal attitudes (beliefs about the outcomes of the behaviour), and subjective norms (perceptions of what others think they should do), and perceived behavioural control (the extent to which people feel able to or capable of enacting the behaviour). It stipulates that intentions alone are not sufficient to predict actual behavioural outcomes, suggesting that perceived behavioural control constitutes an additional predictor of intention alongside attitudes and subjective norms, and plays a critical role which influences the effect of intentions on actual behaviour (Ajzen, 1991; Terry & Leary, 1995). Thus, may go some of the way to addressing the intention-behaviour gap. A meta-analysis by Hagger et al. (2022) found that perceived behavioural control moderated the intention-behaviour relationship in health-related behaviours, compared to the moderating effects on the attitude-intention and subjective norm-intention relationships. This suggests support for the moderating influence of perceived behaviour control on the intention-behaviour relationship. Whilst this was conducted within the broader field of healthcare and health-related behaviours and may offer useful insight into the potential predictive

importance of perceived behavioural control as a moderating variable, generalisability to the helping behaviours of staff within an SMD context may be limited.

Whilst the current study did not measure or explore perceived behavioural control as a potentially influencing construct to account for differences observed between qualitatively reported behavioural intentions and quantitative behavioural responses, it may be interesting for future research to examine the potential influence of this on the translation of behavioural intentions into actual behavioural responses and how this accounts for behavioural outcomes in supporting people experiencing SMD. Whilst some research with healthcare professionals has suggested that intentions can be accurate predictors of actual behaviour (e.g., Eccles et al., 2006; Link et al., 2004), some studies have found that intentions are frequently higher than actual behaviours (e.g., Clement et al., 2015; Sheeran, 2002) and that intentions cannot account for all the variance within actual behaviour (Conner & Norman, 2022).

10.4. Extended Clinical Implications

This is the first study to tentatively suggest that different understandings and conceptualisations of SMD could influence staff attributions and how they subsequently respond to individuals experiencing these challenges. Elaborating on what is discussed within the journal paper, current findings appear to suggest that if psychological information is offered to understand SMD, this should be more in line with incorporating values-based information. Findings tentatively indicate that offering information about an individual's values appears to support in reducing appraisals of dangerousness and blame, decreasing fear, and may help with fostering more sympathetic and collaborative responses, and helping intentions within staff.

Identifying people's values and integrating them into clinical practice is arguably fairly simple and could perhaps be incorporated into existing provision and different interventions, including CBT-informed interventions, at a range of different levels; from interventions which support individual service users, to services, and the wider system. Given the local (Everitt & Kaur, 2019), national (Bramley et al., 2015), and global (Wright, 2000) need to improve service provision for those facing SMD, this may offer a feasible and clinically useful means of supporting people experiencing such challenges. Some research has suggested that increasing exposure and empathy

towards stigmatised groups, such as those experiencing SMD, can improve positive attitudes regarding that group (e.g., Batson et al., 1997; Birtel & Crisp, 2012). This is important because if people were more aware of the idiosyncrasies and relatable values and valued actions of individuals experiencing SMD, could this help to humanise a stigmatised group by reducing stigma and negative attitudes?

This may be especially important for the staff and practitioners working with individuals experiencing SMD, and there is increasing recognition of the limitations of the support and provision currently available. Despite these, there is also a growing acknowledgment and recognition of the need to offer and engage service users in holistic interventions, which address intersectionality, acknowledge historical and current adversity, emphasise current resources and strengths, and support them to build on these to lead meaningful and fulfilling lives (Everitt & Kaur, 2019). Such approaches support individuals to answer the question of “what does a fulfilled life look like for you?”. Since values are a theoretically well evidenced and practically useful tool, could they be incorporated into existing models of provision supporting people to answer this question? Considering the implementation of service-user values into staffs’ clinical practice could support staff to understand what is most meaningful to the individuals they support, and some research has suggested there are benefits to this, even within contexts of significant struggle and suffering (LeJeune & Luoma, 2019). Some evidence has also suggested that values may be more effective in sustaining behavioural change (Gregg et al., 2007) or in supporting the development of a therapeutic space (Lundgren et al., 2006). Given the above, it may also be interesting for future research to explore the relationship between staff and service-user values, and service-user and service values, and how these may interact and impact service provision. Some evidence has suggested that such relationships may be both a helpful and hindering factor in engaging valued living for service users (Buckley et al., 2024). The potential impact and utility of implementing values and values-informed approaches into practice with those facing SMD should be researched further.

Current findings tentatively suggest that solely CBT-informed conceptualisations towards understanding SMD could contribute towards inadvertently shaping practice in ways that may reinforce risk-averse and potentially stigmatising responses. Higher endorsements of attributions of dangerousness and emotional responses of fear were

also mirrored in qualitative findings for the CBT group, who prioritised risk and staff safety the most. This could have heightened participants' perceptions of threat and influenced the fostering of more restrictive practices, which, may limit opportunities for flexible engagement and collaboration with service-users. Some research has suggested the importance of therapeutic risk taking in supporting growth and recovery and challenging restrictive practices, which contribute to stigma and negative attitudes (e.g., Felton et al., 2018). If the focus of risk is largely on managing and mitigating harm posed by an individual, this may limit opportunities to recognise and encourage individuals' strengths, capabilities, and aspirations. Whilst it is important to acknowledge where values fit more broadly within CBT-based approaches, could this nonetheless be a point of potential divergence between CBT and values-based approaches? Whilst CBT may offer clear and well evidenced benefits e.g., structured, teachable, and testable interventions, if applied uncritically and ubiquitously, it may be reductionist. CBT's primacy on individual cognitions may limit how much focus is afforded to the intersectionality of disadvantages, which are central to SMD, potentially framing difficulties as located within the individual, rather than within structural inequalities.

10.5 Extended Strengths and Limitations

10.5.1 Strengths

This is the first study to examine whether different understandings of SMD influence the attributions, and emotional and behavioural responses of staff. To the best of the author's knowledge, this is also the first attempt at empirically applying attribution theory to a staff population working with those experiencing SMD. As such, it is anticipated that findings could make a novel and notable contribution, specifically in broadening the application of psychological thinking and theory to an SMD context; an evidence-base which is currently scant. It was also regarded as a strength of the study that findings may preliminarily suggest that certain psychological approaches and understandings of SMD may be more helpful and clinically useful than others. Findings, however, require replication on a larger scale. This is also the first study of its kind to explore the secondary aim within an SMD context.

The study implemented a mixed-methods approach, to provide an enhanced and more holistic understanding of the phenomena of interest, supporting a breadth and depth of both quantitative and qualitative knowledge (Wasti et al., 2022). Implementing a hybrid methodology enhances the ability to capture dimensions of a phenomenon of interest, that might otherwise remain unexplored (Creswell & Tashakkori, 2007). It was considered that since current literature exploring the attributions and behavioural intentions of staff supporting those experiencing SMD, is very limited, a mixed methodology could provide a more holistic and contextual perspective.

The vignettes used were developed to provide a bespoke conceptualisation of SMD, which alongside input and feedback sought from relevant stakeholders and professionals with working experience and knowledge, was felt to enhance their representativeness, and ecological and content validity. Social validity was also considered in relation to the vignettes. Whilst it could be considered a limitation that standardised vignettes were not used, and as discussed within the journal paper, consideration when interpreting the current findings should be afforded to the potential for bias through specific language used, it was important to ensure as far as possible that the information and presentation of the vignette character mapped closely onto a typical experience of an individual facing SMD, whilst ensuring psychological framings were also congruent with their respective models. Since this is currently an under-researched area, standardised, well validated vignettes that represent SMD accurately, do not currently exist. Social validity has been understood as an iterative and ongoing process in which future implementation is directly informed by feedback from key stakeholders, to encourage and enable meaningful change (Huntington et al., 2023). In seeking feedback, meaningful changes were able to be made to the vignettes, which ultimately rendered them more relevant to the population of interest. The process of actively seeking feedback from stakeholders could be thought of as enhancing the social and ecological validity of the research.

To an extent, a further strength of the study was the measure of attribution utilised. The AQ-27 is considered to have concurrent validity, as it has been utilised and replicated in several studies (e.g., Corrigan et al., 2003). As the AQ-27 encourages participants to respond to a specific individual, it is considered to be a more sensitive measure of attributions, and emotional and behavioural responses (Corrigan et al., 1999; Corrigan et al., 2002; Corrigan et al., 2003; Corrigan et al., 2004). Despite some

criticism regarding the external validity of the AQ-27, mainly focused on it having been developed within a population of university students, the current study may support the external validity of the measure as participants were recruited from a range of demographic backgrounds, and services supporting those experiencing SMD.

As acknowledged within the journal paper, the Good Reporting of a Mixed Methods Study (GRAMMS) guideline (O’Cathlain et al., 2008) was utilised, to enhance the quality monitoring of reporting the qualitative analysis. The GRAMMS guideline was chosen over other appraisal tools due to its explicit application to mixed-methods research in healthcare (Levitt et al., 2018).

