Women with Dependent Children who are Homeless and living in Temporary Accommodation: An Interpretative Phenomenological Analysis of their Experiences of Loss and the Barriers to Accessing Healthcare Services

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Summary

Aims and Research Question

The aim of this thesis was to explore the personal experiences of homeless women with dependent children in accessing healthcare services, whilst residing in temporary accommodation. The research question attempts to understand the perceptions and attitudes of the women in accessing healthcare services for themselves or their children and the barriers that impact and influence their decision making.

Methods

Interpretative phenomenological analysis (IPA) was the chosen methodological stance for this study and supported the phenomenological approach of giving a 'voice' to the women in raising their concerns regarding accessibility of healthcare services. Five women with dependent children who were homeless were recruited and face to face interviews were undertaken. The analysis was conducted using the process of descriptive, linguistic and conceptual exploratory commenting. Each transcript was analysed on a case by case basis with a further across case analysis undertaken. Importantly from an interpretative perspective, was to make sense of the women's experiences using Kubler Ross's stages of grief and grieving.

Findings

The findings revealed the emotional impact that living in temporary accommodation, had on the women's and children's health and wellbeing. The isolation and negativities the women faced on a day to day basis and the stigma associated with homelessness. The women identified barriers to accessing healthcare services including appointment notification when frequently mobile and difficulty in accessing repeat prescriptions. The perceived attitudes of healthcare staff and marginalisation by healthcare providers affected their emotional wellbeing. The loss of home, possessions and identity contributed to feelings of loss and grief, which are new findings from the study, not documented elsewhere. This experience of sense of loss is explained through the theory of grief and grieving.

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WORD COUNT: 47,690 (Excluding summary, acknowledgements, declarations, contents pages, appendices, tables, diagrams and figures, references, bibliography, footnotes and endnotes)

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List of Abbreviations

DBS: Disclosure and Barring Service
ETHOS: European typology on homelessness and housing exclusion
GP: General practitioner
IPA: Interpretative Phenomenological Analysis
NHS: National Health Service
RRESC: Research Review and Ethics Screening Committee
UK: United Kingdom

PART ONE: BACKGROUND AND THEORETICAL CONTEXT

Chapter 1 Introduction

This thesis will explore the experiences of women with dependent children who are homeless and living in temporary accommodation. In particular, the barriers they face in accessing healthcare services. The format of the first chapter will begin with the reasons preceding the emergence of this study, the rationale for the research. The aim and objectives, concluding with the structure and overview of this doctoral thesis.

1.1: The Emergence of an Idea

My interest in homelessness was first aroused when I was a student health visitor out on placement in 1991. The practice teacher who supervised my practice regularly visited a women's aid refuge for women with dependent children who were victims of domestic abuse. To ensure the safety of the women and children, these premises were female only. Communication was limited between relatives and friends of the women while in the refuge and they were not to disclose where they were living to prevent their abuser from finding them. This was my first experience of talking to women who were in temporary accommodation and classed as 'homeless'.

I became aware that these women had fled with only the clothes they wore and no other possessions. There was a delay in accessing medical and health visitor records for the child and family when being transferred between localities. These women were disinclined to come to clinic or uptake any screening or immunisations. Many of the women seemed reluctant to discuss their previous situation and were wary of health professionals. As a qualified health visitor I often visited the refuge to cover for a colleague when she was on leave, even in those days there was limited resources to support these women and children. Within the refuge, there was a communal kitchen and living room where the women and children spent most of their time, they had one bedroom that they shared with their children. Therefore, conversations with the women were in public with other women listening in and so confidential information was never forthcoming. I often thought about these women after I left health visiting and came into academia. My interest of homelessness began to resurface when the media took interest and

portrayed their plight. However, the focus was often single rough sleepers, rather than women with dependent children. I often thought about these women and children and began searching through the literature as I became aware of homelessness, which may have been caused by a variety of factors other than because of domestic abuse.

There is limited research relating to women considered homeless who may be residing in temporary accommodation, therefore resulting in a gap in the research. The gap identified here and through my past experiences as a health visitor were deciding factors in undertaking research with women with dependent children who were homeless and living in temporary accommodation.

1.2: The Research

In my role as a health visitor and working with women and children in temporary accommodation two key issues became evident, the health and wellbeing of these women and their children and the poor uptake of healthcare services. The literature supports these observations. Tischler et al. (2007), for example, found homeless women with dependent children had great difficulty in accessing health, social and educational services. The women and their children usually present at accident and emergency departments for their healthcare needs rather than accessing primary care services. They are unlikely to take up screening or immunisations and usually access healthcare when symptomatic (Vostanis 2002). The health of the women is a concern, the literature highlights depression and drug and alcohol misuse as the leading causes of ill health for the women (Slesnick et al. 2012). There is a plethora of research regarding the mental health problems of homeless people however, there is no consensus on whether the mental ill health caused the homelessness or the homelessness caused the mental ill health. What is evident is that there is a deterioration of their mental ill health the longer the women are homeless.

In 2016, 59,090 people were homeless in England (Department for Communities and Local Government 2017), whereas in Scotland (Scottish

Government 2017), 28,247 homeless applications received. In Wales 10,884 were threatened with homelessness (Welsh Government 2017a). However, because each of the Nations record their statistics differently it is difficult to compare data and to determine a combined United Kingdom (UK) figure. These figures refer to a combination of all categories of homeless people, including single homeless and families. Whereas this study is concentrating on family homelessness where a family consists of one adult and a minimum of one child. The latest figures published by the Department for Communities and Local Government show that a lone mother heads 65% of homeless families and the number of homeless families have increased by 50% since 2010 (Department for Communities and Local Government 2017). There is a worrying trend that the figures on homelessness are increasing (Crisis 2018). The incidence of homelessness and the wider search of the literature supports the key issues identified, as the figures allude to the majority of homeless families headed by women, this strengthens my reasoning to research women with children.

Since the 1970's, the development of policy and legislation to improve homelessness in the UK has been ongoing (Department for Communities and Local Government 2006; 2008; 2015; 2016; 2017). These policies have attempted to tackle the root causes of homelessness such as the supply and affordability of housing stock, including discrimination and inequality in which housing is distributed. Other factors for consideration are mental health, substance misuse, domestic abuse, social isolation, lack of support and lone parenthood, the cumulative effect of these factors exacerbates homelessness (Fitzpatrick et al. 2017a). However, there is no conclusive evidence that these policies are effective as the incidence of homelessness as discussed above is increasing.

The difficulties in accessing healthcare services are not usually attributed to one factor. The literature identifies many barriers that prevent homeless people from accessing healthcare services for example, the mobility of homeless people, lack of flexibility of services, communication and collaboration between professionals (Taylor et al. 2006; Tischler et al. 2007;

Neale et al. 2008; Hwang et al. 2010). One of the main challenges is the mobility of the homeless in changing locations. The lack of flexibility of healthcare services and the inadequate communication and collaboration between professionals makes it more difficult to access resources or appointments. This often leads to additional stress on the individual concerned and can lead to disengagement. Therefore, the focus of the study became clear and led to the main research question.

What are the lived experiences of women with dependent children accessing healthcare services who are living in temporary accommodation?

1.3: Refining the Question

Although the research question outlines the overarching consideration for this study, it was important that key concepts were defined to ensure clarity of the terminology used.

1.4: The Study

1.4.1: Aim

The aim changed and evolved during the writing of this thesis. The original aim was to understand the barriers these women faced in accessing health care but that it subsequently evolved into a more in-depth exploration of the wider effects of homelessness. From undertaking the interviews, it became clear that the experiences of becoming homeless and living in temporary accommodation may have had an impact on the women and children's health. These experiences also influenced how the women accessed healthcare services.

To explore participants understanding of their experiences of living in temporary accommodation and the barriers in accessing healthcare services.

1.4.2: Objectives

- To undertake a review of the literature using a sociological framework on the experiences of homelessness

- To interview women with dependent children who are living in temporary accommodation on their experiences and accessing healthcare services.
- To analyse and synthesise the findings from the study using IPA.
- To disseminate the findings and provide recommendations to inform clinical practice, National Health Service (NHS), Social Care and Government organisations

1.4.3: Research questions

- How do women with dependent children who are living in temporary accommodation make meaning of their experiences of homelessness and healthcare access.

1.4.4: Approach

As a novice researcher, I realised that Interpretative phenomenological analysis (IPA) offered a more idiographic and contextual experience in finding out about the women's life world. The insight into the women's interpretation of their experience of homelessness and accessing healthcare services, culture and language would offer a more genuine interpretation of their experience than if a different approach was used. Therefore, I embarked on the eventful and interesting journey through IPA (which is discussed in depth in Chapter 4).

In keeping with IPA, participants would be recruited and face-to-face interviews undertaken. All interviews would be transcribed verbatim and analysed using the systematic process as described by Smith et al. (2009).

The School of Healthcare Sciences granted ethical approval and the study adhered to the approved proposal throughout. The interviews took place in Wales therefore; Welsh policy was applied to the remainder of this study.

1.5: Organisation of the Thesis

This thesis is divided into four parts, Part one will set the scene and provide the theoretical context for the study including the literature review and research design. Part two concerns the women's experiences ideographically and from a group perspective. Part three presents the women's experiences in the wider context and the fourth part, presents recommendations for practice and future research.

Chapter 2: Background

"The phenomenon of home … used to be an overwhelming and unexchangeable something to which we were subordinate and from which our way of life was oriented and directed... Home nowadays is a distorted and perverted phenomenon. It is identical to a house; it can be anywhere. It is subordinate to us, easily measurable in numbers of money value. It can be exchanged like a pair of shoes."
Vycinas, 1961, pp. 84-85

2.1: Homeless or Temporary Accommodation

Within the literature the use of the word homeless is commonplace and refers to all the different terminologies that homeless equates to such as single homeless, roofless and so on, as defined in more detail in Chapter 2. Homeless conjures up the image of being roofless without anywhere to reside and living on the streets however, this is far from the reality when considering homelessness. The participants for this study had dependent children and therefore, entitled to temporary accommodation. This was preferable to being on the streets, as was considered dangerous for the children. Local authorities and housing charities have a duty to provide shelter for homeless families (Welsh Government 2017b). Temporary accommodation can consist of a room in a Bed & Breakfast accommodation, refuge or hostel. Families that include teenage boys are temporary housed in two or three bedroomed houses, rather than refuges. The participants in this study were housed in different types of temporary accommodation (see Chapter 5). For clarity, temporary accommodation will be the terminology used in the place of homeless for the remainder of this study.

2.2: Home

In order to understand the term homeless, there is a need to understand the meaning of home itself. The definition of home as defined by the Oxford Dictionary is a place where one lives permanently and as a member of a family or household (Oxford University Press 2018a). This conjures up the feeling of belonging as part of a family, somewhere that is permanent; this permanency constitutes security and safety. Although there are other definitions of the word 'home' as stated in Table 1, Somerville (1992) argues

that home is an ideological construct in which people relate to an experience of home or to home as an ideal state. Whereas Watson and Austerberry (1986) suggest there are a range of different meanings, such as adequate standards and living conditions, wellbeing both emotionally and physically, warmth and caring and a sense of control and privacy. Moore (2000) uses the analogy of an onion to explain the different layers of meaning that the word home creates. At first, the concept appears straightforward, but this can be misleading, Moore (2000, pp. 208) suggests, "*That the word home has to be examined in terms of its parts as well as its whole*", by focusing only on one part, the concept of the whole is lost. For example, "*social, political, physical, personal and cultural attributes*" of home make up the whole (Moore 2007, pp.145). Home represents not only a physical space but also a more abstract state of belonging to a particular culture, a source of identity within society and the legal aspects of home as not only a place to live but belonging to a country. From a personal perspective home relates to possessions, memorable objects handed down through families and other gifts that are symbolic with important events (Hill 1991). House and home according to dictionaries and literature have different meanings, these terms are used interchangeably so, both terms are defined.

House is a structure or dwelling, somewhere to live that has a roof and walls (Oxford University Press 2018). Whereas home is more abstract in that, it is the feeling that the term 'home' conjures up that differs from the word house. Therefore, does the same concept exist in other languages? In French the word, for home is *'domicile'* although in translation this word means a 'place of abode' or it can refer to a country that a person classifies as their permanent home. The word '*la maison*', which means house, is the more familiar word that is used in a similar context to home, although it does not have the same multidimensional concept (Collins English-French Dictionary 2018). Similarly, in German 'Heimat' the word for home, meaning attachment to a place and sense of place (Ratter and Gee 2012) and often used meaning homeland or motherland, is more a collective concept relating to the country. *'Zuhause'* meaning where one lives as oppose to the word *'haus'* meaning house are other words used in the German language for

home or house. The complexities of language and meaning have some similarities but differences in these European languages of the concept of home in comparison to the English Language. However, all three of these languages have a word for home whose meaning differs from that of house. In understanding the meaning of home, this would equate to the meaning of homeless is to be without a 'home' but not to be without a roof or shelter (Moore 2000).

Table 1: Definitions of home

Type	Characteristic/ Definition	Source
Home	A house or other dwelling, a place of abode	Collins online English dictionary (Collins 2018)
	The place or a place where one lives	Oxford online dictionary (Oxford University Press 2018a)
	A family or other group living in a house or other place	Merriam-Webster online dictionary (Merriam-Webster Incorporated 2018
	A person's country, city viewed as a birthplace	Hoersting and Jenkins 2011 p18
	To control one's own boundaries	Somerville 1992 p535
	A building or organisation set up to care for orphans or older people	Cambridge online dictionary (Cambridge University Press 2018)
	A way of expressing individual identity and a way of belonging to a culture	Moore 2007 p145
A home from home	A place where one can feel at ease, other than their own home	Mallett 2004 p62

2.2.1: Homelessness

The word homeless is interpreted as being without a home, so if taken literally according to the above meaning of what constitutes a home, a person may have some form of shelter, but not necessarily a home. The notion of walls and a roof will not be a 'home' as previously defined. Therefore, a person living in temporary accommodation with none of the

comfort of being a 'home' constitutionally classed as homeless (Kellett and Moore 2003). So contextually according to this definition, they are homeless. There are many interpretations of the meaning of homeless, some people's understanding is, being without a home therefore living on the streets, which in some cases is true but not in all situations.

Shelter (2017) the housing and homelessness charity establishes the legal definition of being homeless as, not having a home in the UK or anywhere else in the world. Shelter also identify other situations of homelessness, which does not necessarily mean living on the streets. Such as victims of domestic abuse where it is unsafe for the person to stay in the home or where the condition of the home is damaging to their health. Local council's also class persons as homeless if they have no home where the family can live together, or the accommodation is on a temporary basis (Shelter-Cymru 2018). These definitions change the perception of homelessness and can attribute this to the high percentage of people deemed as homeless.

The European typology on homelessness and housing exclusion (ETHOS) classifies homeless people according to their living situation for example, rooflessness, without a shelter of any kind, sleeping rough on the streets (FEANTSA 2015). Houselessness, where there is a place to sleep which is temporary or living in a homeless shelter or institution. Other categories are, living in insecure housing, threatened with eviction, a victim of domestic abuse or living in inadequate housing. These types of inadequate housing are caravans, housing that is in a poor state of repair or where there is severe overcrowding. The media, to describe individuals sleeping rough on the streets, often use the term homeless, however, the term has a much broader meaning than that. Shelter (2008) differentiates between the 'street homeless' and those living in 'temporary accommodation'. The single homeless are those frequently living on the streets, whereas, women with dependent children who become homeless are placed in temporary accommodation. The types of accommodation vary according to the association who is housing the women and consists of voluntary agencies,

local authority, housing associations or bed and breakfast accommodation. These do not include those who live in squats or as travellers (Vostanis 2002). Riggs and Coyle (2002) refer to hearthlessness as the absence of any home like ethos within an accommodation. The hearth represents the focal point of a room that emits warmth and cosiness. This is akin to the feeling of home that this depicts. Many individuals and families 'sofa surf', they reside with family and friends, staying for short periods before moving on to another friend or family member (Clarke 2016). These are the hidden homeless, they are not counted in the homeless data therefore, it is difficult to ascertain how many people are actually without a permanent home (Clarke 2016).

Being homeless refers to many different concepts, some would argue that having a roof over your head does not equate to homelessness, while others would challenge this notion. For people living in temporary accommodation the insecurity of moving to different accommodation has the same consequences of being homeless. Table 2 identifies the different definitions and characteristics of homeless and homelessness.

Table 2: Definitions of homelessness

Definition of homeless/homelessness	Characteristics	Source
Homeless: Having nowhere to live	Destitute, exiled, displaced, dispossessed, unsettled, outcast, abandoned, down and out, dossing, of no fixed abode, sleeping rough, itinerant	Oxford online dictionary (Oxford University Press 2018b)
Homeless: Not having a home in the UK or anywhere else in the world.	Victims of domestic abuse where it is unsafe for the person to stay in the home or where the condition of the home is damaging their health where family relationships have	Shelter (2012)

	become strained and difficult resulting in a person becoming homeless. Evicted for non-payment of rent, mortgage, or other reasons	
Homelessness	Rough sleeping, no permanent housing and lack of a right to secure housing	Wright and Walker (2006)
Rooflessness: Without a shelter of any kind, sleeping rough on the streets.	Classifies homeless people according to their living situation	Somerville 1992
Houselessness: Where there is a place to sleep which is temporary or living in a homeless shelter or institution	Living in insecure housing, threatened with eviction, domestic abuse or living in inadequate housing, such as caravans, unfit housing or severe overcrowding	FEANTSA 2015
Hidden homeless	Those living doubled up with family and friends	Murphy and Tobin (2011)
Hearthlessness	Absence of any home like ethos within a place of abode	Riggs and Coyle (2002)
Street homeless	Living on the streets, in doorways or parks	Diaz 2006
Sofa surfing	Staying with friends or relatives, moving around staying for short periods with either friends or family	Clarke 2016

In this study, the term temporary accommodation is the term of choice as the participants in this study live in temporary accommodation however, the

majority of the literature uses the word homeless, and therefore the term homeless may be included at different points. For these women with a temporary address, their identity and position in society is no different to homeless people living on the streets, both are socially excluded. The media have intensified the assumptions made by society of the causes of homelessness, such as using drugs and alcohol or intentionally making themselves homeless. Homelessness is not the result of one factor, but a combination of factors, which are varied and diverse.

2.3: Causes of Homelessness

The notion of homelessness is not just a recent phenomenon; women with dependent children have been reported homeless since the early 1800's. Women who were poor went to the workhouse. Although they were not referred to as 'homeless' but the 'deserving poor' these families were unable to support themselves, many were on the streets and others were offered accommodation in workhouses. They were undeniably homeless, although not roofless and living on the streets. With the emergence of the National Health Service, the workhouses ceased to exist and many were developed into hospitals. During this period, single women were classified as prostitutes and not homeless (May et al. 2007). Councils were reluctant to provide lodging houses and women who were single and homeless were stigmatised (Watson 1999). The 1960's to the present day saw an increase in the number of women who were homeless and Governments had to acknowledge this situation (Watson and Austerberry 1986). Policy since this time have prioritised homeless families by ensuring temporary shelter over the needs of single homeless women (May et al. 2007).