10.5.2 Limitations

The representativeness of the sample was somewhat limited, despite recruiting across several different SMD services. Most of the participants identified as female and were from roles which did not require a professional qualification. Whilst the proportion of participants from ‘non-professional’ roles may represent typical staff demographics of homelessness services, this still limits transferability to wider groups of professionals working with SMD. Also, as discussed within the journal paper, limited power from a smaller sample size could have increased the likelihood of making a Type II error, meaning smaller effects are more difficult to detect. Although two significant differences were found between the different conceptualisation groups, smaller effects may have been missed due to limited statistical power. Further, despite online survey research utilising convenience samples having advantages for recruitment, a common limitation is that the resultant sample is not representative of the wider population, as it is limited to those who choose to volunteer in research (Dillman, 2007), increasing the likelihood of a recruitment bias. It is likely that those who chose to take part were already interested in the idea of applying psychological understandings to SMD or may have had prior knowledge of psychological theories such as attribution theory, or the therapeutic modalities used. This self-selection bias may have reduced the internal validity of the research and limited the generalisability and transferability of the findings. Since the current evidence base in relation to SMD is so limited, in particular that which is concerned with applying psychological theory / understanding to inform practice, high quality research is of great importance, to increase understanding and subsequently improve service provision and delivery. Although the current study has

limitations, it still offers an interesting and robust addition to a much-needed evidence base.

Although research has generally supported the reliability and validity of the AQ-27 measure, certain constructs are measured using a single question (e.g., controllability is measured via the question “how controllable do you think is the cause of Alex’s present condition?”, and personal responsibility is measured via the question “how responsible do you think Alex is for their present condition?”. Questions relating to constructs of controllability, responsibility, and locus of control (internal vs external) are grouped together and measured via a single score within the ‘blame’ domain. Whilst this may have supported the internal consistency of the measure and reflect the idea that within Weiner’s (1979) theory, attributions are nuanced, this may not have sufficiently captured attributions in relation to the core constructs within Weiner’s (1979) theory. Also, the question relating to locus of control (“I would think that it was Alex’s own fault that they are in their present condition”) is intended to measure how much participants attribute Alex’s difficulties to factors which are internal vs external to the individual. The language of this question could be interpreted as attempting to assess blame but could also be interpreted as assessing controllability and responsibility. This may make it less sensitive and receptive to individual differences, as there are fewer gradations of meaning, making it more difficult to detect subtle differences. A further challenge with single questions is that they may be more susceptible to momentary opinion, rather than reflective of a stable attribution style. In replicating the current study, future research may be improved by exploring the use of additional measures alongside the AQ-27 to further examine attributions of controllability, responsibility, and locus of control.

Finally, in developing the vignettes, the researcher did not consult the feedback of a service-user or ‘expert by experience’. This can be considered a limitation as the representativeness of the vignettes may have been further improved if the lived experience of an individual experiencing SMD was sought. The decision was made not to seek service user feedback primarily because it was important that the vignette content was not reflective of a real individual’s lived experience. There are other limitations acknowledged with research employing vignette designs, many of which are discussed within the extended methods chapter. A further point however may be that due to their artificial nature, vignettes may not be capable of fully eliciting a true

response in relation to the constructs of interest, which are representative and reflective of how participants may respond and behave within their practice. As participants were not directly involved with supporting the vignette character, they were required to make judgments whilst lacking important contextual information, which could have made it difficult to make accurate judgments in relation to their attributions towards Alex. This may be considered a limitation, or perhaps also indeed a strength of the research, as it could have reduced the likelihood and impact of any preconceptions within participants responses.

10.6. Extended Future Research

As the study did not achieve the sample size stipulated by the a priori power calculation, future research should endeavour to replicate current findings utilising a larger sample. This would improve reliability and generalisability of findings and enable more accurate conclusions to be drawn regarding the influence of different understandings of attributions and behavioural intentions within an SMD context. Future studies could seek to address some of the limitations of the current research e.g., social desirability and response bias, for example mitigating or measuring the impact of socially desirable responding. This could be achieved by measuring participant reaction times, which can be used to examine implicit biases (Anderson, 2019) or using a measure of socially desirable responding (Larson, 2018). Some research has also attempted to address these biases by incorporating attention questions which monitor participants' engagement (e.g., Berinsky et al., 2014; Kung et al., 2018). Future research could expand on the primary aim of this study by also exploring whether any demographic factors (e.g., professional background, number of years of professional experience) influence how staff appraise and respond to people facing SMD. Incorporating additional questions to measure constructs e.g., controllability would also strengthen future attribution research into SMD. It would also be interesting to explore whether other modalities of psychological understandings have an influence on staff attributions and responses towards those experiencing SMD, and how different understandings may be incorporated to benefit clinical practice within services.

Further, given current findings which may tentatively point towards there being some benefits of incorporating service-user values and values-based understandings of

SMD, and given that much existing research has focused primarily on the importance / utility of values, rather than how they may connect to behavioural outcomes (Sheldon & Krieger, 2014), it seems important to further explore the connection between values and behaviour. For example, the efficacy of values-based interventions in encouraging behavioural change. This could be explored and measured both within research to extend evidence-based practice, but also within service-related, practice-based evidence. For example, it would be interesting to explore the impact of values support within services e.g., staff training in values, incorporating values into reflective practice for staff support those facing SMD. Also, professionals who endeavour to embed values-based understandings of SMD, could consider evaluating and publishing these interventions.

11. Critical Reflections

According to the British Psychological Society (BPS), psychologists should be aware of the importance of self-awareness and the need to appraise and reflect on their own practice (BPS, 2017). This chapter offers my reflections on the research process, from developing and designing the study, to overcoming challenges, analysing the data, and writing up my findings. Reflections are also given regarding the clinical implications of my findings, as well as those for my own practice.

11.1 Context around the Conception of the Research

Upon beginning the doctorate programme in Clinical Psychology, we were encouraged by course tutors to begin thinking about what we might explore for our thesis projects from the very beginning. At the time this had felt very overwhelming and slightly premature, as I had not imagined that my thesis research would feature as heavily as it did throughout the early days of training. I remember feeling that my research skills were somewhat rusty, and I felt anxious and unprepared. I had hoped that my thesis research would capture an area which I hold a clinical interest in and thus would be grounded in an area of my experience and practice I was familiar with. I had initially been interested, and a few months later, proposed to conduct my research on the impact of Mentalization-based Treatment (MBT) on compassion for staff working with Emotionally Unstable Personality Disorder. Prior to training, I had worked in 'personality disorder' services and not only witnessed and experienced the challenges this client group can present but had also become particularly interested in how psychological models might support and shape staffs' attitudes and practice towards this group. On reflection, the general stigma and disadvantage individuals are more likely to experience in services if they hold a 'personality disorder' label, had drawn me to learn more about how a psychological understanding could influence wider clinical thinking and practice within this group. I had planned and sought ethical approval to recruit participants from training cohorts for NHS staff taking part in the MBT basic training, facilitated by the Anna Freud Centre in London. Only two cohorts a year were offered, but I was hopeful people would share and identify with my clinical interest enough to take part. Despite this, unfortunately towards the end of my second year of training, I experienced a multitude of challenges in recruiting to this project, resulting

in not gaining enough participants, and had to make the tough decision to eventually call it a day and let this project go.

At the very end of my second year of training, the race was now on to either develop or find a new, but somewhat ready to run with project, and start from scratch. Upon realising that that would not only mean embedding myself within a new sphere of literature and becoming familiar with existing knowledge in a new field but also designing and executing a whole new project from start to finish, I was anxious to say the least. Anxious about the above, anxious about knowing that I was about to begin my final year of training, and I did not have a thesis. I was also hugely aware and conscious of my own position in relation to that of my peers. The comparison with the rest of my cohort I projected on to myself was both a professional and a personal challenge I had to reflect on, make friends with, and find ways to overcome, and in doing so, learning to go at my own pace, and embrace the setbacks as learning opportunities. Needing to source and develop a new project also meant needing to seek out and begin to develop new relationships with new supervisors and services involved, all whilst continuing to juggle and spin the many different plates of completing the rest of the DClinPsy.

11.2. Reflections on Study Development, Decisions and Planning

Given the setbacks so far, I decided that pursuing a project that was already somewhat ready to begin moulding and further developing would be a more feasible alternative to creating one solely based on a vague idea of mine. In choosing a project from the course handbook where the rationale and identified gap within the literature was already identified, a primary research supervisor was also already assigned to the project. This was a relief to know that there was someone already identified with an interest, and existing professional network in this area, who had both the expertise and knowledge to support me. In choosing a new project area, I had not realised until much further down the line, that there are several parallels in this research area, and research question, with my first project. A parallel in the backdrop of disadvantage and adversity experienced by both people labelled with 'personality disorder' and of course by those experiencing SMD, a parallel in exploring how applying a psychological understanding of this presentation may influence how people make sense of, and

respond to, such individuals, and a parallel within my interest of examining this within the context of a staff population.

Since the vague research question was already known, the next step was to begin firming up my research aims and then working out the most appropriate methodology to examine this. Since existing literature applying attribution theory to an SMD context is so limited, a mixed-methods approach felt useful as it would offer an opportunity for different kinds of understandings to be captured about attribution and behavioural intentions. My hope was that these findings would work to contextualise one another and enable a more holistic understanding of the influence of different understandings on attributions and behavioural intentions within an SMD context. In designing and planning the research, I had sought feedback from other research tutors, outside of my supervisory team, which was particularly helpful in supporting me to think through my rationale for choosing a mixed-methods approach and helping to ensure that my aims and chosen methodology were compatible with answering my research questions. I also sought guidance from another Clinical Psychologist and other professionals working within the field of SMD whilst developing my vignettes, to help improve their face and content validity, and ensure that they were representative of an individual experiencing SMD. I did not consult an expert by experience throughout the vignette development process, but on reflection, I realise that this could have offered the advantage of capturing a perspective of lived experience for the vignette development, which could have provided another useful angle in ensuring their validity and representativeness. Whilst it would have been interesting to include the feedback of a service user, I was also mindful however, that the vignettes needed to be based on a 'fictional' depiction of SMD, rather than a factual reality of a real individual.

When designing the study and deciding on how I would quantitatively measure the constructs of attribution and behavioural intention, I had identified a well-known and well validated measure from existing literature (the AQ-27). This questionnaire measures attributions via the attributional domains of 'blame' and 'dangerousness', which between them, tap into the core constructs of attribution, stipulated within Weiner's (1979) attribution theory. It was when I arrived at the analysis stage of the research that I had become more aware of how the measure, particularly the 'blame' domain, groups together single questions relating to dimensions of controllability, personal responsibility, locus of control (internal vs external), into a single domain.

This encouraged me to reflect on the potential implications for my findings of only measuring each of these dimensions of attribution via a single question within the one domain of 'blame'.

Throughout the research process, I thought often about my clinical experience in contrast to that of my research experience. Upon reflection, my epistemological position in clinical practice and in research were perhaps somewhat opposed from one another. It felt at times like my clinical work required me to think from more of a social constructionist perspective, whereas within a research context, I perhaps at times leaned into more of a positivist stance. Throughout my learning and development as a psychologist, I was able to think critically and integrate the two; designing and conducting a mixed-methods project was a significant showcase of this learning to balance the two identities in to more of a critical realist stance.

11.3 Reflections on the Ethical Application and Process

I was somewhat familiar with the process of applying for ethical approval from the university, as I had already surpassed that step with my previous project. I did notice some anxieties in drafting and completing my ethics application for this project, likely influenced by the challenges with recruitment I faced with my previous project. However, besides this, I worried that my clinical experience exceeded that of my research, which has been a significant thread of reflection throughout the research process, in learning to blend the two. Obtaining ethical approval was surprisingly straightforward, in comparison to how I had imagined it might be, and it was granted without requiring further information. I had used supervision with my research supervisors on several occasions throughout the process of developing my ethics application, which had supported me in feeling more comfortable about both the process and the outcome, and I later realised that a significant proportion of my apprehension was likely transference related to the difficulties faced within my first project, and jumping ahead to a potential worst case scenario.

11.4. Reflections on Recruitment Process and Challenges

Given the challenges I had experienced with recruitment previously, I had some anticipatory anxiety that I might struggle with recruitment again, and what the implications of this might be for this project, and my training trajectory overall. I

remember thinking about the research process in linear terms – that if I could just surpass the recruitment stage of the process, I would have overcome the toughest hurdle. Looking back, perhaps this reflected my feelings about the part of the process where there is minimal control over whether you can meet the recruitment target, and thinking in more concrete terms about the potential implications of an underpowered study. Following discussions in supervision prior to ethical approval, we had decided that I would recruit staff from a pool of local (and eventually national) homelessness services that support individuals experiencing SMD, via the social media platform, 'X'. Fortunately, my primary supervisor had well established relationships with these local services and organisations, which was helpful in giving me an initial platform to begin sharing my research and recruiting from. Ethical approval was granted on the 26th February 2024. Recruitment began in early April 2024 and finished in early September 2024, resulting in approximately a six-month window for data collection. Throughout the recruitment window, I attended several meetings within various services to advertise the study and raise awareness. I quickly realised that an important part of my recruitment strategy would be focused on building relationships with managers and service providers, and I was surprised at the interest expressed and how keen services were to support me and the project. Given the nature of these services and difficulties staff would be supporting individuals with, I recognised early on that staff may potentially experience being invited to take part in my research as another demand and that this may become a barrier for recruiting.

I had a target based on an a priori power calculation of recruiting at least 159 participants and given the proposed recruitment window of around six months, I had appraised this as a feasible and realistic number to obtain. Also, given the existing network of relationships my supervisor had with local services, the services' familiarity with previous DClinPsy trainee research, and the efforts I had made to raise awareness of the project, I believed this would be achievable. Initially, there was a spate of promising interest, and many people completed the survey. However, in time, this began to drop off, and I had significantly fewer participants than I needed to satisfy the power calculation. Whilst this was a challenging experience, it did encourage me to reflect on why this might be the case, and how I could make sense of it, and discuss this in writing up my project. I had noticed through the analytics function of my survey platform that a significant proportion of people were clicking on the link to the survey

but then dropping out at several different stages prior to completing the survey in full. It became apparent that the key stages people were dropping out at were after viewing the participant information sheet, following screening, and prior to providing informed consent. The high proportion of attrition at these early stages encouraged me to think about how I could perhaps amend how I was framing the research to participants at the beginning of the survey, to maximise the accessibility and likelihood that people would continue to complete the survey in full. Of course, on one hand I felt relieved and hopeful to learn that my screening questions were functioning as intended by filtering out those who did not meet eligibility criteria, however I was concerned that I was not recruiting enough people in the timeframe I had proposed, and worried about the possible implications of this for the quality of my research and the conclusions I might be able to draw. I noticed a familiar pattern in how I was relating to this experience, in that I was jumping to conclusions about the worst-case scenario, without considering the wider context around how unpredictable conducting research can be, and the many factors which lie outside of our control.

Four months into recruitment, in response to the challenges explained above, I decided, following discussions with my research supervisors, to make an amendment to the participant information sheet. This consisted of shortening the information given, and changing the way it was delivered, in the hope of making it more inviting and accessible to people when they first entered the online survey page. Initially I felt frustrated at the new increase in workload, and that this experience had reinforced the anxieties I had first experienced at the beginning of the project, but in time, I began to appraise the ethical amendment as an example of responding to feedback and adjusting my practice accordingly, a core competency of any psychologist, to instead view this new task as an opportunity to make changes which would hopefully render the project more appealing and meaningful to potential participants.

11.5. Reflections on Analysis and Writing Up

I experienced the analysis and writing up processes of the project to be the most challenging. Because of the earlier setbacks and subsequent delays, I was not on track to submit my thesis within the timeline of the doctorate. Instead, much of my analysis and writing was completed within my thesis pending year. I noticed how much I was trying to keep perspective and not compare myself and my trajectory to that of

my peers and friends, however, at points throughout this process, I had felt one-step removed from those around me who could offer guidance and support (including my peers) and had started a new 'qualified' full-time post whilst within my thesis pending period. This had felt like a huge change and challenge, and I was required to find new ways of managing both demands and settling into new roles and expectations, including grappling with those I was placing on myself.

Throughout the process of analysing my data and writing my work up, I also became more aware of limitations and aspects of my research that I may have made different decisions around or done differently, which I had not identified at earlier stages. For example, challenges I came across in understanding the measure I had chosen and how it maps onto the theory I was working within, and the implications of main constructs of attribution being measured in one single domain. Over time, however, I have come to understand these reflections as part of the learning process, and another example of thinking critically about my work, and responding to feedback and experience.

I was also aware that the sample size I had managed to achieve was limited, but I realised when analysing the data that despite this, I still found some interesting and, in my view, significant findings. This encouraged me to reflect again on the pattern described above, of jumping to the worst-case scenario. When running my preliminary analysis, e.g., to check parametric assumptions, I quickly realised that parts of my quantitative data were not behaving as I anticipated, particularly with regards to the assumption of normality, which pushed me to explore options to overcome this, and reflect on the value and implications of each alternative. I had sought guidance from my secondary supervisor, and from another research tutor, and one of the suggestions was to consider transforming my data. In eventually choosing not to go ahead with this, I needed to think carefully about my rationale for my chosen analysis. Whilst this did take a fair amount of time, I felt more confident in my decision-making process and conclusions as a result of taking that time to reflect. This encouraged me to reflect on what constitutes 'good research'. From this experience, I have become more confident in myself and recognising my progress as a psychologist; someone who can integrate conflicting and differing feedback, appraise and think critically about my work and myself, and apply these insights not as drawbacks to my practice, but as evidence that I am reflective and always open to learning.