Temporary accommodation consists of hostels, bed-and-breakfast hotels, and houses provided by local authorities, housing associations, charities or even privately rented accommodation arranged through local authority. Transient individuals/families that move from family to friends, defined as living in temporary accommodation (Warnes et al. 2003). Although the latter tend to be virtually invisible until the homeless individual or family present for temporary accommodation or end up on the street. Women and their

dependent children have no choice in the accommodation in which they reside and the standards vary greatly. The term temporary, is misleading as women and their dependent children can be placed in this type of accommodation for up to 9 months before being re-housed (Shelter-Cymru 2009). Hogan (1995) revealed that a significant proportion of women and their dependent children that were in temporary accommodation were from ethnic minorities, which included refugees seeking asylum.

Person(s) can be defined homeless for various reasons, for example, those who live in a caravan or boat and are unable to site it, or who have accommodation that is uninhabitable due to poor conditions (Shelter 2008). This can also apply to households unable to live together or with a family member at risk of abuse or violence if they remain in the accommodation. Homelessness is not a choice it is the result of rent arrears, or flight because of legal or social issues (Daiski 2007). Weinreb and Buckner (1993) argue that the reasons why people become homeless are often complex and multifaceted. The probable factors include housing arrears, or poor housing (Graham-Jones et al. 2004), drugs and alcohol (Riley et al. 2001), mental health issues (Tischler et al. 2000), relationship breakdown and domestic and neighbour violence (Vostanis 2002; Taylor et al. 2007; Tischler and Vostanis 2007; Tischler et al. 2007). Many studies argue that the majority of women with dependent children are homeless because of relationship breakdown, domestic violence or neighbour violence (Axelson and Dail 1988; Vostanis 2002; Tischler et al. 2004; Anderson et al. 2006; Tischler et al. 2007; Tischler and Vostanis 2007; Shelter-Cymru 2009).

In today's economic climate, structural factors are principally a cause of homelessness, especially with changes within the labour market, such as redundancies and austerity policies. More and more families are losing their homes because of the job situation, being unable to continue mortgage repayments and having their homes repossessed (Queens Nursing Institute 2010). In recent years, the cost of housing has increased which makes it even more difficult to find affordable housing, as there is an insufficient supply of low cost housing. Rae and Rees (2015) raises other factors that

can predispose to homeless situations these being, poverty, ethnicity, substance misuse and mental health issues.

Families headed by the mother are a growing category of the known and recorded homeless population in the UK (Tischler and Vostanis 2007). It is unclear from the statistics whether these mothers are married, single, divorced, widowed or cohabiting. Many of these families receive no support from family or friends. These families are often transient shunted from one temporary address to another, and not always within the same local authority. Although these women and their children are not living on the streets, the temporariness of their accommodation affects their emotional wellbeing. Tischler et al. (2007) and Tischler and Vostanis (2007) found that homeless women with dependent children are more likely to suffer from depression, substance misuse and other mental health issues. Therefore, access to healthcare services and health professionals is fundamental for their wellbeing.

2.4: Accessible Healthcare

Many women and their children are in temporary accommodation in areas away from family and friends. Often this is necessary because of domestic abuse or harassment results in women and children being out of area for their general practitioner (GP) services and often are unaware of the location and nature of services within the new area where they currently reside. Many GP practices are not willing to take on temporary residents such as homeless families (Tischler et al. 2004). Where women have children over the age of 5 years, accessing services is even more problematic as health visitors are unlikely to have contact. As a result women and their children from temporary accommodation are often excluded from mainstream services (Graham-Jones et al. 2004).

Access to health care should be freely available to all individuals, irrelevant of their personal circumstances and accommodation, as constituted by the setting up of the NHS in 1948 (Welsh Assembly Government 2009b). However, many socially excluded groups such as homeless women and their

dependent children find inequity in accessing health care. Frequently, homeless women and their children are unaware of services that are available, how to access these services and information or advice (Scottish Executive Central Research Unit 2002). A study undertaken by Webb et al. (2001) on the health of children in refuges for victims of domestic violence discovered that data from the child health system was inaccurate, with incorrect addresses and GP. Women would not divulge their whereabouts and would not receive mail in the refuge for their own safety. Therefore, appointments for children would be lost. Other barriers were failure of families to register with a GP, or provide information on change of status or address. Vostanis (2002) found similar findings in his study on the mental health of homeless children and families in that many families remained with their previous GP's but did not inform the practice of a change of address. These families, it could be argued are almost invisible, often regarded as the 'hidden homeless' they are marginalised by the health care system and are poorly served by it.

A report by McDonagh (2011) for the Joseph Rowntree Foundation, suggests that there is a lack of integrated working across health, housing and social care. Each agency works in silos undertaking their own assessment of need, where no one is collating the information. This could have serious repercussions especially in regards to safeguarding children as reinforced by Laming (2009). Vostanis (2002) advocates that services for homeless women with dependent children needs a coordinated approach between health care services and other agencies in light of the multiple needs of these families. The number of homeless are rising, more homeless people on the streets, an increase in families in temporary accommodation and possible a rise in hidden homeless (Crisis 2016).

2.5: Demographics

The homeless charity, Crisis (2018) claim that homelessness is increasing. Crisis argue, thousands of women with children who are in temporary accommodation in the UK are not included in official figures (Crisis 2017) in the UK. In 2008 homeless families being 53% of the total homeless

population however, the data had omitted pregnant women; this group adds a further 10% to the overall number. In 2009, 60,230 households in the UK were in temporary accommodation, 45,940 included children or pregnant women. Therefore, the number of children or expected children was, 87,030 in England alone (Queens Nursing Institute 2010).

Data from the Homeless Monitor in England identified a rise in homeless numbers however, the collection and classification of the data has changed (Fitzpatrick et al. 2017a). In 2015/2016, there were 57,740 homeless acceptances (Households formally assessed as unintentionally homeless and in priority need) which was a rise of 18,000 compared to the 2009/2010 figures of 40,020. There has been an upward trend in rough sleeping numbers 4,134 in 2015/2016, compared to 1,768 in 2009/2010. This equates to a 132% increase in numbers of rough sleepers. Homeless placements in temporary accommodation have risen to 73,000 in 2016, a 52% increase since 2010/2011 period (Fitzpatrick et al. 2017a). Throughout England, all categories of homelessness have risen during the last five years. The Homeless Monitor for England and Wales have raised concerns regarding the impact of higher interest rates and the reduced support for homeowners that has been predicted. Welfare reforms have affected lower income families, which has implications for them securing or retaining accommodation. The implementation of Universal Credit has received negative reactions from a range of organisations such as homeless charities, self-help groups and other third sector organisations. The impression is that low income households will be worse off and this could add to the homelessness situation (Fitzpatrick et al. 2017b).

Housing Policies in Wales are similar to England, when Wales received policy-making powers after devolution in 1999. These initially were minimal and were still controlled by Westminster unlike Scotland. More recently, Wales has been granted greater devolved power from Parliament in developing their own legislation on housing and homelessness. Wales' findings are similar to that of England, with an increase in the numbers of rough sleepers from 240 in 2015 to 313 in 2016, which accounted for a 30%

rise (Fitzpatrick et al. 2017b). The amount of temporary accommodation for homeless people saw a reversal of the downward trend seen between 2012 and 2015. In the year 2016/2017 there has been an increase of families placed in temporary accommodation from 1,878 to 2,013, approximately a rise of 7%. Seven hundred and eighty of these families are registered as families with dependent children (Welsh Government 2017). It is unclear from the document what they mean by families with dependent children, whether these are two parents or single parent with dependent children. Although the increase in numbers are not as high in Wales compared to England nonetheless, the numbers are still rising.

The escalation in homelessness is concerning in light of the UK Government's promise to reduce homelessness. Austerity measures have a negative effect on low-income households by reducing and changing benefits. The creation of zero hours working and the 'GIG' economy (free market system, temporary jobs rather than working for an employer). Where workers have more flexibility around the hours they work but, the added insecurity no protection against unfair dismissal, no right to receive national minimal wage or entitled to paid holiday or sickness pay (Department of Business, Energy and Industrial Strategy 2018).

2.6: Homeless Policy

The political ideology of previous and recent Governments has influenced the housing market which has seen a decrease in social and private housing. In the last twenty years or more the supply of housing has not kept up with predicted increases in demand and is unlikely to improve in the foreseeable future. In 1979 the Conservative Government led by Margaret Thatcher came into power. The manifesto had promised promotion of home ownership with the Right to Buy policy. Under the 1980 Housing Act, tenants with a three year history of tenancy had a right to buy their homes at a discounted price. Up to 50% of the value of the property discounts were offered and these rose to 70% in later years. With these incentives there was a

substantial surge in people buying their council houses, almost a quarter of a million a year by 1982. Sales began to slow as capacity to buy was diminishing, only the poorest groups in society were left in social housing. House prices rose which encouraged more people to buy however, when interest rates rose housing market weakened and prices fell. The recession at the end of this decade caused a further downturn in the price of houses and many fell behind with their mortgage repayments. The number of households in negative equity rose from 230,000 – 1.7 million. Repossessions quadrupled and more people became homeless. During this period there was a shift towards deregulation of rents in the private and social sector. The rents were increased in response to demand and there was an expectation that benefits would subsidise households who were on lower incomes. In 1987 there was very little gain in selling council housing stock, so Housing Policy had to change again (1988 Assured Tenancies, Housing Action Trusts). This ensured that tenants who were unhappy with their councils could transfer ownership of their property to housing association or private landlords. The idea that on an individual basis, tenants could change ownership was dropped by Government as impractical. Housing associations and private landlords could bid for estates. As a result of the 1988 Housing Act housing associations became the main provider of social housing. The legacy of this change in tenure saw worsening social problems on some of the most deprived estates and a lowering of standards in social housing (Manoochehai 2009). Although the UK's population was increasing the focus on house building was not prioritised. The change of Government to Labour saw a continuation of the housing policy that was set by the previous Conservative Government. The shortage of rented accommodation coincided with lowering standards of accommodation, the Labour Government under Tony Blair, announced the 'decent homes programme' to ensure that all social housing meets a desired standard,

by making housing organisations responsible for assessing conditions of their housing stock and provision of accommodation. Supply and demand was not a major issue, in deprived estates and the more unpopular areas demand for housing was low. To change this ethos, the Housing Market

Renewal Programme was introduced to improve neighbourhoods and make them more attractive to live and work in (Keohane and Broughton 2013). A key cause of the lack of construction of new homes was Local Authorities lack of money for development. The main income generation for local authorities was the council tax however, the tax was not related to property value and therefore there was little incentive for development within their respective areas. Coupled with the 'not in my back yard' (NIMBY) behaviour which is encouraged by UK planning leads to why there is a massive housing shortage in the UK (Hilber 2015).

In the 1980's the council's new building plans fell below the rate of sales of houses and the rental market was in decline, no council homes were built during this period and this began the demise of council owned housing. The major social housing providers were now voluntary sector housing associations. The Barker Review in 2004 looked at housing supply and demand and the then Labour Government introduced house building targets for an extra 240,000 homes by 2016 and 70,000 per year by 2011. These targets were not reached in view of the credit crunch in 2007-2008. The Coalition Government brought in reforms to free up planning regulation and help to buy scheme. The current housing supply is an affordability problem, housing costs take up an increasing proportion of disposable income, making it difficult for people to get on the housing ladder and social housing is in short supply with very long waiting lists. Many households in the private rented sector are in arrears, currently estimated at around 400,000.

 The current Conservative Government approach to Brexit with no deal option could exacerbate the homeless crisis in the UK. The European Social Fund (ESF) that currently helps with employment and improving skills for homeless people will come to an end if we leave the European Union. At present the £5 million received from the ESF of which the majority goes to England however, Wales gets a significant proportion of this money. At present there is no indication of whether this money will be replaced by the UK Government (Oakley and Thunder 2018).

Through the successive Governments, attempts to bring about improvements in the housing situation and homelessness have been put into action by the following policies. The Housing Act (1996) compelled local authorities to provide homes for certain categories of homeless people but did not recommend any other support (Legislation Government UK 1996). The Welsh Government devolved from the UK Government in 1999 but only had secondary legislative powers at this time. In 2001 the 'Homeless persons (Wales) order' came into existence and included a category of 'priority need' for accommodation (Welsh Government 2001). However, the 'Homelessness Act' went for a strategic approach to homelessness, by changing housing allocation and developing better support systems for individuals and families (Welsh Government 2002). In 2006, the Government of Wales Act (Welsh Government 2006a) gave Wales responsibility for policy and subordinate legislation and in 2011 full law-making powers were introduced. In addition, support for the health needs for all homeless people in Wales was established, which included mental health problems, substance/alcohol misuse, domestic abuse and other social and economic factors under the Homelessness (Suitability of Accommodation) Wales Order 2006 (Welsh Government 2006b). Wales developed a ten-year homelessness plan from 2009-2019 (Welsh Government 2009b). The plan focuses on the causes of homelessness to prevent/reduce the number of homeless in Wales. The plan included the development of five strategic aims in taking the strategy forward:

- Preventing homelessness wherever possible
- Working across organisational and policy boundaries
- Placing the service user at the centre of service delivery
- Ensuring social inclusion and equality of access to services
- Making the best use of resources

Improving health and wellbeing is a priority area within the plan. The Government recognise that structural difficulties can hamper access to healthcare services. They advocate that the implementation of a range of healthcare standards are established and that children and young people prioritised. There is no indication of how these standards will work in

practice. The target set by the policy was for 2019 however, the rate of homelessness seems to be increasing. There appears to be little evidence that healthcare standards are in place as advocated by this policy, or that they are effective. The Mackie review of homelessness commissioned by the Welsh Government in 2012 informed the Provisions of the Housing (Wales) Act 2014 (Welsh Government 2014) and influenced the Homelessness Reduction Act 2017 (Legislation Government UK 2017) in England. The review found two limitations within the current legislation in Wales and England. There was more emphasis on preventative housing, concerns of practice inconsistencies across the regions and unlawful gatekeeping. There was no indication that non-statutory homeless persons received assistance therefore, the recommendation was for a more flexible intervention model, which was amalgamated into The Housing Act in 2014 (Fitzpatrick et al. 2017a; Fitzpatrick et al. 2017b).

The Housing Act (Wales) (Welsh Government 2014) introduced a number of actions, one of these being homelessness provisions. It is the duty of local authorities to prevent homelessness and secure accommodation (Fitzpatrick et al. 2017, pp. xiv). A three-stage process was implemented which includes, when threatened with homelessness the local authority must try to prevent the family from becoming homeless (stage 1). If unsuccessful then they must help to secure housing (stage 2), if this is not achieved it goes to stage three where the local authority has a duty to secure housing for the family as a priority. This process is at present for those who are unintentionally homeless. From 2019, this process will be in place for intentionally homeless families also. The development of these policies in support of the homeless population, when it comes to health and social care, policies should be inclusive of all individuals within the population.

A parliamentary review of health and social care in Wales was undertaken (Welsh Government 2018a). This review came about as a result of the Social Services and Wellbeing Act 2014 (Legislation Government UK 2014) and proposed a quadruple aim which identified four goals. One; to improve health and wellbeing of the population, two; to improve the experiences of

individuals and families and quality of care, three; to engage the health and social care workforce in wellbeing improvement, and four; through innovation and best practice direct funding of valid based health and social care. One of the recommendations was that a seamless service should be developed that would combine health and social care within one system. Reference was made to children and young people, older people, adults with disabilities, mental health and learning disabilities, as priority populations. However, within the review there was no indication of marginalised groups such as homeless. Although, the review does acknowledge that there should be the same approach of national principles and local delivery for all population groups to improve health and wellbeing based on prevention. In response to this parliamentary review, a policy titled, 'A Healthier Wales: our plan for health and social care' (Welsh Government 2018b) was set out by the Welsh Government. The 'quadruple aim' was acknowledged within the plan and the recommendations were actioned as follows;

- ➢ A seamless service in which, information and services were more easily navigated by individuals (to allow easy transition between services).
- ➢ Improved information sharing and partnership working between providers and services.
- ➢ New models of care to be introduced working with partners through research and innovation activities.
- ➢ A more integrated primary and community care approach to include all community services, dentists, physiotherapist, optometrists and so on. Including access to non-medical care such as housing.

With the insurgence of digital technology within healthcare, the policy indicates that individuals will have more control and greater participation in their care such as managing appointments and better communication with professionals concerning their care. These actions are to be put in place by 2021.

2.7: Sociology of Home and Homelessness

A sociological perspective is one, which seeks to understand social patterns in the behaviour of people and also one which can be used to appreciate how attitudes and behaviour can contribute to feelings of hopelessness and low self- esteem in homeless people. Throughout the literature there seems to be certain commonalities arising, these being health outcomes of homeless people, attitudes of healthcare professionals towards homelessness, housing and social exclusion. The impact of homelessness can affect people's sense of autonomy and control over their lives and may lead to poor health outcomes for themselves and their children (Slesnick et al. 2012). Homeless people are often discriminated against (Vostanis 2002); they become marginalised (Fahmy et al. 2012) and are often excluded by society (Cosgrove and Flynn 2005). Burton and Kagan (2003 p5) define marginalisation as "the state of being excluded from society and classed as an outsider", homeless individuals experience social exclusion like so many other disadvantaged groups such as gypsy travellers and asylum seekers. All of these groups are actively mobile and normally have no permanent address. Women who are homeless often feel they are being judged by society and professionals alike (Wen et al. 2007). Therefore, the attitudes of health professionals are important factors as to whether people access healthcare services or engage with professionals.

Contributing factors of homelessness can be categorised as either structural or individual (Public Health England 2016). Although for many people it can be due to a combination of both structural and individual, these can vary from one individual to another and across the life course. Structural difficulties as seen in Table 3 can hamper access to healthcare services, which can lead to an exacerbation of health issues and co-morbidities.

Table 3: Contributing factors of homelessness

Structural	Individual
Poverty	Poor physical health
Inequality	Mental health problems including consequences of adverse childhood experiences
Housing supply and affordability	

Unemployment	Experiences of violence, abuse, harassment or hate crime.
Insecure employment	
Access to social services	Alcohol or drugs
	Bereavement
	Relationship breakdown
(Public Health England 2016, p1)	Experiences of care or prison

Within the literature a range of sociological factors that built up a picture of the impact of homelessness on women and children and the barriers they faced from society have been identified (Leng 2017). These sociological factors include a number of health outcomes for women, such as mental and physical ill health, drug and alcohol dependence and domestic abuse (Leng 2017). These can lead to poor health outcomes in children, including behavioural and emotional disorders and mental ill health. Further evidence shows that children who are exposed to adverse childhood experiences are likely to have poor educational attainment and can become involved in anti-social behaviour and crime, which can lead to these children becoming homeless adults (Public Health Wales 2015). Another sociological factor identified is social exclusion where the women's perception of how they are judged by society and healthcare professionals can create a barrier to them accessing healthcare services (Canavan et al 2012). A third factor is housing, this is dependent on supply and financial circumstances of the individual (Hodkinson and Robbins 2012). Eviction from their homes due to mortgage or rental arrears, which can be a subsequent factor of loss of job or income is a frequent cause of homelessness. Therefore, Welsh Government have developed a policy whereby Local Authorities have been tasked with re-housing people as soon as possible (Welsh Government 2017) however, the lack of sufficient adequate housing is a barrier.