11.6. Reflections on Implications for my Practice

Prior to taking on this research project, I had very limited knowledge and experience of both working with SMD clients and working within a framework which emphasises working with client values. Whilst we had had some brief teaching about Acceptance and Commitment Therapy (ACT) and working with values, CBT was a more comfortable model for me at that time. In learning about an unfamiliar model and applying this in my research practice, I felt some anxiety and apprehension, but at the same time, I was keen to learn more about values and how we can apply them to our understanding of clients. On reflection, when framing this learning and how it may be applied to my clinical practice, I felt more confident and comfortable, compared to thinking about using this within my research. This was perhaps a reflection of how I appraised my abilities and skills, in feeling more competent as a clinician than a researcher. Learning about a new modality for my research encouraged me to bridge that gap and move closer towards viewing research and practice as being intertwined with each other, rather than distinct separate entities. Perhaps connected to this, as I became more settled in my new post following the end of the course, this gave me the confidence to keep pushing forward with my research.

11.7. Concluding Reflections

Undertaking this project has been the most challenging part of my DClinPsy journey by far, but one that I have taken valuable learning and experience from, which I will apply to my wider practice as a Clinical Psychologist. Learning to become more open to, and comfortable with, uncertainty and conflicting feedback, has supported my confidence in making decisions, critically appraising my choices, and standing by my rationale and judgment, but also being reflective and actively seeking feedback to adapt my practice. Several of the challenges I have overcome throughout my doctoral research journey have embedded the importance of seeking feedback and adjusting my practice accordingly, and the realisation that this core competency is something I have been doing, at times unconsciously, throughout. As my project comes to a close, I hope that it can offer some new and interesting insights into the utility and importance of applying psychologically informed understandings when supporting people experiencing SMD and highlight pathways for future exploration, both clinically and within future empirical research.

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Appendices

Appendix A: Author Guidelines for Submission of Original Research Articles to 'International Journal of Homelessness'

Retrieved from: [Submissions | International Journal on Homelessness \(uwo.ca\)](#)

General Information

Following the guidelines helps avoid delays in publication. Authors are responsible for formatting their own manuscripts as a condition for acceptance; however, all manuscripts accepted for publication will undergo minor copyediting. In general, and for all matters not covered by this style sheet, *IJOH* follows the *APA* 7th edition.

To ensure fairness for our reviewers, remove all references to the author(s) from the submission itself. Cite works by any of the authors in the third person, and do not include personal notes (acknowledgments, thanks, references to oral presentation, etc.). This includes removing any identifying metadata and properties from the file submitted.

All manuscripts must be double-spaced (included references and block quotations) in 12-point, Times New Roman font with pages numbered consecutively with the title page as page 1. Use 2.54 centimetre (1") margins on all sides. Normally submissions do not exceed 9,000 words, excluding footnotes and references, but we will also consider longer submissions. Discussion pieces should not normally exceed 4,000 words and may include many or few references as appropriate.

Language of Submission

As part of our commitment to international knowledge exchange, we recognize the value of submissions, reviews, and revisions being conducted in one's preferred language. Therefore, while all publications are ultimately translated to English, we also accept submissions in French, Spanish, Portuguese, Japanese, and Arabic. Translation into English for final publication is available at no cost thanks to funding provided through the Institute of Global Homelessness.

Manuscript Order for Submission

- Title page (separate file, including authors and affiliations)
- Abstract and Keywords (on a separate page, in a file with the manuscript text)
- Text (including embedded tables/figures and reference list)
- Appendices (if applicable, separate file)

Formatting Guidelines

All formatting must follow *APA* 7th edition with no variations from the standard format unless a different format is used within your language of choice.

Open Access

All articles are published open access free of charge. All content published in the Journal is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International license (CC BY-NC-SA 4.0).

Original Content

Articles are screened for originality via turnitin.com as licensed to DePaul University through partnership with the Institute of Global Homelessness. The originality report is reviewed by the Managing Editor and/or Regional Editor-in-Chief.

Appendix B: Ethical Approval



University of
Nottingham
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Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

26/02/2024

Supervisor: Anna Tickle

Applicant : Rachael Nolan

Project: 3130 Do different understandings of people experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working within homelessness services?

The committee is pleased to confirm that the above study now has approval on the basis of your application and any subsequent clarifications. You must conduct your research as described in your application, adhere to all conditions under which the ethical approval is granted, and use only materials and documentation specified in your application.

If you need to make any changes (for example to extend your data collection timeframe, change the mode of data collection, or the measures being used), you must create and submit an Amendment Form. To do this, select the 'Create Sub Form' option from the Actions Menu on the left-hand side of the page in the online system and then select 'Amendment Form'.

With best wishes

Dr Katy Jones and Dr Jen Yates

Chairs of the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

Appendix B1.1: Approval of Ethical Amendment



Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

17/07/2024

Supervisor:

Applicant : Rachael Nolan

Project: Project Id Do different understandings of people experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working within homelessness services?

The committee is pleased to confirm that the amendment relating to ref: MHCN - 2024 - 3130 - 1 has received approval. Please conduct your study following the amended procedures. If you need to make any further changes, please create a new amendment form.

With best wishes

Dr Katy Jones and Dr Jen Yates Chairs of the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

Appendix C: Participant Information Sheet



University of
Nottingham
UK | CHINA | MALAYSIA

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW Division of Psychiatry & Applied Psychology

Project Title: Do different understandings of people experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working in homelessness services?

Student: Rachael Nolan rachael.nolan@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle mszact1@exmail.nottingham.ac.uk

Ethics Reference Number: TBC

We would like to invite you to take part in a research study about whether different ways of understanding people experiencing severe and multiple disadvantage, influences the behavioural intentions of staff who work in homelessness services. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?

This study aims to investigate whether a values-informed understanding of an individual facing severe and multiple disadvantage, influences the attributions made by staff who support them. A value-informed understanding will be compared to a cognitive-behavioural and biographical understanding. The study also aims to explore the impact of different ways of understanding severe and multiple disadvantage on the behavioural intentions of staff to support someone experiencing this. This study is being carried out for educational purposes by a student on the Trent Doctorate in Clinical Psychology (DClinPsy) and the findings will be written up as part of a thesis.

Why have I been invited?

You have been invited because you currently work within a service-user facing role, whereby you have frequent contact supporting individuals facing severe and multiple disadvantage. We are inviting members of staff from several organisations including Framework, Homeless Link, MEAM, and the Practice Development Unit, who work in a service-user facing role, supporting individuals facing severe and multiple disadvantage.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to provide consent. You will be asked to indicate that you have thoroughly read the information detailed within this form, and then asked whether you give your informed consent to take part. Consent will be obtained via an online form, as the first part of the online questionnaire. You may change your mind about being involved at any time or decline to answer a particular question. You are free to withdraw at any point before or during the study without giving a reason. Should you wish to withdraw, you can exit the questionnaire by closing your browser window. If you withdraw during the study, we will no longer collect any information about you or from you. If you decide to withdraw after participating in the study, it will not be possible to remove your data as all data collected from the questionnaire will be anonymous.



What will I be asked to do?

If you choose to take part, you will be asked to complete a brief online questionnaire. The first part of the questionnaire will ask you to read and make sure you have read through this information sheet before being asked to provide informed consent to take part. Following this, you will be asked to complete a brief set of screening questions. This is to help ensure you meet the study's inclusion criteria to take part. If so, you will then be asked to provide some brief demographic information (e.g., gender, age, professional background, and the number of years you have worked within the sector of severe and multiple disadvantage). You will then be directed to view a vignette which details experiences of someone facing severe and multiple disadvantage, before being prompted to answer a series of related questions. It is anticipated that the online questionnaire will take approximately no more than 15-20 minutes to complete in full.

Will the research be of any personal benefit to me?

There is no direct benefit to you from taking part, but we hope that you find the study to be an interesting and positive experience. It is hoped that the information we collect from this study will add to a growing area of important research about the impact of having different ways of understanding people who experience severe and multiple disadvantage. It is also hoped that this study will help us understand more about the factors which may influence staffs' intentions and motivation to support people facing severe and multiple disadvantage. All participants who take part in the study will be asked if they would like to 'opt in' to be entered into a prize draw for the chance to win Amazon gift vouchers (of varying monetary value), to thank them for their time and effort.

Are there any possible disadvantages or risks in taking part?

We don't expect there to be any disadvantages or risks to taking part, however it is recognised by the research team that some of the information written within the vignettes may have the potential to be perceived as upsetting. Should this occur, contact details for the primary researcher can be found at the end of this information sheet, should you have any questions.

What will happen to the information I provide?

To ensure confidentiality, only the research team will have access to the data you provide from the online questionnaire. Data from the questionnaire will be saved and stored securely on a password protected online drive, provided by the University of Nottingham. Only the primary researcher will have access to this, and all data collected will be anonymous. Data will be aggregated for the purposes of analysis, meaning individual data will not be disclosed and so participants will not be identifiable within the findings.