2.8: Summary

The causes of homelessness are multifaceted such as domestic abuse or neighbourhood violence, rent arrears, drug and alcohol misuse. Homeless women and their dependent children are at increased risk of having poor mental and physical health outcomes. These women and their children are

often discriminated against and are socially excluded from mainstream services such as health as discussed in detail in Chapter 3. The Health Boards in Wales have a duty of care to families who reside in homeless refuges; many of these families are in temporary accommodation for up to one year. These women and children need targeted services and better interagency working. Although there has been an increase in families becoming homeless during the past year. The economic situation in the UK and Europe and the austerity measures enforced by the Government during this last decade could lead to a substantial increase in homelessness over the next few years. The result of welfare reform, the negative consequences of flexible working opportunities with the instigation of zero hours and the GIG economy can impact on the rise of homelessness. Although there has been an increase in policy development by UK Governments to improve homelessness, the current evidence is that homelessness is still increasing.

Chapter 3: Literature Review

Interpretative phenomenological analysis does not require that you undertake a literature review, although Smith et al. (2009) suggests that it can be helpful in identifying a gap in the research and development of your research question. Having some knowledge and understanding of the participant group and their experiences and concerns is an important step in the IPA process, and this could be informed by the literature review (Smith et al. 2009). Undertaking a literature review enhanced knowledge of the subject matter and allowed for an exploration of the health needs of women and children, the attitudes of society towards homelessness including attitudes of professionals, alongside social exclusion and housing. Importantly literature pertaining to barriers in accessing healthcare services were reviewed. Although, research is limited in this area especially in relation to homeless women with dependent children, the gap found in existing literature helped to formulate the research question.

3.1: Search Strategy

A review of the literature for qualitative evidence was undertaken using a comprehensive search strategy tailored to individual databases over the 10 years from 2003-2014 for English language papers. An updated search was undertaken up to 2017, after undertaking the interviews and analysing where new areas of discussion was identified that had not previously been anticipated in accordance with IPA methods (Smith et al. 2009). It became apparent that many of the earlier studies used by the later authors and that some of these studies were seen as seminal work. It was decided to use a few of these earlier studies from the 1990's especially as the findings had not changed, or where there were no later studies undertaken. The majority of the studies on homelessness were from USA, although the housing and healthcare system is very different in the USA compared to the UK, these studies were included and the differences acknowledged. Studies from Canada have also been included.

Comprehensive searches were conducted across multiple databases from their inception including: Ebsco Cumulative Index of Nursing and Allied

Health Literature (CINAHL), Ovid MEDLINE, Ovid EMBASE, SCOPUS, British Nursing Index, PubMed and Google Scholar.

A search of the databases took place using Boolean descriptors AND/OR. The key words that were used to search for relevant studies were homeless, homelessness, temporary accommodation, women, child*, marginalisation, healthcare services. Supplementary searches were undertaken to identify unpublished research, research reported in the grey literature such as thesis and dissertations, policy documents and unpublished information from voluntary organisations including: Orca, Google, Welsh Government, UK Government, Shelter, Crisis and Barnado's.

3.2: Inclusion and Exclusion Criteria

The inclusion criteria were all papers that reviewed homeless women or homeless families including mixed gender. Papers pertaining to street homeless, prisons or drug taking, also single homeless as these studies were predominantly men, were excluded.

3.2.1: Context

Many of the studies are from the USA and Canada pertaining to homelessness, these studies were used alongside UK studies, in support and in comparison of the UK studies, as there is a dearth of literature in the UK. In view of the shortage of studies, a number of themes were identified from the literature relating to homeless families. These themes were then centred on a sociological framework as identified in Chapter 2. There is limited research specifically around accessing services by homeless families, Initial searches yielded few results, however later searches identified a few more. Three main themes developed from the search, these being 'health outcomes of homeless families, social exclusion and access to healthcare services'. From these main themes, sub-themes then emerged, women and children's health, attitudes and perceptions and barriers and housing.

3.5: Health Outcomes of Homeless Families

3.5.1: Women's health

From policy, we know that inadequate housing affects certain groups in society more than others, these are the very young, and women with young families, who spend more time in the home (Islington Borough Council 2006; FEANTSA 2007). Mothers who are homeless often feel a sense of loss and powerlessness for the home they have lost and the situation they now find themselves in. In addition to these psychological factors, some women also suffer from depression (Slesnick et al. 2012), substance misuse and mental health issues (Tischler et al. 2000; Vostanis 2002; Schanzer et al. 2007; Tischler et al. 2007; Tischler and Vostanis 2007; Savage et al. 2008).

Parents may have already experienced relationship problems between themselves and their children, which, are then further exacerbated by becoming homeless. The stress of living in temporary accommodation affects the physical, social and psychological ability to cope in this situation, and can lead to unintentional neglect as a result of underestimating the needs of their children (Ghate and Hazel 2002). This can lead to a range of parenting issues, which, if not identified and appropriate interventions put in place, can compound the situation by causing more distress and dis-functionalism. A study undertaken by the Scottish Executive Central Research Unit in 2002 identified that physical and mental health of families deteriorated while in temporary accommodation. Poverty has also been associated with poor mental health in women (Weinreb et al. 2006). Slesnick et al. (2012) suggests that homeless women with dependent children have double the incidence of ill health and hunger than non-homeless families.

The relationship between mother and child is often impaired while these families are in temporary accommodation (Lindsey 1998). A study by Tischler et al. (2007) discovered that parenting was being observed by other residents and staff at the hostel. Therefore, the actions and decisions they took were often judged, which consequently influenced their parenting. In such circumstances, women felt they lost parental authority which gave way

to feelings of hopelessness and failure. 'Public parenting' where shelter staff or others interfere with the discipline of a child can provoke distress, fear and anxiety (Tischler et al. 2007). Another factor that is influenced by homelessness is the daily routine, which is often controlled by the shelter staff and mothers report that they have no control over what time the children eat or go to bed (Thrasher and Mowbray 1995). Many of these relationships between mother and child are 'fractured' as stated by Hausman and Hammen (1993), while they are living in homeless accommodation. So not only are these women traumatised by being homeless, they are also unable to function as parents (Lindsey 1998).

Poor mental health is a well-known risk factor for homeless people (Bassuk et al. 1997; Lauber et al. 2006) and has also been associated with homeless women with dependent children (Tischler et al. 2000; Tischler et al. 2007; Tischler and Vostanis 2007). A longitudinal study undertaken in the UK using the general health questionnaire, reported that the rate of mental illness in homeless mothers were three times higher in the homeless sample, compared to those who were housed. There was a decrease in reported mental health problems from 52% at the first interview to 26% one year on. However, the scores remained significantly higher than those of the comparison group of mothers from the general population. The mothers were in permanent accommodation one year on which may account for their decrease in mental ill health (Vostanis et al. 1998). A further study undertaken by Vostanis (2002) stated that mental illness in mothers was the strongest predictor of child mental illness. Homeless mothers had similar rates of mental illness to that of single homeless women. Similar results have been reported internationally however many of these studies focuses on single homeless adults who may have different stressors to homeless women with dependent children (Cougnard 2006).

There appears to be a higher increase in mental illness among the homeless than among the population in general (Power and Attenborough 2003). It is unclear whether mental illness was a precursor to becoming homeless or whether being homeless led to mental illness. However, a number of studies

identify that homelessness exacerbates mental illness with it being a cycle where one perpetuates (Tischler et al. 2000; Vostanis 2002; Taylor et al. 2006; Tischler et al. 2007; Tischler and Vostanis 2007).

Homeless families are more likely to report substance misuse than low-income families, but less likely than the single homeless (Bassuk et al. 1997; Burt et al. 1999). Heavy alcohol intake was also found to be a risk factor for homelessness in the above studies. Similar findings were found in later research (Fragile families' dataset) that substance abuse is a risk factor for homelessness with families who have recently become homeless having higher rates than families who are in stable housing (Rog et al. 2008). Other research acknowledged the poor health outcomes of this vulnerable population. It is reported that homeless women with dependent children have history of abuse (Bassuk et al. 1996), been in foster care (Bassuk et al. 1997) and substance misuse (Bassuk et al. 1997; Bassuk et al. 1998; Burt et al. 1999). The physical and mental health of women who are homeless is of concern especially with the rise in the homeless population. Their health needs are not being addressed adequately, which may have an adverse effect on their children.

Pregnant homeless women are also at risk of mental illness and the rate of depression in these women is high (D'Souza and Garcia 2004). Pregnant women who are homeless have an increased risk of poor maternal and child health, there is no guarantee that a permanent home will be found before the baby is born. These women will move frequently and there is no continuity of care during pregnancy (D'Souza and Garcia 2004). The findings from this study found that babies may be born preterm of low birth weight and often suffering from the effects of substance misuse or alcohol when born. The rate of depression in these women is high.

3.5.2: Children's health

There are concerns not only about homeless women's health and wellbeing, but also that of their dependent children. Impairment in parental functioning often occurs when parents have mental health issues, sleep deprivation or

other stressors that affect their ability to care for their children adequately. This results in an inability to respond to children's needs or offer protection and can lead to children being unsupervised (Hausman and Hammen 1993). Children who are deprived of attention or support can be psychologically affected, they may have already witnessed domestic abuse or even been physically abused (Hardcastle and Bellis 2019). Women with dependent children who are victims of domestic abuse find themselves in refuges or other homeless accommodation as a means of escaping from a life of abuse or even death. Anooshian (2005) argues that children's behaviour was more aggressive when exposed to domestic violence alongside homelessness. Children then become even more isolated and the incidence of anti-social behaviour increases especially in older children. This study also suggests that parent-child interaction shows aggressive tendencies and therefore this demonstrates less warmth in the relationship between parent and child. It is understandable that these children become isolated from peers and use aggression as a form of expression. Another study showed it can also be attributed to modelling where children who have witnessed or experienced violence will copy this behaviour (Bandura 1995). An earlier study by Vostanis et al. (2001) undertaken with homeless mothers and children found that mental health problems were greater in children who experienced neighbourhood violence or domestic abuse compared to children who were homeless for other reasons. The sample was divided into three groups, (n=48) mothers with children who experienced domestic abuse, (n=14) mothers with children who were victims of neighbourhood violence and (n=31) mothers with children who were homeless for other reasons. The study found that social, professional or family support had a protective element in relation to mental illness.

Harpaz-Rotem et al. (2006) found that housing status such as, homelessness in particular was not significantly associated with poor mental health in children. There was a higher incidence of emotional problems such as depression and anxiety in the child if the mother identified as having emotional problems or suffered from mental illness. Children who suffered from physical abuse and had low self-esteem also showed symptoms of

depression and anxiety. A much earlier study by Buckner and Bassuk (1997) found that 38% of children who were homeless presented with behavioural and emotional disorders. This finding was supported by the work of Vostanis (2004) who identified similar emotional and mental health issues in children who were homeless. Another finding by Vostanis (2004) was that children's behavioural problems improved once the children were re-housed in a more stable environment. However, a percentage of the children showed no improvement in mental health issues after re-housing. The findings were consistent with an early study undertaken by (Vostanis et al. 1998), where 39% of children had higher levels of mental health problems up to one year after being re-housed compared to children who were in stable housing but were socio-economically disadvantaged.

3.6: Social Exclusion

Social exclusion is a shifting phenomenon depending on social status as suggested by Burton and Kagan (2003), this is often seen when a family becomes homeless, their status changes and they become excluded by a society that previously socially included them. Fahmy et al. (2012) in their study explored participants' definitions of exclusion, they found that people felt a sense of not belonging and were treated unfairly by others. Similarly, Wen et al. (2007) suggested that women felt unwelcomed, that they were being ignored, rushed or brushed aside. From these examples it can be considered that people are excluded from participating in society, including access to healthcare services (Shier et al. 2011). Homeless women can be denied access to GP services because they are not in receipt of a permanent address (Rae and Rees 2015). Social exclusion is often associated with attitudes and perceptions of homeless people however, loss and identity is an important aspect of humanisation (Schneider and Remillard 2013).

3.6.1: Attitudes

Homeless women with dependent children are a marginalised group within society and therefore can be socially excluded and ostracised (Parker and Fopp 2004). Many are labelled as demanding and underserving (Neale et al. 2008), hostile and disrespectful (Reid et al. 2005). They are also victims of

negative attitudes and responses from service providers, which often make them feel humiliated. Comments such as, 'homeless people should get employment and help themselves' is not helpful or caring (O'Carroll and O' Reilly 2008).

Cosgrove and Flynn (2005) explored attitudes of staff and the consequences this had on the homeless women with dependent children. The study was based on participatory research where a more collaborative approach was used to explore the lived experience of homeless women (Holloway and Wheeler 2010). Seventeen women from a diverse background were interviewed, the age range was from 20-32 and the children's age ranged from 3 months to 12 years. Participant's referred to an incident where service providers had been discriminatory and stigmatising towards them. The individuals were made to feel worthless and not valued or respected. The women stated that it was not always what was verbalised but the way the health care staff looked at them. Their behaviour was also scrutinised especially their parenting, feeling of constantly being watched and judged made them feel more vulnerable.

Similar findings were found in Nickasch and Marnocha's (2009) grounded theory study. Fifteen participants were identified using snowball sampling and the age of the participants was over 18 years of age. However, there was no indication of the gender of the participants or whether they were single homeless or had dependent children. Participants were asked their views on how they were treated by the health staff; lack of compassion was strongly conveyed by many homeless people. Others voiced concern that health professionals were not caring and compassionate.

Slesnick et al. (2012) reported that homeless women experience greater levels of stress and depression, which was made worse by the attitudes of service providers.Both studies were based in USA where their health care systems are different from the UK so it would be difficult to generalise whether the same attitudes existed in the UK. There appears to be a failure by health staff in demonstrating compassion in both of these studies. A

question that could be asked is could the attitudes of professionals be attributed to lack of knowledge and understanding of the health needs of these people and the reason they became homeless. Homeless people have the same human right to be respected as everyone else. A kind word or someone to listen; is often all that is required to make someone feel good. The Nursing and Midwifery code of conduct (2015) requires nurses to care for all people irrespective of their circumstances.

A UK study by Neale and Kennedy (2002) was undertaken with homeless people who were also drug dependent and service providers, to examine good practice. Semi structured interviews were the method used for data collection. The views of both staff and users were similar. Staff interviewed felt that it was important to be non-judgemental and respectful. Users felt that staff should be approachable, understanding and committed. It was also acknowledged that there should be some awareness by staff of how and why people become homeless and drug dependent. The users felt they were respected, supported and the service was accessible. This is a more positive response compared to the studies conducted by Cosgrove and Flynn (2005) and Nickasch and Marnocha (2009). This could be attributed to specific services that were developed for this population and not a general service that was accessed by the general population. A previous review of the literature demonstrated similar findings (Parkinson 2009) in that many nurses were respectful to homeless people although judgemental attitudes were found especially in student nurses. A clinical placement in a homeless refuge was introduced and the attitudes of these students towards homeless people were changed. Although this was a UK study, the literature reviewed was mainly USA and Canadian, which demonstrates the lack of British studies. Rae and Rees (2015) agreed with the above studies in part but found where homeless people are not treated fairly and made to feel worthless, further engagement with healthcare services is not taken up.

3.6.2: Perceptions

Homeless women were anxious about how others may perceive their behaviour and felt they were being judged more harshly because they were

homeless (Wen et al. 2007). One study found that the homeless shelter where participants lived held mandatory parenting programmes and women were not offered a choice whether they wished to attend or not. The participants stated they were made to feel they were not good parents and their parenting was called into question, simply because of their homeless status (Tischler 2007). This study demonstrated that service providers used a "top down" approach to assess the needs of these women by using a normative approach as defined by Bradshaw (1972), where need is identified by the professional and not by the client. Therefore, the needs of the women may not have been met and this left the women feeling inept. It could be argued that it is an ineffective use of resources, or was the facilitation of the parenting programme the problem?

Wen et al. (2007), argue that many homeless people felt they were discriminated against by healthcare personnel, which made them feel disempowered. Reference is made in this study to Buber's theory of "I-it" where people are regarded as objects (dehumanised) rather than human beings where "I-you" is more characteristic of a welcoming experience. Where homeless people were acknowledged and listened to they were more likely to engage with the service. A study by Shier et al. (2011) interviewed 25 women who were homeless in Canada; the purpose of the study was to understand women's trajectories from homelessness. Three themes emerged from the study and these were social exclusion, having children and personal experiences. The findings from personal experiences identified sociocultural factors such as, beliefs and behaviours. The women suggested that how the general public perceived them impacted on their self-esteem and self-worth, which in turn affected their behaviour. The same effect occurred when accessing healthcare services and engaging with healthcare personnel. Both studies were undertaken in Canada, although the health system is similar to the UK, in that they do not have an insurance system like the USA. The personal experiences of the homeless women may be different in Canada than in the UK and therefore cannot be generalised to all homeless women however, it does offer an insight into their personal experiences.

3.7: Access to Healthcare Services

Once women and children have become homeless regardless of the reasons, support and inclusiveness is essential to allow them to begin a new Chapter in their life. The earlier the interventions are established the better the outcome for their health and wellbeing. Two studies found that delayed interventions in children led to poorer health consequences throughout childhood and into adult life (Field 2010; Allen 2011). For children who witness domestic abuse or are abused themselves this can have lasting emotional scars if not helped and supported (Munro 2008). Accessible healthcare services and resources are needed to enable women and children to recover from their experiences.

3.7.1: Barriers to accessing healthcare

Tischler et al. (2007) found that, homeless women with dependent children have difficulty in accessing health, social and educational services. Homeless women and their children usually present at accident and emergency departments for their health care needs rather than accessing primary care services. They are unlikely to take up screening or immunisations and usually access healthcare when symptomatic (Vostanis 2002). Disengagement, especially for women who are suffering from mental health problems may be the ultimate coping mechanism when they feel out of control (Tischler and Vostanis 2007).

There is a lack of available studies on accessing health care services by homeless women with dependent children; some studies refer to the young homeless who are often adolescents or single homeless. Many of the studies reviewed relate to other marginalised groups who have identified barriers to accessing services, some of which are international studies and UK studies are again limited in this area. Adverse experiences such as homelessness, family breakdown, abuse, poor education or being in care as a child, increases the likelihood of mental health issues. Which in turn hinder the individual's ability to cope and to a greater or lesser degree cause difficulties of engagement with social, health and housing agencies (Taylor et al. 2006). Taylor et al. (2006) perceives that the barriers to accessing services are

many such as, mobility of homeless people and the lack of flexibility of services across different boroughs and NHS services. The lack of communication and collaboration between professionals hinder access to services for these vulnerable people and therefore resources are not effectively targeted.

An early study undertaken in Manchester by Reid and Klee in (1999) focused on young homeless people aged between 16-25 years. Two hundred homeless people who participated in illicit drug use on 2 days or more per week (inclusion criteria) were interviewed. This paper formed part of a larger research study examining risk behaviour and coping strategies among homeless drug users. The participants were mixed gender but whether any had dependent children were not identified. Most of the participants sought GP services however; accident and emergency departments were also used intensively. Reasons why access to GP services were problematic included cost of travel, or GP located near family members that caused the homelessness. Where there were previous experiences of registering with a practice, some mentioned needing to be deceptive such as giving a false address or not stating they were homeless. The processes involved either registering with a GP or up taking services were found to be too difficult. Many felt they were discriminated against because of their homeless situation and preventative health services were rarely taken up. Such as health checks, cervical smears or vaccinations. Although this study was based on young homeless people who were drug users, it is difficult to establish whether the discrimination is aimed at the drug use or the fact they are homeless.

A qualitative study by Neale et al. (2008), interviewed 75 injecting drug users, eight of these were homeless. The research concentrated on the barriers to accessing health and social care services. The study identified that parents were fearful of accessing GP services; their perception was their children would be taken into care. Other barriers were related to time and cost that involved travelling to and from health and social care services and the limited access to telephones making it difficult to make appointments. As

a result, appointments were missed and they were removed from the waiting list. Many of the women interviewed described their reluctance to have contact with social services, again because they felt social services were 'heavy handed' (Neale et al 2008, pp. 152) and would remove the children. Alternately, a number of participants had been helped by social services and felt supported. The findings from this study would be difficult to generalise to homeless families, as the sample were all drug users. Therefore, the barriers were based around the stigma and attitudes that may present themselves with this marginalised group and may not be transferable to the homeless population (Holloway and Wheeler 2010).

Reid et al. (2005) found similar barriers when they undertook a feminist narrative study to explore how young homeless women (n=10) access health services in Canada. The main barriers were lack of money for transport and medication and discrimination by health care professionals as reasons why they did not access services. When they became sick, they were fearful of visiting the hospital or family physician because of the way they were spoken to and judged. These women were reluctant to use the services; therefore, this affected their health and wellbeing. When health professionals were helpful and compassionate, the young women would return to use these services as they felt they were not being judged. These young women mainly lived on the streets and were often not provided with temporary accommodation. The authors acknowledged the limitations of their research being transferred across homeless people in general. Even though their sample was small it did generate rich data, there was consistency in the findings across the sample.

An interesting study was undertaken by Hwang et al. (2010) where, single men, single women and women with dependent children (n=1169) were recruited for this quantitative study in Canada. Overall 17% of the sample had not received health care within the previous twelve months for unmet needs. Single women had the highest rate (22%) followed by women with dependent children (17%). Homeless women with dependent children were identified as being the most in need of healthcare. The disproportion

between the homeless group and the general population in acquiring health care was double. The barriers that were found pertaining to accessing health care services were the mistrust of professionals, financial problems and access to a primary care provider. This was a large study that encompassed different gendered groups within the homeless population and therefore could be generalizable to other homeless populations within Canada and maybe USA. In both countries, individuals obtain health insurance in order to pay for health care but there is a system in which they can obtain healthcare services without insurance. However, resources are limited, which could be a contributing factor as to their access difficulties. There are some similarities to the access difficulties in the UK.

3.7.2: Housing

It is argued that housing is a temporary state and once families are rehoused in more stable accommodation, the health outcomes improve (Shinn 1997). However, it is not only the structural components that need to be considered. Poverty, trauma, instability, abuse and victimisation contribute to poor health outcomes as discussed previously and that health needs have to be met (Stickley et al. 2005). This is not to say that housing is not important, a study by Smith (2005) confirmed that 50% of participants reported that being in a permanent house improved their mental health. Better housing quality also been associated with improvements in mental wellbeing (Evans et al. 2000). The length of time in temporary accommodation affected their emotional wellbeing; it was compounded by the stress and isolation that homeless women endured especially those who had fled domestic abuse. Women who had adolescent sons are usually temporary housed in a three bedroomed house rather than a refuge. They are instructed for their own safety not to disclose where they are living to family or friends. This makes them even more isolated and miss the socialisation of being with other adults.

3.8: Summary

The health outcomes of homeless families are poor compared to the remainder of the population who are in stable housing. The rates of mental ill health are three times higher than those who are permanently housed.

These women are often victims of domestic abuse and users of drugs and alcohol. The dependent children of homeless women also suffer from mental ill health especially when they have witnessed domestic abuse or neighbourhood violence. Where the mother has emotional problems, there is a higher incidence of emotional problems in the child.

The women become socially excluded and they have a sense of not belonging. Homeless people are often victims of negative attitudes and responses from service providers and healthcare professionals are often perceived as not being caring or compassionate, which impacts on the homeless person's self-esteem and self-worth. There appears to be many barriers in accessing healthcare services, which encompass the lack of flexibility of services, communication and collaboration between professionals and mobility of homeless people. These lead to health needs often not being adequately addressed for this homeless population.

Chapter 4: Philosophical and theoretical considerations

This chapter explores the theoretical and methodological considerations that underpin the study. In addressing the aim of this study; the experiences of women with dependent children living in temporary accommodation and the barriers in accessing healthcare services, IPA is the methodology of choice for this study. Interpretative phenomenological analysis allows the participant to have a voice, in that it not only allows participants to tell their story but, to engage in their experiences and reflect on them. So in essence the "researcher is trying to make sense of the participant making sense of their experience" (Smith et al. 2009, pp. 3). This chapter will explore social constructivism and how the theory underpins IPA, to identify the three areas of phenomenology, hermeneutics and idiography that form IPA and conclude why IPA was chosen for this study.

4.1: Social Constructivism

Social constructivism is concerned with how individuals construct and make sense of their world through social interaction between individuals (Robson 2011). Social constructivism was founded in sociology and has been around since the 1970's and is classified as post-modernist qualitative research (Creswell 2013). This kind of approach adopts an interpretivist stance, which focuses on how the social world is interpreted by those who are involved in it. It is argued that the social world should be studied from the inside through shared experience, culture and empathy than purely from the outside in attempting to explain behaviour (Hammersley 2013). The focus is to try to understand people and events in specific social phenomena. From a philosophical stance, it is argued that knowledge of the world comes from experiences that have direct impact on the person at that time. The description from these experiences should not be influenced by theoretical assumptions (Robson 2011).

The relationship between people is influenced by specified roles, and whether people fit or conform into these roles, as well as how others perceive them. Therefore, knowledge and experience becomes more meaningful. In this study, the participants (women) describe their

experiences of homelessness. What is important is how they, (the women) perceive their experience and not whether these experiences reflect reality. Therefore, the purpose is to develop the understanding of the experience and not to influence the other about the interpretation of the experience.

The challenge now is to explore the perspectives of the participants and how their experience unfolds in the context of their situation. Biggerstaff and Thompson (2008) point out that the attitudes and behaviour of the participant, however strange or irrational it seems, should be acknowledged by the researcher. In the context of the experience, the behaviour is meaningful to that participant and no explanation is needed. Within the context of this research and IPA, homeless women with dependent children each have different experiences of living in temporary accommodation and while trying to make sense of their situation, the researcher must make sense of the women making sense of their experiences (Smith et al. 2009). To elicit these experiences, open-ended questions were used to allow the participants to relay their experiences of homelessness, based on an interpretive method of social constructivism (Creswell 2013). The role of the researcher is to listen and interpret the findings based on the participant's experience. Therefore, it can be determined that the underpinnings of social constructivism and IPA are closely aligned.

4.2: Theoretical/methodological fit

Social constructivism recognises that individuals perceive the world in a unique way; people construct their reality centred on their experiences. It focuses on how people make sense of the world by creating realities through their interpretations. In a similar way, IPA explores how people make sense of their experiences with the double hermeneutic aspect where the researcher is making sense of the participant making sense of their experience. The participants (women) unique experiences of accessing healthcare services whilst living in temporary accommodation are the focus of interest in this study.

4.2.1: Interpretative phenomenological Analysis

Interpretative phenomenological analysis is a qualitative approach within research to explore how people make sense of the phenomenon in question (Smith et al. 2009) and is a method that examines the lived experience of people. People are often immersed in their experiences but are not always aware of the reality of their experiences (Brocki and Wearden 2006). When a major event occurs in someone's life, the person will often consider the impact of the event. In IPA, these experiences are examined by the researcher as to how the person makes sense of their experiences. Smith et al. (2009 p.2) suggest a "hierarchy of experience" people encounter experiences all the time often without being aware of them. When there is an awareness of an event, then this can be described as "an experience". This experience is where it has had an impact on the person's life; the purpose of IPA is to engage the participant in reflecting on the meaning of the event.

Interpretative phenomenological analysis is made up of three significant areas

- phenomenology - which is the study of experiences,
- hermeneutics - the theory of interpretation and
- idiography - which is concerned with the particular.

Each of these three approaches will be discussed in more detail. The chapter will conclude with a rationale for choosing IPA.

4.2.2: Phenomenology

Phenomenology is the philosophical study of experience, 'ideas and challenges' (Tomkins and Eatough 2013, pp. 2). The meaning of the experience constitutes, what it means, how it feels, how it is perceived and how you make sense of it. Some of the important phenomenological philosophers Husserl, Heidegger and Merleau-Ponty have differing interpretations of phenomenology. Husserl, describes experience as being the science of consciousness, the understanding of the experience and how that is transformed into consciousness (Smith et al. 2009). He suggests that the phenomena in question should be looked at individually, described and

interpreted. These descriptions and interpretations often becomes one as they become interlinked. Patton (2015, pp. 116) explains this idea as

> "*Interpretation is essential to the understanding of experience and the experience includes interpretation".*

In so doing phenomenologists can make sense of the participant's world. Heidegger offered a different opinion he called it '*Dasein*' meaning 'there-being' the world is only meaningful by the processes and experiences that are encountered (Larkin et al 2006). Whereas Husserl considered consciousness and assumptions acknowledging epistemological ideas. Heidegger leaned towards a more ontological view of existence, about 'being there'. He challenges the notion that existence can be moved in and out of, to exist we must be part of the world and part of the experience to make sense of the world (Larkin et al. 2006).

Husserl also makes reference to our '*natural attitude*' moving outside of our experiences in order to fully explore the experience of the object (Smith et al. 2009). We see objects as real and existent, this is experienced as fact without questioning the existence. Husserl views 'natural' as a way of seeing things, 'being-in-the-world' as he describes it. From a phenomenological perspective, facts are not enough; perceptions and intuitions must also be recognised and interpreted. Heidegger and Merleau-Ponty acknowledged the interpretative stance that Husserl was making but considered it in different ways. Merleau-Ponty talks of embodiment, how we see ourselves within the world, being different to others because of sense of self. While we can empathise with someone who is suffering, we cannot share the experience (Smith et al 2009). Larkin et al. (2011, pp. 326) characterises how culture influences embodiment such as health and illness and environment.

> "*These can have an impact upon the body as lived and as the body as perceived and upon the affordances which the world offers us*".

The lived body cannot be absorbed into culture but is situated 'within' and 'permeated' with the cultural body (Ihde 2003).

To be actively engaged within phenomenology there is a need to consider the effect of our everyday world of objects in what Husserl called 'bracketing' this means putting to one side or separating out past knowledge not based on direct intuition so that attention can be based on the phenomena in question (Pietkiewicz and Smith 2014). Smith et al. (2009) interprets this as getting to the essence of the experience by a series of reductions by directing the researcher away from preconceptions and prior knowledge so that new experience is developed. Heidegger a student of Husserl disagreed with Husserl idea of reduction and argued that it is not possible to separate out completely these two phenomena (Smith et al 2009). Le Vasseur (2003) argues that even if this was possible 'what of the participants', it is unlikely they are aware of assumptions or preconceptions when relaying their experiences during an interview. From a pure phenomenological stance, this could be viewed as the data being flawed. However, from an IPA position, the data would be enriched because the feelings and emotions and how they make sense of the experience would be tied up in these preconceptions.

Phenomenology focuses on the perception of how people understand themselves and others. The underlying focus for the researcher is to develop a deep insight and understanding of the meanings of life experiences. Robson (2011) suggests it is about the quality and texture of the experience, in understanding what is the experience like' for that person. This is irrespective of what is really happening, so for homeless women, their experience of being homeless, living in temporary accommodation and accessing healthcare services is what the researcher wishes to extract, rather than what lead them to become homeless. Phenomenology is about getting as close to the participant experience as is possible seeing the world through their lens (Biggerstaff and Thompson 2008). Although the same event can be experienced by different people, each experience will be unique to that person. Within the context of this research, each of the participants became homeless and were living in temporary accommodation with their children. So in essence the event was the same for all however, their experiences of the event were different in each case.

Within the descriptive approach, the experience is captured exactly as it is presented in the transcript without sense making of the event. An interpretative approach seeks to understand the experience by moving away from the account and evaluating its meanings in the wider context. Hammesley (2013) argues that people make sense of their experience which is shaped by their environment or culture in which they live; this influences their beliefs and their actions. Therefore, a phenomenological interpretivist researcher must understand the different cultures and bracket out their own assumptions and beliefs as much as possible. Smith (2011) conveys that in interpretative phenomenological analysis the descriptive element seeks to create the quality and texture of the experience while also capturing the sense making in the wider social and cultural contexts. Interpretative phenomenologists believe that pure description alone is not possible, as there will always be some interpretation.

4.2.3: Hermeneutics

Hermes the winged messenger of the gods delivered and interpreted messages to the underworld, which saw the beginning of words and of language. Hermeneutics comes from the Greek word *hermeneuein*, which means to interpret (Ihde 1980). Hermeneutics is the theory of interpretation and was originally used to interpret text from the bible and other sacred documents (Robson 2011). In the 19th century, Frederich Schleiermacher classified interpretation as *grammatical* or *psychological* interpretation (Smith et al 2009). Psychological interpretation is based on the researcher interpretation, whereas the grammatical interpretation is objective and more exact using linguistics. Interpretation means a deep understanding of the text (interview) to elicit richer meanings using both types of interpretation. Heidegger viewed interpretation as being an integral part of phenomenology; he suggests that when interpreting experience there are two aspects, the hidden meaning and the detectable meaning (Smith et al. 2009). Heidegger sees this as hermeneutic phenomenology. Smith et al. (2009, pp. 10) refers to the *double hermeneutic* aspect of IPA

> "*Where the researcher is trying to make sense of the participant trying to make sense of what is happening to them*".

The researcher in essence has a double role, that of interpreting the experience of the participant while the participant is trying to make sense of their experience. The researcher is similar in a way to the participant, where they are both making sense of the world. However, the researcher is also unlike the participant, whereby the researcher only has access to the participant's experience through the lens of the participant (Smith et al. 2009).

In relation to interpretation, Heidegger makes an interesting point he talks about '*fore-conception'* where individuals will not be completely detached from prior experience or preconceptions and the new experience will be influenced by it. He believes this notion can have a positive effect on interpretation (Smith et al 2009). So when undertaking an interview Heidegger's theory suggests, it is not always clear at the beginning what assumptions need to be bracketed out, after the interview the preconceptions may become clearer, so could benefit the interpretation (Pietkiewicz and Smith 2014). This suggests that the idea of bracketing as discussed previously, when using IPA needs to be considered with caution.

The hermeneutic circle is concerned with the relationship between the part and the whole. One cannot be understood in context without the other for example the meaning of a word has more relevance when it is viewed as part of a sentence. However, the collection of words in a sentence offers meaning to the sentence. The cyclic element within hermeneutics occurs throughout in that, a quote is part of the transcript and the transcript viewed as part of the research.

The Part	**The Whole**
The word	The sentence
The quote	The transcript
The transcript	The research

(Smith et al. 2009 p28)

The part is required to understand the whole and the whole is essential in understanding the part (Patton 2015). This forms the process of analysis in

qualitative research. In IPA, the movement through the hermeneutic circle is not necessarily a step-by-step process because of its iterative aspect. The meaning of the text becomes clearer as we read and re-read the text and develop new ways of thinking.

4.2.4: Idiography

Idiography is concerned with the particular, examining each case individually in depth before making more general comments (Smith et al. 2009). Within an idiographic study, claims can be made on an individual basis, as a case-by-case examination has been undertaken (Smith and Osborn 2007). Pietkiewicz and Smith (2014) suggest this is a very different way of interpreting data compared to other qualitative methods. The researcher examines a case in depth before moving on to the next case and so on however, a single case study approach can also be justified using this particular methodology. A study undertaken by Flyvbjerg (2006) on the misunderstandings of case study research raises a valid point that more evidence found from deep examination of a case study than from more information generated from large groups. In relation to women with dependent children who live in temporary accommodation and access healthcare services, a small sample of five women interviewed as recommended by (Smith et al. 2009). Each of these cases were analysed on a case-by-case basis.   After the case-by-case analysis, themes developed and the researcher would move back and forth between these themes, comparing and identifying similarities and differences. Narratives used to convey the participant's stories within the themes.

4.2.5: Challenges to IPA

More recently IPA methods have been challenged firstly by Giorgi (2011) in challenging the use of the term bracketing and its use within IPA. In IPA the term is used loosely to prevent ideas and assumptions that have formed from the first case from biasing the second case and so on (Smith et al 2009). Another criticism refers to the step by step process and the flexibility that Smith et al (2009) advocates when using these steps. Giorgi (2011) interpretation is that it is unclear what the steps are and in what order they

should be undertaken, however, he argues, whatever steps are taken need to meet "scientific criteria" (p214). Similarly, Van Manen (2017) disputes the step by step model and argues that phenomenological insight and understanding cannot be guaranteed. The interpretation of IPA is also challenged here by Van Manen (2017) who claims that this method is not phenomenological but psychological and should be titled as 'interpretative psychological analysis'. Lastly, Paley (2017) challenges phenomenology in general and includes IPA into this dispute. Paley suggests that the identification of deeper meanings is not possible without the researcher's use of assumptions and background information, in that it cannot be identified from text alone.

Smith et al (2019) has replied to some of these criticisms especially Giorgi (2011) offering further explanations on this method of analysis when using IPA. In recognition of meaning making for the researcher and participant, Smith (2019) has explored the double hermeneutic in greater depth to answer the criticisms above. In seeking meaning by the interpretation of the text is akin to detective work, participants are searching for the meanings of their experiences and so are the researchers. Thus in bringing both of these elements together, the hermeneutic circle is completed. The interpretation is similar in some ways to the participant, but different in other way's as they do not have direct access to the experience, only through the participant's sense making. The critics of IPA have a strong grounding in the philosophical aspects of phenomenology. They see the existential world as being unordered and we can 'become' whatever we wish. Smith (2019) on the other hand recognises this is too abstract and researchers in the real world need structure and direction when trying to make sense of experiences. Therefore as a novice researcher it is important that I understand how other people see and understand their existence.

4.3: Why IPA

Interpretative phenomenological analysis supports a milder version of social constructivism than Foucauldian discourse analysis and is concerned with the personal experience and interpretation of the phenomena in question.

This was in keeping with the study's aims and meaning making in the women's life world where, attitudes, identity, personal history, accessibility, culture and socialisation is recognised. In descriptive phenomenology the idiographic exploration may be used within the analysis however, the main aim is to explain the phenomenon as a whole irrespective of the individuals concerned. Therefore idiographic elements are simplified or otherwise ignored. Whereas in IPA the idiographic element is a crucial factor, highlighting how psychological meanings are interpreted through the meticulous exploration of individuals experiences (Shinebourne 2011). IPA also includes hermeneutic methods so that interpretative analysis as well as contextualising participants narratives help to connect the findings to the psychological literature (Smith et al 2009). When using descriptive phenomenology the study would lend itself to the third person account detailing a more generalised structure for the phenomenon under question. Whereas in an IPA study, is a more idiographic, interpretative account mixed with participants extracts (Shinebourne 2011).