The information that you provide will be used to write a dissertation for the fulfilment of the Trent Doctorate in Clinical Psychology (DClinPsy) and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor, Dr Anna Tickle mszact1@exmail.nottingham.ac.uk for a copy.

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



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reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: <https://www.nottingham.ac.uk/utilities/privacy.aspx>

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 above.

What if there is a problem?

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator: MS-MHCNS-Ethics@exmail.nottingham.ac.uk and the Administrator 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

We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Sources of support

If you have any queries, please contact the primary researcher, Rachael Nolan, via email: rachael.nolan@nottingham.ac.uk

PARTICIPANT INFORMATION

Project Title: Do different understandings of people experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working in homelessness services?

Student: Rachael Nolan rachael.nolan@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle mszact1@exmail.nottingham.ac.uk

Ethics Reference Number: 3130

What the study involves?

We are looking at whether a values-based understanding of a person facing severe and multiple disadvantage has an influence the way staff may make sense of the person and their behavioural intentions to support them. Staff currently working within homelessness services, who have regular contact with service users, are invited to take part in a short online survey. You will be asked to view a short vignette which describes a fictional person experiencing severe and multiple disadvantage, and then to answer a series of short questions.

Do I have to take part?

It is up to you whether you decide to take part, and if so, you will be asked to provide informed consent at the beginning of the online survey. You may change your mind about being involved and withdraw from the study at any time without giving a reason. If you withdraw during the study, we will no longer collect any information about you or from you.

What will happen to my information?

All information you provide will be anonymous and only the researcher will have access to this. All data will be stored securely on a password protected online drive, provided by the University of Nottingham. The information that you provide will be used to write a dissertation for the fulfilment of the Trent Doctorate in Clinical Psychology (DClinPsy) and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor, Dr Anna Tickle mszact1@exmail.nottingham.ac.uk for a copy.

Are there any risks in taking part?

We don't expect there to be any risks to taking part, however it is recognised by the research team that some of the information written within the vignettes may have the potential to be perceived as upsetting. Should this occur, contact details for the primary researcher can be found at the end of this information sheet, should you have any questions.

Who to contact

If you have any questions or queries, please contact the primary researcher, Rachael Nolan, via email: rachael.nolan@nottingham.ac.uk

Appendix D: Participant Consent Form



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

Participant Consent

Interactive form for online consent

STUDENT RESEARCH PROJECT ETHICS REVIEW Mental Health and Clinical Neurosciences

Project Title: Do different understandings of people experiencing severe and multiple disadvantage (SMD) influence the attributions and behavioural intentions of staff working in homelessness services?

Researcher: Rachael Nolan
Supervisor: Dr Anna Tickle
Ethics Ref: TBC

Have you read and understood the Participant Information? ☐Yes ☐No

Do you agree to take part in a brief online survey, where you will be asked to read a short vignette and then answer a series of questions about attributions towards the service user described within the vignette? ☐Yes ☐No

Do you agree to complete two follow-up questions, where you will be asked to give details about supporting the service user described within the vignette? ☐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 taken part it may not be technically possible to withdraw your data? ☐Yes ☐No

Do you give permission for your data from this study to be shared with other researchers in the future, provided that your anonymity is protected? ☐Yes ☐No

Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications? ☐Yes ☐No

I confirm that I am 18 years old or over ☐Yes ☐No

By selecting 'Yes', I indicate that I understand what the study involves, and I agree to take part. I consent to take part in this research study. ☐Yes ☐No

Appendix E: Advertisement for Recruitment

Appendix E.1: Email Advertisement

Dear staff member,

I hope this email finds you well. My name is Rachael Nolan and I am a Trainee Clinical Psychologist at the University of Nottingham. I am currently looking to recruit staff members who work to support service users within Framework homelessness services, as part of my thesis research for my Doctorate in Clinical Psychology.

I am interested in looking at whether **different ways of understanding service users within homelessness services influences the attributions staff may make about service users' difficulties**. I am also hoping to explore how these attributions may impact staffs' intentions to provide support to service users.

To take part, we ask that you are currently be a staff member working in a service-user facing role, have at least six months experience of working within the sector of severe and multiple disadvantage, and have passed your probationary period (if your employment has one).

All participants recruited to the study will be offered the opportunity to opt into a prize draw for the chance to win Amazon vouchers of varying amounts (£50, £25 or £10), to thank you for your time and participation.

If you would like more information and / or are interested in taking part, please click the link here [insert link to online information sheet and survey]. The link will firstly direct you to view the study information sheet, where details of the study aims and procedure are given. If you choose to take part, you will be taken to a further page and asked to provide informed consent. The survey is brief, taking approximately 15-20 minutes to complete. All the information you provide will be stored securely and is strictly confidential.

If you have any questions or queries, please feel free to contact me via email at rachael.nolan@nottingham.ac.uk and I will be happy to assist where I can.

With Kindest Regards,

Rachael Nolan (Trainee Clinical Psychologist)

Supervised by:

Dr Anna Tickle (Consultant Clinical Psychologist & Associate Professor at the University of Nottingham).

Appendix E1.2: Bulletin Advertisement

Are you a staff member working within homelessness services?

Do you have at least six months experience of working in a service user facing role, where you provide direct support to service users?

We'd like to hear from you!

I am a Trainee Clinical Psychologist at the University of Nottingham and I am currently looking to recruit staff members to take part in my thesis research. I am interested in looking at whether **different ways of understanding service users within homelessness services influences the attributions staff may make about service users' difficulties. I am also hoping to explore how these attributions may impact staffs' intentions to provide support to service users.**

To take part, we ask that you are currently be a staff member working in a service-user facing role, have at least six months experience of working within the sector of severe and multiple disadvantage, and have passed your probationary period (if your employment has one).

All participants recruited to the study will be offered the opportunity to opt into a prize draw for the chance to win Amazon vouchers of varying amounts (£50, £25 or £10), to thank you for your time and participation.

If you would like more information and / or are interested in taking part, please click the link here [insert link to online information sheet and survey]. The link will firstly direct you to view the study information sheet, where details of the study aims and procedure are given. If you choose to take part, you will be taken to a further page and asked to provide informed consent. The survey is brief, taking approximately 15-20 minutes to complete. All the information you provide will be stored securely and is strictly confidential.

Appendix F: Recruitment Poster

Do different understandings of people experiencing severe and multiple disadvantage influence staff responses towards them?

 Participants will be entered into a prize draw for the chance to win Amazon vouchers

 We are interested in finding out more about if different understandings of people experiencing severe and multiple disadvantage influence staffs' attributions and their intentions to support them

 **What will I be asked to do?**
If you would like to take part, please complete a short online survey, taking approximately 15-20 minutes

 **Who can take part?**
Staff who currently work within a service user facing role in UK homelessness services
Must have at least 6 months experience working with SMD

 **Interested in taking part?**
If you have any questions, please email:
rachael.nolan@nottingham.ac.uk
To take part please click the link below or scan the QR code:
<https://unioflincoln.questionpro.eu/t/AB3uzG8ZB3vlze>



This research is being conducted as part of the Doctorate in Clinical Psychology and has received ethical approval from the University of Nottingham Research Ethics Committee. [Ethics Reference no: 3130]

 University of Nottingham
UK | CHINA | MALAYSIA

Appendix G: Participant Questionnaire

Appendix G1.1: Screening Questions

Please read each question carefully and answer as accurately as possible. This will help the researchers assess your eligibility to take part in the study.

Q1. Are you currently working in a UK homelessness service?

YES / NO

Q2. Are you currently working in a service user facing role within your service, whereby you have frequent and direct contact with service users? (e.g., support worker, support planning role)

YES / NO

Q3. Do you have at least six months experience of working within this role or previous roles whereby you have directly supported people accessing homelessness services?

YES / NO

Appendix G1.2: Demographic Questions

Please read each question carefully and answer as accurately as possible.

Please select which of the below options best describes your:

Q1. Gender

Male

Female

Other

Prefer not to say

Q2. Age

19-29

30-39

40-49

50-59

60+

Prefer not to say

Q3. Professional background

Medical

Nursing / Support work

Psychology / Psychotherapy

Occupational Therapy

Other Allied Health Professional

Other

Prefer not to say

Q4. Number of years you have worked within the sector of severe and multiple disadvantage (NB: this may be across multiple roles within SMD)

0-1 year

2-4 years

5-10 years

10+ years

Prefer not to say

Appendix H: Vignette Conceptualisations

Appendix H1.1 Biographical Vignette

Alex has a history of experiences related to severe and multiple disadvantage. Growing up, Alex had difficult and chaotic relationships with their parents, and frequently witnessed domestic violence. Alex's physical and emotional needs were often neglected. As a result of domestic violence and neglect, Alex was removed from the family home and taken into foster care. Alex would often flee foster placements and spend periods of time homeless on the streets. Alex does not have any lasting relationships. Alex found education difficult and did not regularly attend school or obtain qualifications. During Alex's time living out on the streets, they became involved with a group of peers and began using various substances.

Alex has historically experienced difficulties with their mental health and frequently struggles with episodes of depression and anxiety. During such times, Alex has used substances and alcohol excessively. On previous occasions, Alex has had altercations with peers in the hostel they reside at, sometimes leading to aggressive outbursts which have required police involvement. On one occasion, Alex had an altercation with two other residents, having thought the peers were talking about Alex. Alex responded aggressively towards the two peers and the police were required to support staff in managing the incident. Alex also has intermittent contact with the criminal justice system for other behaviours, such as shoplifting.

Appendix H1.2: CBT-informed Vignette

Alex has a history of experiences related to severe and multiple disadvantage. Growing up, Alex had difficult and chaotic relationships with their parents, and frequently witnessed domestic violence. Alex's physical and emotional needs were often neglected, and as a result of domestic violence and neglect, Alex was removed from the family home and taken into foster care. Alex found it difficult to build trusting and secure attachments with different foster carers and would often flee foster placements and spend periods of time homeless on the streets. Alex's chaotic lifestyle meant they found regularly attending school difficult and did not obtain any qualifications.

It is likely that Alex's early history of relationships contributed to the development of core beliefs about themselves, others, and the world, such as "the world is unsafe" "others are dangerous and cannot be relied upon or trusted to meet my needs", "I am vulnerable" and "I am unlovable". Alex believes there is a need to protect themselves, and that violence is helpful for this. Alex's beliefs about themselves, others, and the world have often meant they have struggled with their mental health, and Alex has consequently experienced episodes of depression and anxiety. Alex has described feeling hopeless, isolated, and disconnected from others. During these times, Alex has racing thoughts, such as "I can't trust anyone", "No one understands me or accepts me". These cause Alex to experience physical sensations like racing heart and sweating. Alex has used substances and alcohol excessively as a strategy to avoid intense and difficult feelings, which they describe as helpful for "cutting off" from distressing thoughts, feelings, and physical sensations. To support Alex's substance

use, they have also been in intermittent contact with the criminal justice system for behaviours, such as shoplifting.

Previously, Alex was involved in an altercation with two peers in the hostel they were staying at. Alex overheard a conversation between the two peers and interpreted this as them talking about Alex. This activated Alex's core beliefs about others not being trustworthy and themselves as being vulnerable, threatening Alex's sense of safety within their relationship with the two peers. Alex began to feel angry, thinking to themselves "I have to do something about this". Alex responded aggressively towards the peers in an attempt to keep safe, and the police were required to support staff in managing the incident.

Appendix H1.3: Values-informed Vignette

Alex has a history of experiences related to severe and multiple disadvantage. Growing up, Alex had difficult relationships with their parents and frequently witnessed domestic violence. Alex's physical and emotional needs were often neglected, and they were removed from the family home and taken into foster care. Alex found it difficult to build trusting and secure attachments with different foster carers and would often flee foster placements, spending periods of time homeless on the streets. Alex's chaotic lifestyle meant they found regularly attending school difficult and did not obtain any qualifications. Despite the risks being homeless poses to Alex, the ability to choose how they live, and to live freely, are very important to Alex, as growing up many of the decisions about where Alex lived and who with were made without them. These experiences encouraged Alex to value freedom and independence.

During a period of being homeless, Alex became involved with a group of peers and began using substances. Alex finds that using substances and alcohol helps them to avoid intense and difficult feelings, which they describe as helpful for "cutting off" their traumas. To support Alex's substance use, they have also been in intermittent contact with the criminal justice system for behaviours, such as shoplifting. Alex feels using substances and alcohol helps them to manage their mental health, and they have experienced several episodes of depression and anxiety. This can leave Alex feeling isolated, and different to others, which has impacted on their sense of feeling connected to and being accepted by others. Because of this, safety and acceptance are important values for Alex.

Alex has often felt themselves to have been treated unfairly throughout their early life, particularly in their relationships with their parents, and so has come to really value fairness and equality. Because of this, Alex can be outspoken about instances they perceive as unfair. Previously, Alex was involved in an altercation with a peer in the hostel they were staying at. Alex overheard a conversation between two peers and interpreted this as the peers talking about Alex. This made Alex feel threatened and violated their sense of justice and fairness. Alex responded aggressively towards the peers in an attempt to uphold justice and the police were required to support staff in managing the incident.

Appendix I: Qualitative Questions Exploring Behavioural Intention

1. What ideas do you have about how you would support the person described in the vignette?
2. What factors do you think would be important for supporting this person?

Appendix J: Participant Debrief Message

Thank you for taking part in this research study, your participation is valued greatly. The aim of this research was to explore if different ways of understanding service users within homelessness services has an impact of the attributions staff may make about their difficulties. We also aimed to look at how these attributions may impact staffs' intentions to support service users.

It is hoped that findings from this study will contribute to a growing evidence base interested in understanding more about what factors may influence how staff understand service users who have experienced severe and multiple disadvantage, who are accessing homelessness services, and the support staff may then provide.

Further information can be found at both <https://homeless.org.uk/> (Homeless Link) and <https://www.pdunottingham.org/> (Nottingham Practice Development Unit).

If you have any questions, queries or concerns, or would like further information regarding the research findings, please feel free to contact the primary researcher at rachael.nolan@nottingham.ac.uk.

Appendix K: Preliminary Analysis Tables

Appendix K1.1: Table 11. Skewness and Kurtosis Results

Variables	Skewness Statistic	Skewness Standard Error	Z-score	Kurtosis Statistic	Kurtosis Standard Error	Z-score
Blame	.245	.271	.904	-.574	.535	-1.073
Anger	1.820	.271	6.716	2.855	.535	5.336
Pity	-.046	.271	-.170	-1.046	.535	-1.955
Sympathy/Concern	-.463	.271	-1.708	-.685	.535	-1.280
Help	-1.402	.271	-5.173	2.179	.535	4.073
Dangerousness	.838	.271	3.092	.286	.535	.535
Fear	1.933	.271	7.133	3.623	.535	6.772
Segregation	1.371	.271	5.059	2.472	.535	4.621
Coercion	1.093	.271	4.033	.155	.535	.290
Avoidance	-.066	.271	-.244	.385	.535	.720

Note: For medium sample size ($50 < n < 300$), a z-score within ± 3.29 is deemed to indicate non-significant deviations from a normal distribution (Kim, 2013). Z-scores which fall outside of this range are displayed in bold.

Appendix K1.2: Table 12. Skewness and Kurtosis Results (Split by Group)

Variables	Group	Skewness Statistic	Skewness Standard Error	Z-score	Kurtosis Statistic	Kurtosis Standard Error	Z-score
Blame	Bio	.033	.456	.724	-.747	.887	-.842
	CBT	.689	.472	1.459	-.354	.918	-.386
	Values	.008	.434	.018	-.629	.845	-.744
Anger	Bio	.932	.456	2.044	-.199	.887	-.224
	CBT	1.481	.472	3.138	1.441	.918	1.569
	Values	2.076	.434	4.783	3.337	.845	3.949
Pity	Bio	-.147	.456	-.322	-1.209	.887	-1.363
	CBT	.311	.472	0.659	-1.066	.918	-1.161
	Values	-.255	.434	-.588	-.486	.845	-.575
Sympathy/Concern	Bio	-.445	.456	-.976	-1.256	.887	-1.416
	CBT	-.630	.472	-1.334	-.323	.918	-.352
	Values	-.289	.434	-.666	-.945	.845	-1.118
Help	Bio	-.930	.456	-2.039	.170	.887	0.192
	CBT	-.205	.472	-.434	-1.192	.918	-1.298
	Values	-1.699	.434	-3.915	2.415	.845	2.858
Dangerousness	Bio	.745	.456	1.634	.520	.887	0.586
	CBT	.243	.472	0.515	-.118	.918	-.129
	Values	1.779	.434	4.099	3.582	.845	4.239
Fear	Bio	2.054	.456	4.504	5.653	.887	6.373
	CBT	1.413	.472	2.994	1.674	.918	1.824
	Values	2.305	.434	5.311	5.209	.845	6.164
Segregation	Bio	.345	.456	0.757	-.915	.887	-1.032
	CBT	.609	.472	1.290	-.238	.918	-.259
	Values	2.150	.434	4.954	5.209	.845	6.164

Coercion	Bio	1.055	.456	2.314	.061	.887	0.069
	CBT	.696	.472	1.475	-.698	.918	-.760
	Values	1.361	.434	3.136	.717	.845	0.849
Avoidance	Bio	-.199	.456	-.436	.803	.887	0.905
	CBT	-.164	.472	-.347	-.490	.918	-.534
	Values	.076	.434	.175	1.469	.845	1.738

Note: For small sample size ($n < 50$), a z-score within ± 1.96 is deemed to indicate non-significant deviations from a normal distribution (Kim, 2013). Z-scores which fall outside of this range are displayed in bold.