IPA is concerned with the particular firstly, the depth of analysis and secondly, as advocated by Smith et al. (2009 pp. 29),

> "*committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context".*

The reason for choosing IPA as the preferred methodology is to enable understanding of the experiences of how women access healthcare services when they are in temporary accommodation. Therefore, it is crucial that a methodology was chosen that represents the participant's experiences in a rich and meaningful way. Interpretative phenomenological analysis is a humanistic study of phenomena (Smith et al. 2009) and was chosen to enable a greater understanding of the lived experiences of these women and how they make sense of their personal and social world. Therefore, this thesis strives to broaden the mothers understanding of their experiences of accessing healthcare services while in temporary accommodation. In using an interpretative methodology aided by IPA double, hermeneutic (where the researcher interprets the women's sense making of the experience) would

facilitate this (Pringle et al. 2011). As a novice researcher, IPA provides a structured process that is flexible enough to allow creativity. Where topics are sensitive and complex as in the case of women living in temporary accommodation, IPA literature supports this. The increase in IPA studies and publications on healthcare related topics demonstrate the versatility of this qualitative method (Tuffour 2017). A study on homelessness using IPA namely Riggs and Coyle (2002) where the experiences of young people's homelessness influenced their psychological wellbeing and identity is one such study.

Noon (2018) suggests that IPA allows the experiences of groups of individuals, especially those from marginalised groups to have their voice heard. Women with families living in temporary accommodation are one such group. Another aspect that is unique to IPA is the moving away from a structured interview set of questions to allowing the participant to take the lead. In so doing, unexpected and unprompted information would be elicited allowing exploration of the participant's social world. Therefore, IPA from a social constructivist and phenomenological aspect allows a detailed exploration of sense making and meaning making of the phenomenon in question.

Chapter 5: Research Design

5.1: Methods

5.1.1: Sample

Smith et al. (2009) considers that small samples of four to ten participants are a realistic sample size. The reason for such small samples is to enable the researcher to undertake a detailed analysis of each case, and to facilitate

> "*The development of microanalysis of similarities and differences across cases*" (Smith et al. 2009, pp. 52).

As this is a hard to reach group there were difficulties with recruiting a larger sample of participants and therefore five was realistic in terms of recruitment of these individuals and in accordance with IPA ideology.

The research sample were women with dependent children who were homeless and living in temporary accommodation. For these particular participants three were temporary housed in three bedroomed houses and two were in homeless refuges. The temporary accommodation was provided by homeless charitable organisations.

A purposive sample was deemed appropriate for this study; Purposive sampling is used to identify specific groups of participants who possess similar characteristics or live in circumstances relevant to the social phenomenon being studied (Polit and Hungler 1997). This form of sampling had been used in other studies with homeless families although; these were not IPA studies (Stuttaford et al. 2009; Tischler and Vostanis 2007). The social phenomena being studied in this research are women who are homeless with dependent children and living in temporary accommodation. Smith et al. (2009) suggests that a homogenous sample of participants would be more significant in relation to the research question. Therefore, the sample of participants would be women with dependent children who are homeless but living in temporary accommodation. Previously as a health

visitor, it became apparent that these women and children had significant health issues and were poor up takers of health services (Warnes et al. 2003). There are limited studies using this group of participants and therefore their homeless issues may be different to other homeless people. Families containing both parents or men, single men with depended children were excluded from this sample. It is important as suggested by Smith et al. (2009) that you have a homogenous group therefore it was decided to only include women with dependent children to be able to examine the experiences of this particular group

Pielkiewicz and Smith (2014) suggests that homogenous incorporates two concepts, one, in that it can contain a measure of similarity of the phenomenon. The second concept, where there are difficulties in recruitment, small groups can be explored in relation to the phenomenon. Both groups could account for their experiences of accessing health care services. These factors will be acknowledged within the limitations later in the thesis.

When researching a vulnerable group such as homeless women, the sample size is understandably going to be small and therefore reaching saturation would be very difficult in the case of grounded theory. The participant's personal perception of the experience and the researcher trying to get close to the participant's personal world is more achievable using IPA. Therefore, in asking the research questions; how are women with dependent children who are living in temporary accommodation accessing health care services, and what are the barriers that influence the uptake of health care services for women with dependent children who are living in temporary accommodation will allow detailed exploration of this particular group of people.

5.2: Research Procedure

5.2.1: Recruitment

Criteria for inclusion would be women with dependent children who were homeless, living in temporary accommodation. I initially intended to recruit women who were residing in temporary accommodation.

I encountered many difficulties in recruiting women from this vulnerable group, only two had been recruited in an 18-month period, from a charitable organisation. However, I was not informed by the organisation that these women had been permanently housed, I found this out during the interview. The delay in getting participants led to a delay in the completion of my doctoral thesis. In enabling me to recruit more families, the search area was widened and two Local Authorities were approached, one Local Authority responded and a meeting was set up with the head of Homeless Services and myself to explain the research. The Head of the homeless service appeared to be interested in my research and promised to recruit participants to be interviewed however, this unfortunately did not materialise. Two more Local Authorities were contacted via email no reply was received. Further contact on two more occasions failed to elicit any contact.

A different charitable organisation was contacted in a further attempt to recruit participants. The research was explained and the organisation were happy to recruit families to be interviewed but there was one condition set that the interviews must be undertaken in the Organisation's offices. The day and times of the interviews were arranged by the charity that fitted in with their schedule. Three participants were recruited to be interviewed, the interviews were all arranged to be held on the same day at hour intervals. A support worker was present to care for the children in another room while the interviews were taking place.

Although my intentions were to have a sample size of six participants, as Smith et al (2009) suggests as a realistic sample for IPA, I realised that it became unrealistic to delay my research any longer in trying to obtain another participant. Therefore, in discussion with my supervisor, the sample remained at five. This was still in line with IPA consideration as 'small is more' (Hefferon and Gil-Rodriguez 2011). This is not strictly speaking a pure homogenous sample as there was variance surrounding the time of the women's homelessness experiences but I had to take a pragmatic approach due to constraints on data collection. The sample consisted of five

participants, two of these participants had been permanently housed for two years or more therefore, their interview was based on recall. The other three participants were residing in temporary accommodation at the time of interviewing. All the participants in this sample had similar commonalities, in that, they had all experienced homelessness and resided in temporary accommodation. Due to the difficulties in recruitment of participants with this extremely hard to reach group, the timeframe for recruitment took up to two years. Ideally, the preference would have been for all five participants to have the same homelessness characteristics at the time of interviewing. Either all participants residing in temporary accommodation or recently been permanently rehoused. However, this proved impossible and I had to go with the five participants I was fortunate enough to recruit. I acknowledge this could be seen as a limitation of this study, as there may be more variations in the participant responses especially those through recall.

5.2.2: Participant demographics

The five participants that were interviewed was given pseudonyms to maintain confidentiality. The names were not chosen in any particular order, just randomly selected. What was interesting and became evident after the interviews were conducted was that all the women were white and British. The participants' age, health needs and number of children are indicated in Table 4.

The first two participants Emily and Amy had been permanently housed between two to three years at the time of the interview. The following three participants, Julie and Ginny were in temporary accommodation and Susie had recently been rehoused permanently.

Table 4: Participant demographics

Participant	Age	Dependents	Health issues	Ethnicity
Emily	Approx. late 30's	Two teenage sons, 11 and 13 yrs.	Depression, bipolar disorder, drug and alcohol misuse	White British

Amy	Approx. early 40's	Two children, daughter 13yrs, son 9 yrs.	Daughter mental health issues (sexually abused) Son hypermobility of joints	White British
Julie	29 yrs.	Three children, aged 9,6 and two	Domestic abuse, depression and anxiety	White British
Susie	36yrs	Four children, 2 boys aged 18 and 16, two daughters aged, 13 and 20 months and a 18 year old stepson	Domestic abuse, drug dependent. Eldest daughter self-harming and attempted suicide. Baby taken into care for three months	White British
Ginny	Approx. 30's	Three children, aged 11, 7 and 5	Possibly Domestic abuse. Daughter, with learning disabilities. Son, cystic fibrosis. Son, behavioural problems	White British

5.3: Ethical Considerations

Early on when writing the proposal for this dissertation, the care of homeless women with dependent children in the community came under the remit of a lead health visitor for Homeless families in a named Health Board. This was going to be my resource to gain access to these families. However, when the proposal was ready to be submitted to the School Research Review and Ethics Screening Committee (RRESC), there had been some organisational changes in the Health Board and there was no longer a named health visitor for homeless families. Individual health visitors were now responsible for homeless families registered with a named General Practitioner (GP). This change in organisation made it difficult and unmanageable to access numerous health visitors to gain access. From some empirical studies identified in Chapter 3, authors highlighted (Vostanis 2002; Tischler et al. 2007; Neale et al. 2008) that many homeless families do not always register with GP's as they find difficulties in accessing appointments and experience

stigmatisation. Health visitors may not be aware of families in the area who are living in temporary accommodation.

My proposal was submitted to the RRESC for consideration, as following my decision not to access participants via the NHS there was not a requirement for me to apply for NHS approval through the IRAS process. Approval was granted with conditions (see Appendix 1) these being, rewording of some sentences within the interview section and refining of the interview questions and title. A Disclosure and Barring Service (DBS) check on myself was a requirement also made by the committee. The proposal with the amendments was completed and returned to RRESC. Full approval was then granted (see Appendix 2) and the DBS check was undertaken and approved. The proposal was then submitted to the School Research and Ethics Committee and approval gained (see Appendix 3).

5.3.1: Informed consent

Informed consent is a person's right to autonomy and protects the participant. Beauchamp and Childress (2001) define autonomy as the right to self-determination and have their choices respected. The information offered to participants should be free of jargon and explained in plain English to enable the participant to make an informed choice. The use of medical terminology or the use of jargon was not used within the discussion, as this would confuse or misinform the participant. Fouka and Mantzorou (2011) maintain that, participants should be informed on the risk and benefits of the research to enable them to make an informed choice. Risks such as harm, invasion of privacy or threat to dignity, benefits such as gaining new knowledge and informing policy.

Participants were informed prior to consent being obtained regarding the reasons and benefits for the research study; that very little is known about why homeless women and dependent children have difficulty in accessing healthcare services and that the information provided will help to establish ways of improving the accessible of services. The rigour of the research process was explained in lay terms to each participant, whereby explaining

that the design of the research had been checked by a panel of experts and been through an ethics review as stipulated by research ethics and governance (Welsh Government 2009a). Those who agreed to take part were issued with an information pack, which consisted of an information sheet and a consent form (see Appendix 4). The consent form was signed prior to the interview being undertaken. Participants can often find a therapeutic effect when unburdening themselves during the interview process, especially when discussing quite emotive issues. Similar findings about the 'therapeutic' value of these experiences have been found in other studies (Taylor et al. 2007). In the literature Lowes and Gill (2006) identified that allowing people to talk freely and openly about their situation and being listened to, was helpful.

Freedom to withdrawn from the research at any time allows the participants freedom of choice and respects their autonomy. Where a participant becomes upset and emotional during the interview or after, the interview would be discontinued and support would be offered. The type of support offered would be professional support if the participant was agreeable or offered social support, such as support workers, friends or family.

5.3.2: Negotiating a non-threatening space

'The dignity, rights, safety and wellbeing of participants must be the primary consideration in any research study,' as stipulated by the Research Governance Framework for Health and Social Care in Wales (Welsh Government 2009a, pp. 11). The risks may be reduced by the researcher being open and reflexive in relation to their professional position, and in ensuring that the participants are fully informed before they consent to take part in the study (Richards and Schwartz 2002). There is a potential for harm and risk to the participants in relation to qualitative research (Dickson-Swift et al. 2007). From an ethical stance, Beneficence, a duty to act in the participant's best interest and non-maleficence, to do no harm must be considered before undertaking any research with individuals.

Research that potentially poses a threat to those involved, or emotionally taxing to participants is classed as 'sensitive research' (Dickson-Swift et al. 2008). This is especially evident when undertaking qualitative research with vulnerable people because of the nature of data collection such as in-depth interviews. The topic in question homeless women with dependent children is classed as sensitive research in view of their vulnerability and the emotive nature of their situation. Brannen (1988) suggests when undertaking such sensitive research to allow the topic in question to emerge gradually throughout the interview. To let the participants define their problem on their own terms without the researcher defining the problem or prejudging the issue in question. IPA methodology fits closely with this ethos by the researcher making sense of the participant making sense of their situation (Eatough et al. 2008).

These personal experiences can be seen as sensitive, as they have the potential to evoke emotional responses and can have implications for the researcher and the participant (Johnson and Macleod-Clark 2003). The information is personal to the participant, they are allowing the researcher into their lives and the participant should be respected. A study by Dickson-Swift et al. (2007) exploring the challenges faced by researchers undertaking sensitive research, purports to the willingness of the participants in sharing their personal information with the researcher. A decision was made that my professional identity would not be disclosed, that of health visitor. It was disclosed that I was a lecturer from the University. In not divulging this information, I hoped the participants would be open and honest about their experiences of accessing health care services. As all of the participants had dependent children, they would have previously or still be receiving health visiting services. I hoped to capture some of their views on this service as well as other primary and secondary care services. The Women may have refused to talk to me if they knew I was a health visitor because of their vulnerability, maybe fearful that the children would be taken into care such as safeguarding referrals if they disclosed risky behaviour. They may prejudge the reasons why I was interviewing them and be less honest and more guarded in their responses if they did agreed to go ahead with the interview.

From a researcher basis, I also had to be careful that I did not take on the health visitor role and try to offer help and support to these women. I found this very difficult in staying neutral, as my instincts and experience made me want to reach out to them from a professional perspective. I had to really concentrate and remind myself internally that I was a researcher and not a health visitor.

Other sensitive factors in relation to the participant was not considered fully by the charitable organisation, they insisted that the interviews be undertaken in their offices. Although using the offices as a venue could have been considered if the women were given a choice whether to be interviewed at home or in the offices. Some of the women may have opted for this venue, as there was childcare facilities. Interviewing all three in succession with limited opportunity to reflect on each interview affected the quality of the interview. I felt the discussion did not flow freely, one of the women seemed to be guarded in what she disclosed. There may be numerous reasons why this participant did not want to fully engage. The participant was a victim of domestic abuse; her child was sitting alongside as he refused to stay with his siblings and the support worker in the adjoining room. She may not have wanted to become emotional or to discuss experiences when her child was sitting alongside, or she was not comfortable in relaying her experiences in this environment. It may have been too soon and too raw for the participant to make sense of her experience. Many prompts were used to try to get the women to be open about their experiences. Although I did get an insight into the women's experiences of homelessness and how they accessed healthcare services, these interviews were shorter in length. In view of the interviews being scheduled to run concurrently, it did not give me the opportunity to reflect and adjust the questioning or think about other prompts to use between interviews.

A researcher has a duty to listen without interruption to validate the experience of the participant. These women have dependent children and could inadvertently disclose information regarding their children such as abuse or their own drug taking behaviour. Therefore, the threat of sanction is

possible in these circumstances. The researcher was aware of these possibilities and criteria was put in place to deal with the issues. There were no concerns raised during the interviews that placed the children in danger or need of protection. Although there was disclosure of drug taking previously by two of the participants, they were no longer using drugs when the interviews were undertaken.

Homeless women have experienced stressful situations and may have mental, as well as physical health needs (Vostanis 2002; Tischler et al. 2007; Tischler and Vostanis 2007) the consequences of this may not have healed and could be still raw but hidden. The interview process may bring these feelings of despair and anguish and rage to the fore resulting in the participant experiencing the emotional trauma once again (Paradis 2000). Participants were informed they could withdraw from the research study before, during or after interview. This is in accordance with research governance and ethics (Welsh Government 2009a). Information was given to the participants on who to contact if they become distressed by the interview such as 'counselling service'. Participants were given the name and contact number of an independent person from the University, (school ethics contact) if they were unhappy about the research undertaken and wish to make a complaint. Participants were made aware that any questions they may not wish to answer for any reason would be acknowledged by the researcher. All information has been kept confidential however, the participant can share information with someone else if they so choose.

I monitored for signs of distress during the interviews and no pressure was put on the participants to answer questions. Where distress was evident, the interview was stopped and only resumed with agreement from the participant. It was made clear to the participant that the interview could be discontinued at any point and made null and void or resumed at another date and time if so wished. One of the participants became distressed during the interview, the interview was paused to enable the participant to recover and was offered to stopped the interview or postpone until a later date. The

participant wanted to continue, and was offered a referral to an appropriate professional, such as the community mental health nurse or counsellor (Hadjistavropoulos and Smythe 2001). The participant refused the referral, the charity was informed of the participant's distress. Each of the families that were interviewed was offered access to the support worker from the charity or a counsellor and social worker could be accessed through these organisations if they preferred.

I acknowledged that children would be present during the interviews, which could divert attention during the interview process and may influence the questioning and the sensitivity of information revealed. I used professional judgement to ensure that the questioning was sensitive to the needs of the children when present. Where the interviews took place in the charity offices, childcare arrangements were set up and support workers cared for the children in another room with the exception of one of the participants whose youngest child stayed with her throughout the interview as previously discussed.

5.3.3: Anonymity

The interviews were recorded using audio recording equipment loaned by the School research department. Participants were asked permission to record the interviews using this equipment prior to interviews being undertaken. Participants' names were changed during the recorded interviews in line with confidentiality and anonymity requirements. Participants were given pseudonyms, and then referred to by these names throughout the transcription and in the analysis and discussion as suggested by Smith et al. (2009). The audio recordings were electronically stored onto a computer that was password protected. (The recordings were erased from the audio recording equipment once the recordings were stored onto the computer). These recordings were then transcribed onto the same computer and filed again these were password protected. The recordings will be kept in password protected files until the research has been completed and will then be destroyed in accordance with the Caldicott principles of data protection and the University requirements for data storage, which is 15

years for public health research (Cardiff University 2018). Electronic documents will be stored on a secure site within the University and will be password protected. Information that is stored on USB sticks has been encrypted.

5.4: Data Collection

In depth, interviews were chosen as the most suitable method of data collection for this study, as it allows the participant to tell their story in their own words and is supported by IPA (Smith et al. 2009). Three previous research studies using IPA have undertaken semi structured interviews as their method of data collection (Dibsdall et al. 2002; Crouch and Wright 2004; Hale et al. 2006). The advantages of using semi-structured interviews can facilitate empathy and rapport and tends to produce richer data (Denzin and Lincoln 1998). An interview schedule was developed (see Appendix 5) setting out questions to be asked that would allow the research question to be answered (Smith and Osborn 2007). The order of the questions was constructed that would best suit the participant however, the question order did change during the interviews and other prompts used as is supported by Smith et al. (2009). The questions were discussed with my supervisor and were piloted using a colleague to role-play being a homeless person. Some questions and prompts were re-written after the pilot as there were too many questions and some were asking similar questions. These questions were written in accordance with IPA recommendations.

When undertaking the first interview and being a novice researcher, I tended to stick to the questions as they appeared in the schedule however, I did use different prompts to delve deeper into some points that were made by the participant. On reflecting after the interview, I only used the schedule as an aide memoir for the next interview and allowed the discussion to flow and picking up on relevant points where appropriate. I listened more intently to the participants' experiences and probed more to enable them to make sense of their experiences of being homeless. One participant stated that discussing her situation over and over to healthcare professionals was "a nightmare", so I asked her how it made her feel. The participant then

reflected on how this made her feel and gave more insight into her relationship with healthcare professionals.