Appendix K1.3: Table 13. Levene's Test for Homogeneity of Variance

Variables	Levene Statistic	df	Significance
Blame	.283	2	.754
Anger	.864	2	.426
Pity	1.10	2	.337
Sympathy/Concern	.305	2	.738
Help	1.01	2	.369
Dangerousness	.454	2	.637
Fear	1.60	2	.209
Segregation	.893	2	.414
Coercion	.879	2	.420
Avoidance	.176	2	.179

Note: a significant result indicates variances of the groups are not equal, thus homogeneity cannot be assumed.

Appendix K1.4: Table 14. Test for Randomisation of Groups

Sample Characteristics	Between Groups df	Within Groups df	F-Value	p-Value
Gender	2	76	2.38	.099
Age	2	76	.44	.64
Professional Background	2	76	.92	.40
Years of Experience in Profession	2	76	.28	.76

Appendix L: Histograms to Test for Normality

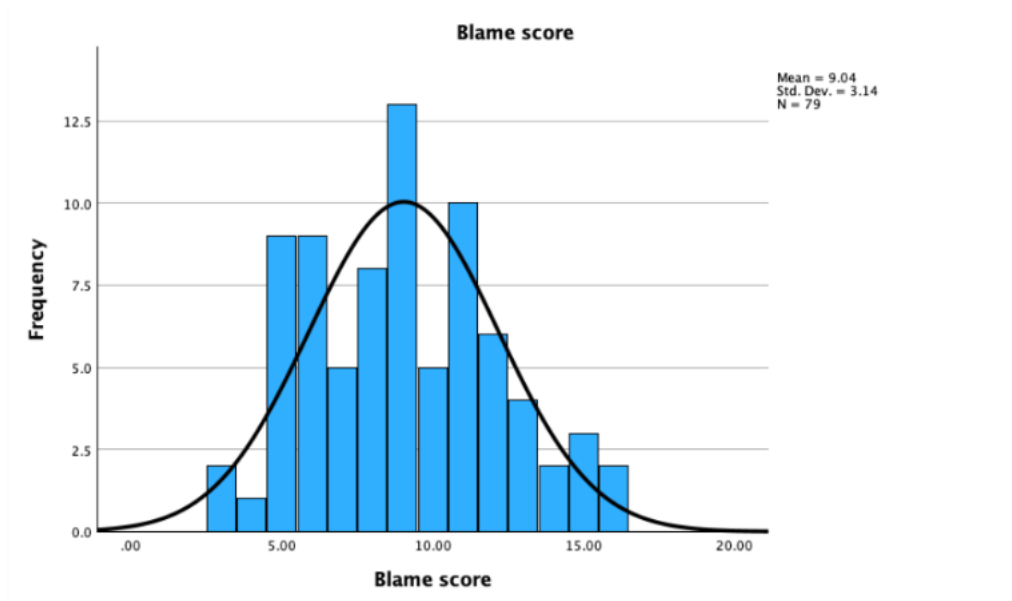


Figure 4. Histogram to assess normality for 'blame' variable

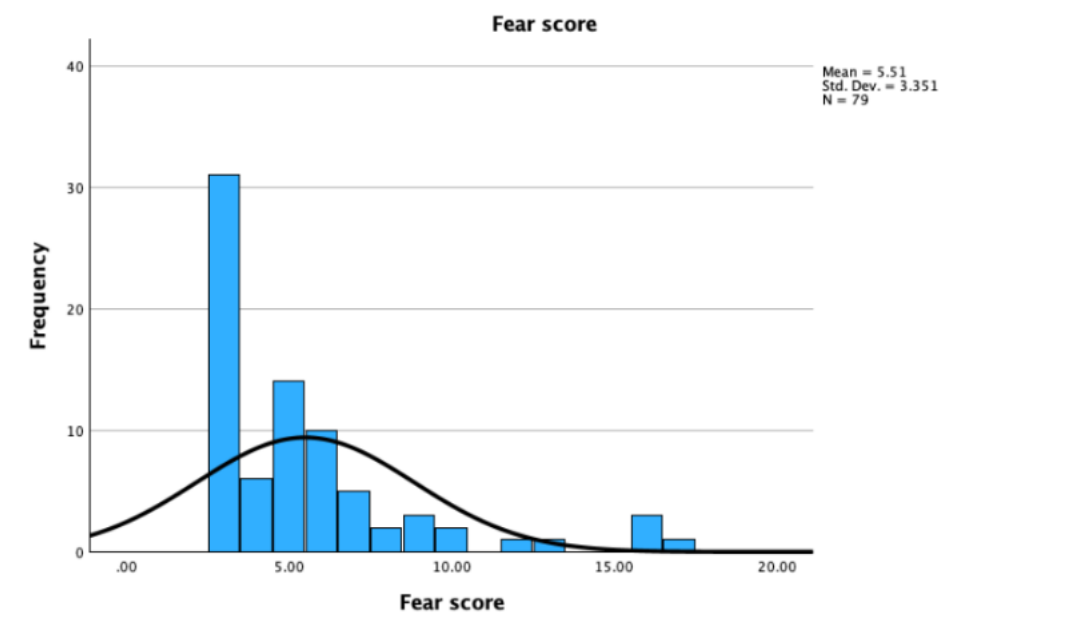


Figure 5. Histogram to assess normality for 'fear' variable

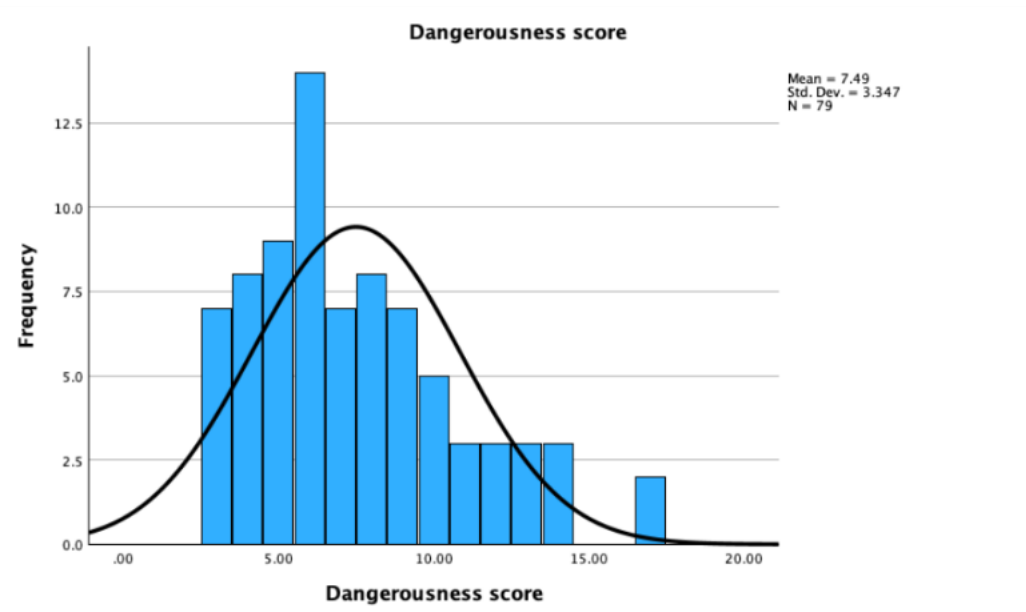


Figure 6. Histogram to assess normality for 'dangerousness' variable

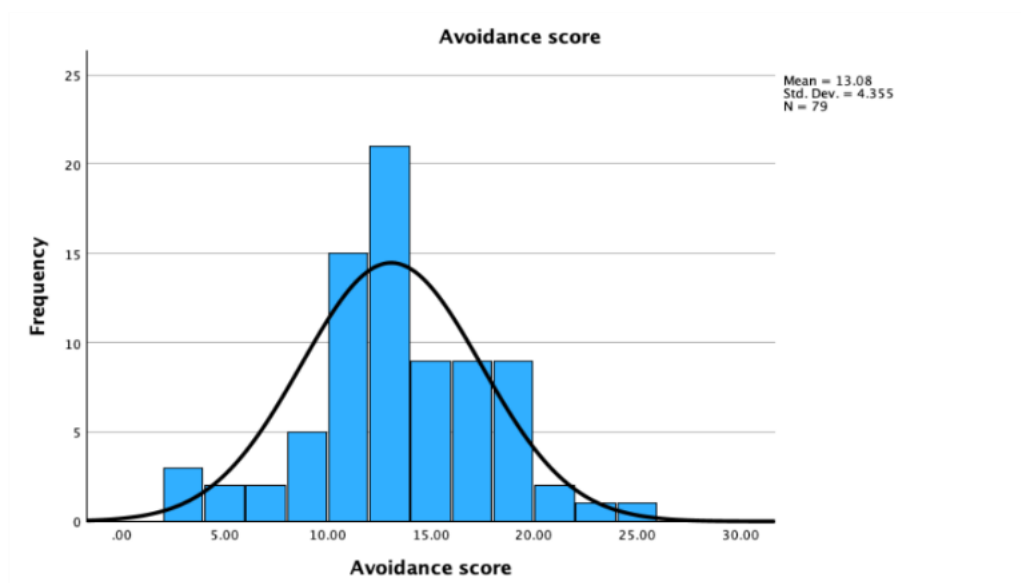


Figure 7. Histogram to assess normality for 'avoidance' variable

Appendix M: Content Analysis Model (Elo & Kyngäs, 2008)