Participants were contacted through two different third sector organisations, with different processes for each organisation. The first organisation agreed that I would contact each of the two participants by telephone to arrange a suitable time and date to undertake the interview. The interviews for these participants were held in their homes. There were delays in carrying out both of these interviews, on arrival at the first interview, scheduled at midday the participant was in bed she had forgotten about the interview. In hindsight, I should have contacted her the previous day as a reminder. A new date and time was arranged for the following day. On arrival, the participant was at home and happy to be interviewed. The second of the participants was not at home when I arrived, (she was contacted the previous day as a reminder and agreement that the day and time was still convenient). I attempted to contact her by telephone and left a message. The participant returned my call later that afternoon and apologised. She enquired whether it was convenient for me to return to her home that day and undertake the interview. This was agreed, when I arrived at her house for the second time that day, she was again not at home, while getting into my car I received a phone call from the participant asking me to wait; she was at a neighbours and would be there shortly, where the interview then took place.
The other three participants were currently in temporary accommodation, the charity arranged for the interviews to be undertaken in a room in their local offices and their support workers would care for the children while the interviews were taking place.

The interviews ranged from 30-45 minutes, and were audio recorded using a digital MP3 player with permission from the participants. This method of recording is efficient and allowed me to listen intently and observe the nuances and expressions that can be missed when taking notes. I became very aware of their reactions when the discussion led them to reflect on their feelings and experiences, this became quite emotive for one of the participants and she got very tearful and upset. The interview resumed at the

participant's request. When the recorder was turned off, she apologised for getting emotional and stated that she did not realise how much the experience of being homeless affected her.

There were interruptions during the interviews, children coming and going as to be expected, this did lose the flow of the conversation slightly, but did not cause any other problems. I was able to pick up the thread of the discussion. What I was not fully aware of was my body language, I did try to stay neutral and was sensitive to the emotions of the participants and tried to convey this by touch and reassurances. The stories were filled with emotions and these emotions were evident in the participants, I become very emotional listening to their experiences. Notes were not taken during the interviews, as this would have distracted me from listening to the participant and exploring some points in more depth. However, journal notes were written down straight after the interview including my observation of the interview, body language and emotions of the participant during the interview and how I felt about the process. This also enabled me to reflect on my own values and judgements and to try to remain subjective when asking prompts. The audio recordings were transcribed verbatim including pauses, emotions and hesitations.

The first interview question was to set them at ease and to establish a trusting relationship during the interview. This involved them telling their story about becoming homeless and allowing them to talk freely about their experiences. During this exchange aspects of the conversation could be drawn out more by asking 'how did you feel', 'what were you thinking' to get more depth to the discussion and to try to gain a clear understanding of their experience. There were moments of silence where the participant took time to organise their thoughts before answering the question or enlarging on the discussion point.

5.5: Data Analysis
Smith et al. (2009) advocates using a step-by-step process especially for a first time researcher using IPA. Each of the interview recordings was

transcribed verbatim; one of these initial steps is the close reading of the transcripts, alongside listening to the audio recordings. Each interview recording was listened to on its own and together while reading the transcript, to allow for immersion into the lived experience of the participant to gain a better understanding of their experiences of being homeless.

5.5.1: Individual case analysis

While reading and listening to the transcripts notes were made on observations recollected from the interview. Anything of interest was also noted from the transcripts, which helped in gaining a better understanding of the participant's experience. It is important that the researcher remains objective and does not make assumptions during this process or allow insider knowledge to influence the analysis. In engaging with the transcript, descriptive comments were noted alongside the transcript dialogue, which remain as close to the participants meaning from a phenomenological perspective. The use of language used within the transcripts was also noted and more exploratory comments made from a conceptual analysis of the transcribed material.

The next step in the process of analysis is to develop emergent themes. The data was reorganised which fragments the flow of the transcript, this represents the hermeneutic circle where the whole is divided into a set of parts, these parts then come back together when writing up the analysis (Eatough and Smith 2006). The emergent themes are made up of phrases that reflect the words of the participant and the researcher's interpretation. The list of emergent themes for each of the interview transcripts are considerable and unmanageable in this state so the next step was to make connections across the emergent themes. These themes were clustered together according to similarities or related meanings. Smith et al. (2009) suggests that not all of the themes will be used and some can be discarded. This was apparent during the clustering of the themes; some of the emergent themes did not fit with the research question and were set aside.

Patterns between the emergent themes were identified and these new themes are called super-ordinate themes. This grouping of emergent themes by putting similar themes together and identifying a new name for the bundle is called abstraction (Smith et al. 2009). The sub-ordinate themes for the first participant – Emily, are 'emotional pain, drinking all the time, mental ill health, loss of possessions, loss of home, being judged, being powerless'. In funnelling down in this way, the themes are reduced further to identify super-ordinate themes. The super-ordinate themes for this participant being 'wellbeing, Loss and Being done to' (Appendix 6). Other means of developing super-ordinate themes are by using the emergent theme as a super-ordinate name and bringing the bundle of similar themes together in this way, which is classed as subsumption. Some themes were formed by identifying the contextual components (Smith et al. 2009). For example, the effect of being homeless lead to a series of 'being done to' such as being powerless, negative attitudes, othering and being judged. Another way of establishing themes is the frequency or numeration of a theme that is evident throughout the transcript. The frequency can demonstrate the importance of a theme in this way. However, a theme, which is only identified once, can still be classed as an important theme where particular language or metaphors are used (Smith et al. 2009). Some of the themes were dropped as they did not fit into the bundles and the emphasis was weak within the transcript. Smith et al. (2009) states that 'less is more' the fewer the themes the more depth of analysis. The development of emergent and super-ordinate themes was undertaken by funnelling down in this way for all of the participant's transcripts, on an individual basis. This resulted in the development of four super-ordinate themes, which relate to 'Wellbeing, Being done to, Loss and Social Exclusion.

5.5.2: Patterns across cases

When all the transcripts had been analysed and the emergent themes and super-ordinate themes identified, a table was collated of the themes identified for all the transcripts. This next stage identifies patterns across the cases, of shared themes or higher order concepts. Themes were recognised across the participants in relation to loss of home and loss of identity, which

also contributed to their feeling socially excluded when attempting to access healthcare services. Health issues especially mental ill health affected the women's day to day functioning and that of their children. These participants felt judged by society and powerless because of their change of identity when becoming homeless.

5.6: Summary

Social constructivism is where individuals construct and make sense of their world through social interaction. The combination of IPA and social constructivism are interlinked where both is interpretivist and focuses on how the social world is interpreted by those who are involved in it. IPA is a qualitative approach that is used to explore how people make sense of their experience, in this study how women with dependent children make sense of being homeless and living in temporary accommodation. The participants were recruited from two homeless charitable organisations, after ethical approval was granted. Informed consent was obtained from each of the participants and the research was fully explained before consent was agreed. Sensitivity and understanding of participants needs prior to and after the interviews has been explored and acted upon. All data and confidential information such as recordings and written material was kept in password-protected files and locked cabinets. Semi structured interviews were undertaken with a sample of five participants; these interviews were transcribed and analysed using the IPA process.

The IPA process to analyse the interviews will be explored in detail in Chapter 6, where the descriptive data analysis will be undertaken.

PART TWO: THE WOMENS' EXPERIENCES

Chapter 6: Descriptive Data Analysis

In order to address my research question of the experiences of women who are homeless and living in temporary accommodation with dependent children and the barriers in accessing health care services. Interpretative phenomenological analysis was chosen to interpret and analyse the interviews, which was discussed in more detail in the previous chapter. Interpretative phenomenological analysis in summary considers three areas, firstly phenomenology in exploring the description of what it means to be homeless. Hermeneutics, the interpretive element or in the case of IPA, a double hermeneutic where the participant is trying to make sense of their lived experience of being in temporary accommodation and accessing health care services. The interviewer is trying to make sense of what being homeless and accessing healthcare services is like for the participant (Eatough et al. 2008). This interpretative element identifies the relationship between the part and the whole. Smith et al. (2009) explains the whole cannot be interpreted without the part and the part cannot be interpreted without the whole. This becomes evident within the descriptive analysis, as the extracts cannot be interpreted in isolation, but as part of the whole interview transcript. The hermeneutic circle is the building block of the interpretation of the participant's experience, this begins with the descriptive element as explored below and then a more critical exploration based on deeper interpretation as seen in (Chapter 8).

This chapter will begin with a brief biography of the participants, followed by a descriptive discourse of the women's experiences, explored on a case-by-case basis and supported by direct quotes. A table identifying the sub-ordinate and super-ordinate themes for each interview will then be included. All names of participants have been changed to protect their confidentiality.

6.1: Emily
Emily has two teenage sons aged 11 years and 13 years, she has been separated from her partner for a number of years. Emily and her sons were illegally evicted from their home and were only given four weeks' notice. Initially they stayed with Emily's mother in a two bedroomed flat, within two

weeks they were placed in temporary accommodation, a three bedroomed house. The family remained in temporary accommodation for nine months before they were permanently housed. Emily described her periods of depression and substance misuse, stating she was drinking heavily again as a way of coping while she was in temporary accommodation. Emily was aware of her problem and felt her drinking was now under control. When interviewed Emily had been permanently housed for three years, this interviewed explored her experiences whilst in temporary accommodation.

Emily began her interview by telling her story of how she became homeless; the emotional pain that she endured becomes evident throughout the interview.

> *"I was illegally evicted from the home I was living in, lady gave me four weeks' notice and she was supposed to give me eight. Left me with no choice but to go to our local housing advice centre…I then moved in with my mother in a two-bedroom flat with both my boys. We were there for about two and a half weeks and they moved me into a three bedroomed temporary house, um I was only supposed to have been there for a couple of months and I was there for about eight or nine in the end."*

Emily seemed unsure of why she was evicted from her home and seemed to think she was made homeless unlawfully. I did not ask Emily why she thought her eviction was illegal. Emily believed becoming homeless was out of her control.

> *"During the Christmas period the pipes in the house I was in froze and burst in my kitchen. I was staying with my sister for a week over Christmas with the kids, celebrating all together. Came home, didn't think to pop back, the heating was on, gas was on while I was away and it was three feet deep in snow and when I opened my front door I was two feet deep in water, it ruined everything. I lost everything downstairs. I couldn't stay there my youngest and I are both asthmatics it didn't matter how much I tried, I just couldn't dry it out enough, it was too damp for us to stay there so I was stuck with my sister then for another month."*

Emily's recall of the experience was that there was a heavy fall of snow; her perception was that it was three feet, and that there was two feet of water in the house due to a burst pipe. Emily seemed unhappy in having to stay with her sister while her temporary home was made habitable again. Emily referred to her loss of possessions where the water damaged all the

downstairs area. Emily expressed the meaning of home in the following extract.

> *"It was a really nice house and all that but it still felt, it wasn't mine all my belongings were there, what I'd managed to take, you know, with me, nothing was mine, it didn't feel like mine, I never said let's go home, it was let's go back to the house, it wasn't home, it was a house because it wasn't mine".*

Ownership of the house seemed to be an important aspect of whether a house is a home as experienced by Emily. She seemed to suggest that her temporary accommodation has no feeling of homeliness, even with her own possessions scattered around.

> *"Being a manic depressive as well, on top of that it was just more than I could cope with, it pushed me over the edge a bit. Then I moved in here I just went a little too far off the rails and it took me a while to pull myself back from that."*

Emily openly discussed mental illness and she did not seem embarrassed or hesitant when admitting she suffers from this condition. The use of language that Emily used was interesting, '*it pushed me over the edge' and 'too far off the rails*,' she feels out of control, unstable. Although Emily was now in permanent accommodation and she referred to the fact that the emotional impact did not improve instantly, it took time.

The interview was encompassed by Emily's emotional anxiety and how her mental illness affected her coping ability.

> *"Take my mental health I got very good at not showing people how I was really feeling the true state of me then, just how far everything in my life had slid to a point where I just couldn't pick myself back up, it was still very easy to hide it."*

Emily was hiding her feelings from people, she wanted to keep her mental health problems private, and by showing the world, she is coping and hiding her true state of mind. Emily is aware that her children witness her emotional turmoil as can be seen in the following extract:

> *"It might have been easier if the kids had been younger, they wouldn't have understood what was going on so much and known just how precarious things were. So they were stressed, I was stressed, they were feeding off me, um because there were times that as much as I could hide it, nobody else could see it but the kids were with me 24/7 and they'd hear me crying*

> *or they'd notice me standing in the kitchen staring at something*
> *real sharp, wanting to hurt myself because it was just so much."*

Emily's emotional pain was expressed and her son's also witnessed her pain and suffering. Emily suggested that her son's stress was a consequence of seeing her stressed, and not as a result of their situation. As epitomised in her statement *'they were feeding off me.'* This was a distressing time for them as acknowledged by Emily. In the extract above, Emily hid her emotions from the outside world. She openly admitted that it was impossible to hide her emotions from the children as they were always with her. Emily thought about self-harming, she stated '*staring at something real sharp, wanting to hurt myself'*. Emily's emotional state was exacerbated by her mental illness as described below.

> *"There were times when I'm not 100% and it's a lot easier to*
> *hide from people. Where you're in a constant state of stress like*
> *I was its impossible, everybody can see it, can see the, you*
> *know you're on the verge of that mental breakdown, just waiting*
> *for you to tip over."*

Emily suggested that her mental health was not always good; previously Emily stated that she has manic depression. She talked about *'everybody'* and '*just waiting for,'* by whom is not clear whether Emily was referring to family, friends or the public. Emily suggested she no longer has control over her mental health, the consequences of her mental illness was evident below, she explained the affect it had on her health.

> *"I'd stopped leaving the house completely, I wouldn't answer*
> *the door, I wouldn't answer the phone. Even now going outside*
> *is still a struggle for me, I have to be accompanied even to the*
> *little shop behind me... because I don't feel safe, I don't feel I*
> *can cope, I have panic attacks."*

In view of the emotional pain that seems to engulf Emily's life, she referred to how it continued to affect her daily life. Emily's withdrawal from society, unable to face the world. The emotional pain and mental illness surrounded the whole interview and seemed to control Emily's life, so much, so that she turned to alcohol.

> *"I was drinking every night and not just one or two, but glasses*
> *of wine more like one or two bottles, um or a bottle of vodka,*
> *whatever I happened to fancy at the time but it would be one or*
> *the other."*

The extent of her drinking alongside her mental illness was the only way that Emily described how she coped with the emotional rollercoaster that she felt was taking over her life. Emily explained why she turned to alcohol.

> *"Helped me not to care, helped it not matter of all the stuff that was going on, of how I was feeling, it was easier to suppress if I was drunk. When you're sober, you've got to face it, when you're drunk nothing matters any more. Nothing seems so big, nothing, and then when you're sober you're constantly thinking about, it's all you can think about and it's just, it's overwhelming but when you're drunk none of it matters…. then you can laugh and you can smile and you can be human."*

Emily did not have to face up to reality when she was drunk, she suggested it was easier to block out the emotions and pretend it was not happening. Emily felt carefree when she was under the influence of alcohol. She saw the alcohol as a crutch and wanted to feel normal, which was something she was unable to feel when she was sober. The alcohol for Emily was giving her some control over her emotions, having control was important to Emily as we can see in the following quote.

> *"Where you'll do anything to have a small amount of control, physical pain is a lot easier to control than emotional pain. So it was a way of boxing up what I was really feeling and squashing it in, putting it one side and dealing with this pain and not ever having to open that box and deal with that again"*

Emily talked of being able to have some form of control over her situation and state of mind. She was still toying with the idea of self-harming; she talked about physical pain as something that can be controlled. Emily used the term '*boxing up'* she wants to compartmentalise her feelings, by putting them at the back of her mind, not having to face them or deal with them, but blocking them out.

Emily needed to obtain medication for her manic depression, she explained the negativity she experienced when attending the GP practice.

> *"they want me to tell them how I'm feeling and they never understand and you go down there and you never know, you know who you're going to see, you don't see the same doctor every time and they all look at you like you're making it up and then you're constantly re-telling the same story so it's easier to avoid them."*

Emily's experience of visiting the GP practice had a negative effect on her. Her expectations were very different to what she experienced. Emily referred to *'they'* but who the *'they'* are who she was referring to were not explicit in the interview. It could be the GP's or other healthcare professionals. She implied '*they want me to tell them'* as opposed to Emily voluntarily offering the information, that she has no control over the situation. She goes on to say '*they all look at you,'* Emily described that she felt she was being judged by the way she was looked at and how they responded to her, she was being treated differently to other patients because of her temporary status.

> *"I was put in a position where I felt like I couldn't seek help because they made everything feel worse you know, to sit there and have somebody you know, the eyebrows go up and yeah alright, whatever, and I think how the hell do you know how I feel, how can you sit there and judge me…Explaining myself time and time again just, you sit there and what's the point, why as I talking to you people when nobody is listening, you are all passing me from pillar to post."*

Emily described feeling uncomfortable seeking help; she felt she was being judged because of her situation. She observed the body language that is portrayed. There was an element of defeatism, where she stated '*what's the point,'* the retelling of her story she suggested is pointless as the person is not listening to what she has to say.

In summary, the temporariness of Emily's homeless situation and her mental illness had taken its toll on her emotions. Emily had subjected herself to harmful coping strategies such as alcohol and has even contemplated self-harm. The loss of Emily's home has left Emily feeling stressed and in a situation that she has no control over.