**Appendix N: Good Reporting of a Mixed Methods Study (GRAMMS) Checklist
(O’Cathain et al., 2008)**

GRAMM Guideline	Journal Paper	Extended Paper
	Section: Page Page	Section:
Justification to use a mixed methods approach to answer the research question	Methods (Epistemological Position, Design) p:22	Extended methods (rationale for mixed methods) p:104
Articulation of the design in terms of purpose, priority, and sequence of methods	Methods (Design) p:22	Extended methods (Design, Procedure) p:105-106, 120-122
Describe each method in terms of sampling, data collection and analysis	Methods (Design) p:22, (Procedure), p:25	Extended methods (Design, Participants, Quantitative Analysis, Qualitative Analysis) p:105-107, 125-129
Delineate where and how integration occurs and who has participated in it	Methods (Design) p:22, Participants) p:22	Extended methods (Rationale for mixed-methods, Design) p: 104
Describe any limitation of one method associated with the presence of another	Discussion p:49	Discussion p:156-157
Describe insights gained from mixing or integrating	Conclusion p:50	Discussion p:156-157

Appendix O: Extracts of Coding for Development of Main Categories

Appendix O1.1: Extract of Initial Coding for Biographical Group

	A	B	C	D	E	F
11	No lone working	Risk & Safety				
12	Only meeting Alex in public places	Risk & Safety				
13	Understanding environment so it's conducive to recovery	Environment				
14	Allow Alex to make decisions for himself	Promoting engagement & autonomy				
15	Allow Alex to feel he has agency and control over his life to make changes	Promoting engagement & autonomy	Quote?			
16	1:1 discussion to understand Alex's needs	Flexible approach				
17	Support Alex with substance and alcohol misuse	Interventions				
18	Ask Alex what they want help with	Promoting engagement & autonomy				
19	Offering information about services	Interventions				
20	Offering information about emotion regulation, coping skills	Interventions				
21	Offering information depending on what Alex wants to address	Interventions				
22	Consider if staff are working in psychologically-informed environments	Trauma-informed, early adversity				
23	Consider if staff are working in trauma-informed ways	Trauma-informed, early adversity				
24	Using person-centred approaches	Person-centred				
25	Staff need to look after own wellbeing when interacting with Alex	Risk & Safety				

Appendix O1.2 Extract of Initial Coding for CBT Group

	A	B	C	D	E
8	Ensure I was safe	Risk			
9	Collect information on agencies to help Alex	Different interventions			
10	Discuss support information with Alex	Therapeutic relationship	Alex's position		
11	Ensure Alex has benefits and accommodation	Different interventions			
12	Ensure Alex has sufficient food and clean warm clothes	Different interventions			
13	Meet basic needs before addressing trust	Different interventions			
14	Trust required for accessing support	Therapeutic relationship			
15	Provide safe environment	Risk	Safety		
16	Not force him to engage	Alex's position			
17	Make him understand importance of engagement	Staff stance	Engagement		
18	Empathy instead of sympathy for Alex	Alex's position			
19	Linking Alex with helpful agencies	Different interventions			
20	Consider Alex's safety	Risk			
21	Consider staffs' safety	Risk			
22	Impact of Alex's early experiences of feeling unsafe on how safe they feel now	Influence of past on present	Trauma-informed		
23	Being mindful of Alex's anxieties	Alex's position			
24	Being mindful of their relationships with others	Alex's position			

Appendix O1.3: Extract of Initial Coding for Values Group

	A	B	C	D	E
7	Listening to what's important to Alex	position			
8	Alex's priorities	Empathising with Alex's position			
9	Voluntary psychological assessment & intervention	Staff stance continuum			
0	Voluntary physical health assessment	Staff stance continuum			
1	Building therapeutic rapport	Therapeutic relationship			
2	Peer involvement	Multiple support agencies			
3	Risk assessment and care planning	Risk			
4	choice over information sharing	Empathising with Alex's position			
5	Help with registering to meet basic needs (GP, benefits, housing)	Multiple support agencies			
6	Small steps	Empathising with Alex's position			
7	Led by Alex's wishes	Empathising with Alex's position	Flexibility		
8	Accompany Alex to appointments	Staff stance continuum			
9	Following through on what you say you'll do	Therapeutic relationship	Building trust		

Poster

Do different understandings of people experiencing severe and multiple disadvantage influence the attributions and behavioural intentions of staff working in homelessness services?



Rachael Nolan, Dr Anna Tickle, Dr Heather Cogger-Ward, Dr Sophie Buckley
Trent Doctorate in Clinical Psychology



Background

Severe and Multiple Disadvantage¹ (SMD) describes people experiencing 3-5 domains depicted on the right. Such individuals face entrenched inequality and have often experienced trauma. There is growing emphasis for services to apply psychologically informed approaches when understanding this group². Attribution theory offers a framework for understanding how different explanations of SMD may shape attributions, emotional responses, and behavioural intentions towards people facing SMD. CBT and values-informed approaches are both examples of psychological models which have been applied in SMD services^{3,4} and incorporating information from these approaches could influence how staff understand and respond to service users.



Method

Data: Seventy-nine staff working in homelessness services viewed 1 of 3 vignettes (biographical, CBT, or Values), and completed an online attribution questionnaire. Of these, 70 participants also provided qualitative data, by answering two questions to explore behavioural intentions to offer support. **Procedure:** Participants were staff working in homelessness services supporting people experiencing SMD, recruited via social media. **Analysis:** Quantitative data were analysed using one-way between groups ANOVA and Kruskal-Wallis tests. Inductive content analysis was used to analyse qualitative data.

Discussion

This is the first study to examine if staff attributions and behavioural intentions are influenced by different understandings of SMD. Findings show staff attributions and emotional responses are sensitive to different understandings of SMD, and these understandings also influence behavioural intentions to offer support to individuals. Findings tentatively suggest CBT-informed understandings of SMD may inadvertently increase attributions of dangerousness and emotional responses of fear, whilst values-informed conceptualisations may reduce them. Incorporating information about an individual's values into conceptualisations of their presentation may thus have important implications for practice and quality of support provided to people facing SMD.

Limitations: Limited sample size and demographics limits representativeness and generalisability of findings. Vignettes may have reduced ecological validity. Self-selection bias could have resulted in individuals who were more interested in psychological understandings of SMD.

Implications: Findings highlight there may be benefits of incorporating values information into how staff understand and support people facing SMD.

Aims

The study had two aims. The primary aim was examined quantitatively, and the secondary aim was explored qualitatively.

1. To examine if staff attributions, emotional responses, and behavioural intentions were sensitive to different conceptualisations of SMD
2. To explore staffs' behavioural intentions to offer support to a person facing SMD

Results

Primary aim:

Quantitative analysis demonstrated that staff attributions and emotional responses are sensitive to different conceptualisations of SMD.

1. ANOVA revealed a significant difference between groups for attributions of 'dangerousness' $F(2,76) = 6.56, p = .002$. Post-hoc analysis revealed the CBT group endorsed attributions of 'dangerousness' significantly more than the Values group and the Biographical group, with the Values group endorsing 'dangerousness' the least.
2. Kruskal-Wallis tests revealed a significant difference between groups for the emotional response domain of 'fear' $X^2(2) = 6.46, p = .03$. Post-hoc analysis revealed that the CBT group endorsed emotional response items related to 'fear' significantly more than the Values group.

Secondary aim:

Qualitative analysis generated main categories across groups including; prioritising risk, multi-agency approaches, influence of past context on present behaviours, importance of the therapeutic relationship, flexible approaches and promoting autonomy and engagement.

References. ¹ Making Every Adult Matter. (2018). 'About Multiple Disadvantage', available at: [About Multiple Disadvantage – MEAM](https://www.lawworks.org.uk/sites/default/files/files/TIC-PIE-briefing-March-2017.pdf) (accessed 15 September 2025); ² Homeless Link. (2017). *An introduction to psychologically informed environments and trauma informed care*. <https://www.lawworks.org.uk/sites/default/files/files/TIC-PIE-briefing-March-2017.pdf> (accessed 15 September 2025); ³ Maguire, N., Grellier, B., & Clayton, K. (2017). The impact of CBT training and supervision on burnout, confidence and negative beliefs in a staff group working with homeless people. *Behavioural and Cognitive Psychotherapy*. <https://eprints.soton.ac.uk/155113/>; ⁴ Buckley, S., Tickle, A., Eagle, R., & Dawson, D. L. (2024). 'My values keep me well... would they help other people?': A thematic analysis exploring the values and values-based behaviours of people facing severe and multiple disadvantage. *International Journal on Homelessness*, 4(1), 19–38. <https://doi.org/10.5206/ijoh.2023.3.15102>