Table 5: Super-ordinate themes and extracts from the interviews - Emily

Super-ordinate	Wellbeing	
Sub-ordinate	**Quote**	**Line. No**
Emotional Pain	Take my mental health I got very good at not showing people how I was really feeling the true state of me then, just how far everything in my life had slid to a point where I just couldn't pick myself back up, it was still very easy to hide it.	4.1-4.3
		5.4-5.9

	It might have been easier if the kids had been younger, they wouldn't have understood what was going on so much and known just how precarious things were. So they were stressed, I was stressed, they were feeding off me, um because there were times that as much as I could hide it, nobody else could see it but the kids were with me 24/7 and they'd hear me crying or they'd notice me standing in the kitchen staring at something real sharp, wanting to hurt myself because it was just so much.	
Drinking all the time	I was drinking every night and not just one or two, but glasses of wine more like one or two bottles, um or a bottle of vodka, whatever I happened to fancy at the time but it would be one or the other. Helped me not to care, helped it not matter of all the stuff that was going on, of how I was feeling, it was easier to suppress if I was drunk. When you're sober you've got to face it, when you're drunk nothing matters any more. Nothing seems so big, nothing, and then when you're sober you're constantly thinking about, it's all you can think about and it's just, it's overwhelming but when you're drunk none of it matters…. then you can laugh and you can smile and you can be human.	10.1-10.3 11.1-11.7
Mental ill health	Being a manic depressive as well, on top of that it was just more than I could cope with, it pushed me over the edge a bit. Then I moved in here I just went a little too far off the rails and it took me a while to pull myself back from that. There were times when I'm not 100% and it's a lot easier to hide from people. Where you're in a constant state of stress like I was its impossible, everybody can see it, can see the, you know you're on the verge of that mental breakdown, just waiting for you to tip over. Where you'll do anything to have a small amount of control, physical pain is a lot easier to control than emotional pain. So it was a way of boxing up what I was really feeling and squashing it in, putting it one side and dealing with this pain and not ever having to open that box and deal with that again I'd stopped leaving the house completely, I wouldn't answer the door, I wouldn't answer	2.10-2.12 3.17-3.20 6.5-6.8 17.36-17.40

	the phone. Even now going outside is still a struggle for me, I have to be accompanied even to the little shop behind me. ….. because I don't feel safe, I don't feel I can cope, I have panic attacks.	
Super-ordinate	**Loss**	
Sub-ordinate	**Quote**	**Line. No**
Loss of possessions	During the Christmas period the pipes in the house I was in froze and burst in my kitchen. I was staying with my sister for a week over Christmas with the kids, celebrating all together. Came home, didn't think to pop back, the heating was on, gas was on while I was away and it was three feet deep in snow and when I opened my front door I was two feet deep in water, it ruined everything. I lost everything downstairs. I couldn't stay there my youngest and I are both asthmatics it didn't matter how much I tried, I just couldn't dry it out enough, it was too damp for us to stay there so I was stuck with my sister then for another month.	1.11-1.17
Loss of home	It was a really nice house and all that but it still f[ ]wasn't mine	2.2-2.3
	all my belongings were there, what I'd managed to take, you know, with me, nothing was mine, it didn't feel like mine, I never said lets go home, it was lets go back to the house, it wasn't home, it was a house because it wasn't mine.	3.12-3.14
Super-ordinate	**Being done to**	
Sub-ordinate	**Quote**	**Line. No**
Being judged	They want me to tell them how I'm feeling and they never understand and you go down there and you never know, you know who you're going to see, you don't see the same doctor every time and they all look at you like you're making it up and then you're constantly re-telling the same story so it's easier to avoid them.	13.4-13.7
	I was put in a position where I felt like I couldn't seek help because they made everything feel worse you know, to sit there and have somebody you know, the eyebrows go up and yeah alright, whatever, and I thing how the hell do you know how I feel, how can you sit there and judge me…Explaining myself	14.1-14.8

	time and time again just, you sit there and what's the point, why as I talking to you people when nobody is listening, you are all passing me from pillar to post	
Being powerless	I was illegally evicted from the home I was living in, the lady gave me four weeks' notice and she was supposed to give me eight. Left me with no choice but to go to our local housing advice centre……I then moved in with my mother in a two-bedroom flat with both my boys. We were there for about two and a half weeks and they moved me into a three bedroomed temporary house, um I was only supposed to have been there for a couple of months and I was there for about eight or nine in the end.	1.1-1.6

6.2: Amy

Amy is a single parent with two children; they lost their home due to a fire. Her daughter Kathy was 6yrs at the time of the fire and son Mark who was much younger and suffered from hypermobility of his joints. They had nowhere to live and were put into temporary accommodation. Amy described that she was moved 28 times in six years. The first temporary accommodation they were in, drug users lived upstairs and broke into their accommodation and robbed them. They were eventually permanently housed and her daughter was raped so they were moved into alternative temporary accommodation. The family of the abuser found them and caused trouble for Amy and her children, so subsequently they had to move again. Amy and her children were moved to different locations around the UK, until they were again permanently housed. At the time of interview, Amy had been in permanent accommodation for almost two years. Here Amy describes her ordeal:

> "We finally got a permanent address and then my daughter was raped and the family came after us so we were put into temporary accommodation, again, moved around a lot, the family found us and we ended up moving to…. And the family came after us so we were put, again moved around a lot the family found us and we ended up moving to .... and they found us in …… and we had to move here. So in total it's 28 moves in six years".

It is unclear in the narrative how many times Amy and her children moved after Kathy got raped and was followed by the abuser's family. They were

tracked down by the family each time they moved. It is unclear how long they were in each area before the abuser's family found them. This is how Amy remembered the situation.

Throughout the interview, Amy often referred to her frustration in getting healthcare services for herself and her children. The attitudes of healthcare personnel and the stigma of being in temporary accommodation did not deter Amy from battling on regardless in trying to get access to healthcare services.

> *"It's an uphill battle with every service that you try and get to when you're in temporary accommodation, as soon as you mention the word temporary accommodation you can sort of almost see the shutters coming down as if to say oh-oh, no need to worry too much about them, obviously not necessary because they are in temporary accommodation. It's like a stigma if you like and the don't know why you're in that's what gets me, they've no idea why you're in, but as soon as you, it is like having a stigma attached to you."*

The struggle that Amy was suffering in this extract is highlighted by the use of the metaphor, '*uphill battle*' to show the effort it had taken in her fight for services. Amy felt the rebuff she got when people knew she was temporary housed, she used an interesting phrase, '*can almost see the shutters coming down.*' This appeared to have made Amy feel excluded, not a priority that she was treated differently than if she was in permanent housing. Amy referred to being labelled; she used the word '*stigma*' to explain how she was made to feel because she lived in temporary accommodation.

Being a temporary resident has its drawbacks as Amy alludes to below.

> *"Trying to get a doctor, because we didn't have as such a permanent address because we didn't know how long we were going to be anywhere they wouldn't take us on as patients, we'd have to every time we needed a doctor's appointment we'd have to fill out a temporary form and they'd see us as a temporary patient but it meant that you never get to see the same doctor so you'd have to explain everything time and time again which was just as distressing for me having to go over it constantly."*

The impact on her mental health is reflected; when she described having to repeat her story over and over again each time, she visited the doctor.

> *"Well I suffer from depression anyway and one of the problems I was finding was actually trying to get medication because as I said with moving around so much, you don't have a permanent doctor and I'd say look I've been on these tablets for a long time. I need them otherwise something serious is going to happen and I'd be fighting all the time, just say well get my notes, they'll be in my notes, oh yes well they haven't been passed on and it was constantly, every time, oh well we haven't got your notes, are you sure those are your tablets you're taking. In the end I used to take a photocopy of the prescription and carry it around with me"*

In the previous extract it was important to Amy that she maintained taking her medication for depression, as she stated, '*something serious is going to happen*' if she stopped taking the medication. Amy implies the ongoing battle she had with medical staff and not being believed.

Amy appears to be reflecting on the judgemental attitude that she had been subjected to, this is a prominent feature in many of the extracts. Amy referred to her parenting and being a better mother, Amy was making the link between her feelings of failure as a mother, and what people were thinking. Amy voices this as '*you get the impression*' of what was being said, not that this had been stated, it is Amy's assumption.

> *"I know a couple of times they used to make me feel pretty awful, when speaking to them, you know it was always oh well if you were, you get the impression well if you were a better mother you'd make sure you got the appointments wouldn't you. You know and it's just stuff like that so if you've got somebody that's pretty low and doesn't have a sense of face within them, somebody turning around and saying that to them is going to be absolutely diabolical and they would probably give up."*

Again as shown in the extract below the attitudes of healthcare personnel towards Amy as she described.

> *"I used to get questioned well, you know, how many times are you going to use this as an excuse, it's not an excuse, it's the truth, you know we moved 28 times in five years, not through any fault of our own, but you know, a couple of times it was oh again? Yes, sorry, again and you could hear it in their voices, oh yes ok, whatever and you think no, it's not okay, whatever, if I'd have known my son was due there, he would have been there."*

Amy picked up on the staff's tone of voice, and some of the nuances that they did not believe her such as, '*as an excuse*' 'oh' '*yes ok whatever*'. This

is how she remembered it. From the language that Amy used, it suggested she was becoming annoyed by the healthcare personnel's attitude towards her and makes her case forcibly by stating they would have attended the appointment. It was evident in the next extract where a similar pattern of judgement was presented.

Below Amy described why she was not believed when her children failed to attend appointments.

> "It doesn't help the fact that when they do finally write to you and you don't get in touch because you're no longer living there, that sort of just boosts their thing oh well you see temporary accommodation they don't bother turning up when we do get in touch with them. They don't bother finding out why, they just assume that you haven't bothered to turn up and the number of times I'd phone them and say but I've moved so I didn't get the letter and our GP should have written to you. Oh well we haven't received anything so it's your fault. But they're very quick to put the blame back on you, rather than accepting that okay, there may have been a lack of communication between one service and the other."

Amy was trying to make sense of the situation, the word '*they*' was used again in this extract. The projected meaning appears to change, firstly Amy is referring to homeless people collectively as '*they,*' and secondly she referred to healthcare personnel as *'they.'* Amy speculated that the assumptions held by healthcare personnel, about the non-uptake of services by homeless people, is made credible in Amy's situation, she stated '*just boosts their thing.'* Further, on in this narrative Amy questioned the blame that was being inflicted on herself by the healthcare personnel and turns this around by finding fault in the system.

> "One section had my correct address and yet so my daughter's address has been correct and yet the physio for my son has had the wrong address and that's within the same hospital. So if it's like within the same establishment how on earth is it supposed to when you've got all these different services, so it's just a nightmare, it's very frustrating and I can feel for anybody that has to go through that. Fortunately, I'm the sort of person that doesn't give up, I tend to fight especially when I know it's needed and especially if it's for my children I will fight and I did. There were times when I despaired and thought I just can't do this anymore, I cannot fight any more because I just seem to be fighting against everything and everybody and just getting shoved back all of the time."

In this narrative, there is a sense of Amy's exasperation with hospital administration. She makes a judgement that if one service cannot get the addresses correct, then there is little hope where you have services from a range of different providers. Amy used the word '*nightmare*' to determine how traumatic this was for her. She empathises with others who have to endure the same as her. Within the narrative Amy gets fired up, using the expression '*I will fight and I did.*' She also reflected on times when she was not so strong, '*I seem to be fighting against everything and everybody.*'

Amy described the lack of consistency in healthcare personnel in addressing her daughter's needs.

> *"It's not good for my daughter because she struggles to build trust with people, and we'd be changing constantly so she'd just get to know somebody and then she'd have to get to know somebody else, then they either leave or because they do seem to have a high turnover of staff so you know just as she gets to know somebody she can trust and starts talking to them it's oh well we're leaving now you'll have somebody else. Well we have to start all over again, you know building up that trust."*

Amy does not state whom she was talking about here and I did not ask her to clarify during the interview. She talked about '*people', 'somebody'* and '*they.*' When referring to people it is uncertain whether Amy means people in general that Kathy (daughter) has trouble trusting or healthcare personnel. Amy is trying to understand the situation that the healthcare service was in, she was aware of some of the constraints and states '*they do seem to have a high turnover of staff.*' Speaking to someone, she trusted and building up a relationship with a person was difficult for Kathy.

> *"You know in a very big way and I don't think it sort of helps because my daughter's never been allowed to move on from it, so she still needs to see, like I said we had to go to counselling, she still needs them now whereas I think if it had been dealt with at the time she'd have been able to move on and probably wouldn't be in the state she's in now."*

Amy blames '*them*' the counselling service for the delay in getting help for Kathy, she suggested the delay had impacted on her recovery. That her daughter constantly suffers the trauma of the house fire and rape which Amy alludes to when she talked about her daughter not being able to move on. Asking Amy what would have helped, she replied:

> *"Being treated as an individual rather than as you know, for people not to assume you're something just because you live a certain way, I think it would be quite handy to have had sort of like maybe drop in clinics or something like that where everybody could actually go and be spoken to as an individual so you've got one point of contact instead of having to go through every single department."*

The attitudes of healthcare personnel, Amy sees as a priority that needs changing, she alluded to the fact of being '*treated as an individual*' and not as a result of living in temporary accommodation, she wanted to be treated the same as everyone else. The negative attitudes of people were a strong thread throughout Amy's story. Amy felt this service would best understand the needs of people in her situation, as she stated '*everybody could go and be spoken to as an individual*'. Another barrier as perceived by Amy was the inconsistency of being able to see the same health professional.

> *"But it's just a shame that it works out that way because also I've noticed when you're in temporary accommodation you just tend to get put in with any doctor, you don't get to see, like now I can phone up and ask to see the same doctor each time. So every time you're see a new doctor you're having to repeat yourself again and you think well, what's the point. You know there is no point because going there it's making me more upset than if I didn't bother and so in the end I tend to not go, I just shut myself away and get on with it myself rather than go through the stress of having to go and see somebody and having to explain it all again when all I wanted to do was go in and say look, I'm really struggling, what can we do. But because they didn't know what medication I was on or they only had my word for it, it was a case of well why are you on this medication, what's happened to make you feel like this, well I told the doctor this last week and the week before and the week before. I don't want to sit here saying it again".*

The stressful nature of having to explain her circumstances repeatedly as reported here by Amy, which resulted in disengagement with healthcare services. Amy feels let down by the service she is receiving and perceives this as a barrier to accessing healthcare services.

Amy's flight from the rapist and their family, the continually movement from one accommodation to another to safeguard herself and her children demonstrates her strength of character. The interview appears to demonstrate Amy's frustration with the healthcare services for herself and her children.

Super-ordinate	Wellbeing	
Sub-ordinate	**Quote**	**Line. No**
Emotional impact	You know in a very big way and I don't think it sort of helps because my daughter's never been allowed to move on from it, so she still needs to see, like I said we had to go to counselling, she still needs them now whereas I think if it had been dealt with at the time she'd have been able to move on and probably wouldn't be in the state she's in now.	3.43-3.46
Super-ordinate	**Loss**	
Sub-ordinate	**Quote**	**Line. No**
Loss of identity	Being treated as an individual rather than as you know, for people not to assume you're something just because you live a certain way, I think it would be quite handy to have had sort of like maybe drop in clinics or something like that where everybody could actually go and be spoken to as an individual so you've got one point of contact instead of having to go through every single department.	8.1-8.5
Super-ordinate	**Being done to**	
Sub-ordinate	**Quote**	**Line. No**
Being judged	It's an uphill battle with every service that you try and get to when you're in temporary accommodation, as soon as you mention the word temporary accommodation you can sort of almost see the shutters coming down as if to say oh oh no need to worry too much about them, obviously not necessary because they are in temporary accommodation. It's like a stigma if you like and the don't know why you're in that's what gets me, they've no idea why you're in, but as soon as you, it is like having a stigma attached to you	4.10-4.15
	I know a couple of times they used to make me feel pretty awful, when speaking to them, you know it was always oh well if you were, you get the impression well if you were a better mother you'd make sure you got the appointments wouldn't you. You know and it's just stuff like that so if you've got somebody that's pretty low and doesn't have a sense of face within them, somebody turning around and saying that to	4.40-4.45

	them is going to be absolutely diabolical and they would probably give up.	7.4-7.8
	I used to get questioned well, you know, how many times are you going to use this as an excuse, it's not an excuse, it's the truth, you know we moved 28 times in five years, not through any fault of our own, but you know, a couple of times it was oh again? Yes, sorry, again and you could hear it in their voices, oh yes ok, whatever and you think no, it's not okay, whatever, if I'd have known my son was due there, he would have been there.	
Negative attitudes	Well I suffer from depression anyway and one of the problems I was finding was actually trying to get medication because as I said with moving around so much, you don't have a permanent doctor and I'd say look I've been on these tablets for a long time. I need them otherwise something serious is going to happen and I'd be fighting all the time, just say well get my notes, they'll be in my notes, oh yes well they haven't been passed on and it was constantly, every time, oh well we haven't got your notes, are you sure those are your tablets you're taking. In the end I used to take a photocopy of the prescription and carry it around with me	3.2-3.8
Othering	It doesn't help the fact that when they do finally write to you and you don't get in touch because you're no longer living there, that sort of just boosts their thing oh well you see temporary accommodation they don't bother turning up when we do get in touch with them. They don't bother finding out why, they just assume that you haven't bothered to turn up and the number of times I'd phone them and say but I've moved so I didn't get the letter and our GP should have written to you. Oh well we haven't received anything so it's your fault. But they're very quick to put the blame back on you, rather than accepting that okay, there may have been a lack of communication between one service and the other	4.16-4.23
Being powerless	One section had my correct address and yet so my daughter's address has been correct and yet the physio for my son has had the wrong address and that's within the same hospital. So if it's like within the same establishment how on earth is it supposed to when you've got all these different services, so it's just a nightmare, it's very frustrating and I can feel for anybody that has to go through that. Fortunately, I'm the sort of person that	4.24-4.33

	doesn't give up, I tend to fight especially when I know it's needed and especially if it's for my children I will fight and I did. There were times when I despaired and thought I just can't do this anymore, I cannot fight any more because I just seem to be fighting against everything and everybody and just getting shoved back all of the time	1.6-1.9
	We finally got a permanent address and then my daughter was raped and the family came after us so we were put into temporary accommodation, again moved around a lot, the family found us and we ended up moving to…. And the family came after us so we were put, again moved around a lot the family found us and we ended up moving to……. and they found us in …… and we had to move here. So in total it's 28 moves in six years.	

Super-ordinate	Social Exclusion	

Sub-ordinate	Quote	Line. No
Access to healthcare services	Trying to get a doctor, because we didn't have as such a permanent address because we didn't know how long we were going to be anywhere they wouldn't take us on as patients, we'd have to every time we needed a doctor's appointment we'd have to fill out a temporary form and they'd see us as a temporary patient but it meant that you never get to see the same doctor so you'd have to explain everything time and time again which was just as distressing for me having to go over it constantly.	1.21-1.26
Barriers	But it's just a shame that it works out that way because also I've noticed when you're in temporary accommodation you just tend to get put in with any doctor, you don't get to see, like now I can phone up and ask to see the same doctor each time. So every time you're see a new doctor you're having to repeat yourself again and you think well, what's the point. You know there is no point because going there it's making me more upset than if I didn't bother and so in the end I tend to not go, I just shut myself away and get on with it myself rather than go through the stress of having to go and see somebody and having to explain it all again when all I wanted to do was go in and say look, I'm really struggling, what can we do. But because they didn't know what medication I was on or they only had my word for it, it was	9.25-9.35

	a case of well why are you on this medication, what's happened to make you feel like this, well I told the doctor this last week and the week before and the week before. I don't want to sit here saying it again.	
Struggle to build trust	It's not good for my daughter because she struggles to build trust with people, and we'd be changing constantly so she'd just get to know somebody and then she'd have to get to know somebody else, then they either leave or because they do seem to have a high turnover of staff so you know just as she gets to know somebody she can trust and starts talking to them it's oh well we're leaving now you'll have somebody else. Well we have to start all over again, you know building up that trust.	2.21-2.26

6.3: Julie

Julie was 29yrs old and had three children two boys and a girl aged nine, six and two years. Julie and her children became homeless because of domestic abuse; she had no option but to leave her home to keep herself and children safe. Julie was living in England with her partner for 15 years, their relationship was always volatile and the turning point for Julie was after she had been viciously attacked by her partner. Julie was not aware of any services for victims of domestic abuse; the police informed her when she called them after the physical assault by her partner. Julie and her children were currently in temporary accommodation in Wales when the interview took place; they had been in the refuge for three months at the time of the interview.

The interview took place in the offices of an organisation, which was a registered charity to improve the lives of homeless people. Julie seemed really settled in Wales and voiced that she did not want to go back to England. The children seemed happy to play in another room away from Julie while the interview was taking place. Julie smiled throughout, however I felt this was for my benefit, she was trying hard to convince everyone

including me that all was well. Julie stated that the two older children had settled in school, her partner is currently in prison.

Julie felt powerless in the situation she was in and had no option but to leave her home and her possessions.

> "Horrible it was just a complete violation of everything, it's like my home was my home, you know and it was sort of like I had to leave and he could stay, so you know it kind of made me quite angry as well but I mean I had to get from there where me and the children were safe and so I was just sort of riding on that really but it was absolutely horrible."

Julie was aggrieved and frustrated about having to leave her home, she was angry of the injustice that her partner was allowed to remain in the home. She felt violated, her loss of everything, the effect this has had on her life and that of the children.

> "It's the little things that you miss as well and it's just having your own, especially being in a refuge just like not having your own four walls, it plays quite a big part in your life you know, your home is everything, when you lose it you kind of realise what it meant to you."

Julie felt the loss of her home and everything she left behind difficult to accept. She did not appreciate what she had until it was lost. For Julie her life and everything important to her centred around her home. In the following extract, Julie sees herself as different from other residents within the refuge.

> "What like my situation is a bit more different because obviously I've come into refuge, I've got no like issues that obviously you've got other women at refuges who are alcohol dependent, drug dependent, who've got numerous medical sort of things and I don't have any of them so I'm just there to be safe and to keep my children safe and you know to start a new life you know."

Julie appeared to be of the opinion that women who reside in refuges are usually drug and alcohol misusers. She referred to these women as '*other*' to indicate the difference between herself and them. Julie was distancing herself from these behaviours and appeared to want to make clear her reason for being in a refuge. Having an identity was important to Julie as indicted in the interview.

> "Like I'm just there and I'm just another number aren't I just another number, that's how it makes you feel, well makes me feel like that, you know. It doesn't really make you feel like a

> *human, you're just like you know, it's kind of like you don't want*
> *to go and see your GP because it's like you know well just get*
> *on with it, its life, that's the kind of impression I get."*

Julie was trying to make sense of her feelings of why she did not access the GP. She suggested that she felt dehumanised by the way she was treated at the practice. She felt she had no identity, just treated as an object. Julie alternates between '*you'* and '*me*' in the narrative, directing the conversation at myself and then herself, as if she was having a two-way conversation with herself. She was trying to justify why she would rather not go to the GP practice.

The frustration Julie feels when accessing the GP is evident in the next extract.

> *"I tend not to go to the GP which is you know, and you know*
> *when you do go you're like literally, you're so rushed you can't*
> *even have like time to talk to a doctor about anything, you know.*
> *It's like they just sort of rush you and that's what really annoys*
> *me and I just think okay well you know, because they don't really*
> *want to look at you or communicate with you they just want to*
> *write you a script and that's it and then the next one in so yeah it*
> *kind of feels a bit rushed when I go to the GP's to be honest with*
> *you"*

Here Julie felt she had no real opportunity to discuss her concerns with the doctor. There was some repetition of '*you know'* in this extract, where Julie feels there was a shared understanding between myself and her, she wants validity of the points she was making. Julie's impression is that the doctors do not want to talk to her. She used this as an excuse not to go to the practice.

The emotional trauma when faced with a potential diagnosis of cancer was described here by Julie. Julie found a lump in her breast and went to see the GP who referred her to the hospital. The anxiety that Julie felt was evident in her thoughts, which she has reflected on in this extract. She talked about having many questions, but seemed unsure about whom to ask. Julie confirmed the point she was trying to make here by using the word '*yeah,'* she seemed to be having a conversation with herself. She implied that doctors were not good at explaining the facts to patients and patients

accepted what they were told, whether they understood it or not. Julie desperately wanted to talk to someone as she reiterates this within the extract.

> *"When I was going through my scare where I thought I had cancer because there's so much of it in my family, you know I was thinking all sorts of things like who's going to have the kids, what am I going to do when I go to chemo, like about a million and one questions like going around in my head and I wished I had someone to speak to about it, you know because you can't exactly go to your GP and talk to your GP about something like that so yeah, if there was someone that I could have spoken to rather than leaving it to my appointment, yeah that would have been really helpful. Just so someone sort of explains thing to you, because the doctor is just going to diagnose you and they explain but they don't explain, they kind of explain it in their terms, it's like okay and you sort of nod and agree."*

At the end of the interview when the recorder was turned off, Julie began telling me her experience of health visitors when she was living in England. I had permission from Julie to resume and record the interview.

> *"It feels like you don't want to open up to them, you know, or you feel like if you do something wrong then you know, like, would social services be called in, you've always sort of got that worry as well and even when I'm changing a nappy or you go to baby clinic like, when you go and weigh and things like that, like they're watching you all the time, like you're on the edge all the time and you're going to be doing something wrong, nine times out of ten when I'm at home I'm fine, just get on with it, but when I'm around that yeah I just feel like a million eyes just sort of watching me, you know, if you're doing it right or doing it wrong, yeah."*

In this narrative, Julie believed all her actions were being judged, she felt as if she was under surveillance all the time. The uncomfortable feeling Julie had when attending baby clinic was strengthened by the inference to social services being called. Julie suggested that the value judgements here were that her actions must be either '*right*' or '*wrong.*'

> *"Makes me feel like rubbish really, I feel like I'm not doing what I'm supposed to be doing but I know that I am doing it right because the child is happy and healthy and there's nothing wrong with the child but then in your brain because someone is watching over you you know, I don't know it's hard to put it into words, it's just like a feeling and then toward the end of that I stopped going to baby clinic and things because I just felt you know, because they were saying you shouldn't be doing it this way you should be doing it that way and he should be eating like this and I just think well it's all like, every baby is different, you know."*

In the previous extract, Julie implied she was made to feel worthless; she became defensive and argued that she was a good mother. Julie's non-attendance at clinic was a defiant action against the healthcare personnel.

The loss of her home and possessions for Julie was emotional. Julie felt her parenting had been monitored which resulted in her loss of trust towards the health visiting service. Julie wanted support and needed someone to talk to about her health anxieties.

Table 7: Super-ordinate themes and extracts from the interviews - Julie

Super-ordinate	Wellbeing	
Sub-ordinate	**Quote**	**Line. No**
Emotional impact	When I was going through my scare where I thought I had cancer because there's so much of it in my family, you know I was thinking all sorts of things like who's going to have the kids, what am I going to do when I go to chemo, like about a million and one questions like going around in my head and I wished I had someone to speak t about it, you know because you can't exactly go to your GP and talk to your GP about something like that so yeah, if there was someone that I could have spoken to rather than leaving it to my appointment, yeah that would have been really helpful. Just so someone sort of explains thing to you, because the doctor is just going to diagnose you and they explain but they don't explain, they kind of explain it in their terms, it's like okay and you sort of nod and agree.	8.14-8.22
Super-ordinate	**Loss**	
Sub-ordinate	**Quote**	**Line. No**
Loss of Home	It's the little things that you miss as well and it's just having your own, especially being in a refuge just like not having your own four walls, it plays quite a big part in your life you know, your home is everything, when you lose it you kind of realise what it meant to you.	2.4-2.7
Loss of identity	Like I'm just there and I'm just another number aren't I just another number, that's how it makes you feel, well makes me feel like that,	5.1-5.4

	you know. It doesn't really make you feel like a human, you're just like you know, it's kind of like you don't want to go and see your GP because it's like you know well just get on with it, its life, that's the kind of impression I get.	
Super-ordinate	**Being done to**	
Sub-ordinate	**Quote**	**Line. No**
Being powerless	Horrible it was just a complete violation of everything, it's like my home was my home, you know and it was sort of like I had to leave and he could stay, so you know it kind of made me quite angry as well but I mean I had to get from there where me and the children were safe and so I was just sort of riding on that really but it was absolutely horrible.	2.1-2.4
Othering	What like my situation is a bit more different because obviously I've come into refuge, I've got no like issues that obviously you've got other women at refuges who are alcohol dependent, drug dependent, who've got numerous medical sort of things and I don't have any of them so I'm just there to be safe and to keep my children safe and you know to start a new life you know.

I tend not to go to the GP which is you know, and you know when you do go you're like literally, you're so rushed you can't even have like time to talk to a doctor about anything, you know. It's like they just sort of rush you and that's what really annoys me and I just think okay well you know, because they don't really want to look at you or communicate with you they just want to write you a script and that's it and then the next one in so yeah it kind of feels a bit rushed when I go to the GP's to be honest with you | 12.1-12.5

4.1-4.8 |
| Being judged | It feels like you don't want to open up to them, you know, or you feel like if you do something wrong then you know, like, would social services be called in, you've always sort of got that worry as well and even when I'm changing a nappy or you go to baby clinic like, when you go and weigh and things like that, like they're watching you all the time, like you're on the edge all the time and you're going to be doing something wrong, nine times out of ten when I'm at home I'm fine, just get on with it, but when I'm around that yeah I just feel like a million eyes just sort of watching me, you | 13.10-13.16 |

	know, if you're doing it right or doing it wrong, yeah. Makes me feel like rubbish really, I feel like I'm not doing what I'm supposed to be doing but I know that I am doing it right because the child is happy and healthy and there's nothing wrong with the child but then in your brain because someone is watching over you you know, I don't know it's hard to put it into words, it's just like a feeling and then toward the end of that I stopped going to baby clinic and things because I just felt you know, because they were saying you shouldn't be doing it this way you should be doing it this way and he should be eating like this and I just think well it's all like, every baby is different, you know.	14.1-14.7

6.4: Susie

Susie was 36 years old and had four children and a stepson. The youngest of her children was 20 months, a daughter 13 years old and two sons 16 and 18 years old, and a step son who was also 18 years old. Susie was in a violent relationship for about three years; her partner used to withhold cash, got her addicted to drugs and was violent to the children. There was an incident where Susie's partner held her by the throat while she was holding the baby. The daughter came into the bedroom and tried to take the baby to protect her from being harmed, and Susie's partner hit her out of the way. Susie phoned the police, when they arrived at the house Susie's partner told the police that the baby had ingested amphetamine, social services were contacted and the baby was put into foster care. The partner was charged, he breached his bail conditions, Susie reported him to the police and he was detained in prison. When they released him from prison Susie and the children moved out of their home, as it was not safe for them to remain in the house or the area. They were in a homeless situation and were put into temporary accommodation. The family were not accommodated in a refuge in view of Susie having teenage boys, as teenage boys and men are not allowed in refuges where women and children are accommodated. They

were put in a three bedroomed temporary house, Susie and her children had been in temporary accommodation for seven months and had recently been permanently housed. The baby was returned to Susie after three months from foster care.

Throughout the interview, Susie seemed agitated and nervous; she kept rubbing her hands and neck. Although I had introduced myself and discussed the research with her and agreed to consent to being interviewed. Therefore, the nervousness was possibly due to some other reason. It could be that the environment was not conducive in making Susie feel comfortable. The interviews took place in the organisations offices; there were staff in the rooms adjacent to the room where the interviews took place. This may have made Susie feel uneasy. However, I did not check with Susie how she was feeling, in hindsight I should have clarified why she was uncomfortable talking to me.

It was evident that she was holding back information, even when prompted she tended to laugh or shut down the conversation by not answering or shrugging her shoulders. I did not pursue these questions, as I clearly perceived that Susie was uncomfortable discussing her situation.

Susie explains her feelings of becoming homeless and moving to a new area.

> *"It was one of the scariest things I've had to do, do you know, it is so scary and socially isolating, you've got to leave everything and everyone behind, nobody can know where you live, you can't have friends around for a cup of tea and a chat, it's so isolating so it's something that apart from your support worker that you've got to do yourself, it's and us going into a stand-alone refuge so there was nobody else there to sort, no other women going through the same thing so it was extremely isolating"*

Susie had no control over her situation and she felt vulnerable. The loss of her home, possessions and friends was emotionally painful for Susie. She perceived herself as being in this vacuum where she had no contact with the outside, the isolation and loneliness for Susie was overwhelming.

Susie went on to explain the positive aspects that came out of her temporary situation.

> *"But in another sense it bonded us as a family because we talked to each other and it probably would have helped if I wasn't so socially isolated but it made us stronger as a family unit."*

Isolation was a continual theme throughout the interview; Susie identified isolation as a conduit to her coping ability. The bonding that took place would have been more beneficial to them as a family Susie felt, if she was not so lonely.

There were two things going on for Susie the security for herself and her children in being accommodated in a place of safety and where friends and family were unaware of where she was now living. Susie missed her friends and felt the isolation of living in temporary accommodation.

> *"No it was lovely to feel safe, it was nice to be safe and for my children to be safe and not have people knowing where we lived so a friend couldn't come over and you know, so nothing could get back to him but in the same time, it would have been nice to have had a bigger support system…because it was seven months of being isolated but no I think, I think that's it, I've come through it, I'm smiling."*

Susie reflected on the positives and negatives of their situation, for Susie the positives outweighed the negatives. The safety of herself and her children was a priority over her social needs such as loneliness.

Susie was trying to make sense of why she became addicted to drugs.

> *"I don't know, I just think that women, a lot of women in the situation that I've been in were drug and alcohol dependent because that's the only way that we can be controlled, is to have our brains turned to mush"*

Susie suggested that women who were victims of domestic abuse became drug and alcohol users by default, as a means of control by their partners. She was shifting the blame of her drug misuse to her partner, she was implying that she had no control over taking the drugs; this was how Susie saw it.

Susie found the ordeal of repeating her story every time she visited the doctor difficult to cope with.

> "But to go to a new doctor and say look I was dependent, its hard work, you've already done it once so then you've cleaned yourself up and go to another doctor and say, relive it, it's a bit, it's hard work"

This suggested Susie's struggle in admitting her addiction to drugs. Susie felt the lack of communication between healthcare personnel, resulting in recalling of her experience had caused her additional emotional stress.

Susie explains why she was not accepted on a drug rehabilitation programme.

> "It is difficult, yeah, they tend to not accept you unless you've been, you've done a crime, otherwise you're not accepted on the rehab courses which is ridiculous, there are honest drug takers out there, as honest as you can be."

Susie' classed herself as an honest drug user; she implied that she had not been involved in any criminal behaviour. She felt ostracised because she was unable to get support for her addiction. Support for her children was also difficult to access, as explained here by Susie.

> "My thirteen-year-old is a self-harmer and we're waiting for out of service help because she took, a couple of weeks ago she took an overdose so we had to get an ambulance and go to hospital. The other children are fine but my thirteen-year-old does cut herself and stuff like that so we are waiting for somebody, some out of service mental health team for her."

Susie implied that her other children with the exception of her daughter had no psychological or emotional effect of their experiences, which was contrary to what Susie stated later. It was unclear what Susie meant by '*out of service help*' as she referred to the mental health team. It suggested she was not familiar with the third sector in relation to NHS services. The concern over her daughter's mental health as well as the psychological impact on the other children was indicated below.

> "Well her confidence has been shot, my son got offered to go white water rafting today and he wouldn't go and I'm sure it's his confidence issues and my daughter's confidence issues, they do need a lot of work with their selves and I might talk to… my support worker this morning if she says about getting some, putting a referral in for my daughter, to try and do it through here

as well as the hospital but yeah, I think we're all just healing at the moment."

Susie was aware of the negative effect that her previous life and the isolation of living in temporary accommodation had had on two of her children. She recognised they needed help and support from outside agencies, which she was unable to offer. In a way, she contradicted this viewpoint by suggesting they were recovering.

Susie was asked what could have been done differently.

> *"Probably pamphlets or leaflets saying where the doctors were and telephone numbers, because I thought the doctors was just down the road from where I was because it said medical centre so I kept going there every day and trying to catch them on the day but they'd moved and not told anyone so it wasn't until my support worker phoned them up and said where are you and it turned out they were in a different area."*

Information and communication between the charity staff and residents seemed to be a sore point for Susie. Susie felt she wasted valuable time in trying to gain access to the medical centre that was no longer a GP practice. She suggested that the GP practice moved secretly without any one's knowledge, as this was her understanding of the situation.

Susie fled from a dangerous situation, she found the isolation difficult to adapt to and was lonely for adult company. Her children were trying to adjust to the area and their new surroundings, accessing services for Susie and her children was fraught with difficulties.

Table 8: Super-ordinate themes and extracts from the interviews - Susie

Super-ordinate	Loss	
Sub-ordinate	**Quote**	**Line. No**
Security	No it was lovely to feel safe, it was nice to be safe and for my children to be safe and not have people knowing where we lived so a friend couldn't come over and you know, so nothing could get back to him but in the same time, it would have been nice to have had a bigger support system…because it was seven months of being isolated but no I think, I think that's it, I've come through it, I'm smiling.	11.6-11.12

Loss of friends	It was one of the scariest things I've had to do, do you know, it is so scary and socially isolating, you've got to leave everything and everyone behind, nobody can know where you live, you can't have friends around for a cup of tea and a chat, it's so isolating so it's something that apart from your support worker that you've got to do yourself, it's and us going into a stand-alone refuge so there was nobody else there to sort, no other women going through the same thing so it was extremely isolating.	10.1-10.6
Isolation	But in another sense it bonded us as a family because we talked to each other and it probably would have helped if I wasn't so socially isolated but it made us stronger as a family unit.	10-6-10.8
Loss of self confidence	Well her confidence has been shot, my son got offered to go white water rafting today and he wouldn't go and I'm sure it's his confidence issues and my daughter's confidence issues, they do need a lot of work with their selves and I might talk to… my support worker this morning if she says about getting some, putting a referral in for my daughter, to try and do it through here as well as the hospital but yeah, I think we're all just healing at the moment.	9.11-9.15

Super-ordinate	Being done to	
Sub-ordinate	**Quote**	**Line No**
Being powerless	I don't know, I just think that women, a lot of women in the situation that I've been in were drug and alcohol dependent because that's the only way that we can be controlled, is to have our brains turned to mush	5.1-5.3
Being judged	It is difficult, yeah, they tend to not accept you unless you've been, you've done a crime, otherwise you're not accepted on the rehab courses which is ridiculous, there are honest drug takers out there, as honest as you can be.	4.8-4.10
Super-ordinate	**Social Exclusion**	
Sub-ordinate	**Quote**	**Line No**
Access to healthcare services	My thirteen-year-old is a self-harmer and we're waiting for out of service help because she took, a couple of weeks ago she took an overdose so we had to get an ambulance and	3.17-3.21

	go to hospital. The other children are fine but my thirteen-year-old does cut herself and stuff like that so we ae waiting for somebody, some out of service mental health team for her.	
Dependent	But to go to a new doctor and say look I was dependent, its hard work, you've already done it once so then you've cleaned yourself up and go to another doctor and say, relive it, it's a bit, it's hard work	5.5-5.7
Helpful information	Probably pamphlets or leaflets saying where the doctors was and telephone numbers, because I thought the doctors was just down the road from where I was because it said medical centre so I kept going there every day and trying to catch them on the day but they'd moved and not told anyone so it wasn't until my support worker phoned them up and said where are you and it turned out they were in a different area.	8.2-8.6

6.5: Ginny

Ginny had three children a girl aged 11yrs, and two boys aged 7yrs and 5 yrs. They were residing in a homeless refuge at the time of the interview. Ginny and her children previously lived with her partner for 10 years, Ginny and the children left their home and moved into the refuge because of circumstances, which she wished not to disclose. Ginny and her children had been in temporary accommodation for seven weeks when interviewed. All of the children had health needs. Since moving into temporary accommodation, the children had not attended school and they had all been living in one bedroom within the refuge.

Ginny was guarded in her response as her youngest child was seated next to her throughout the interview. He was very clingy and would not go and play with his siblings and the support worker in the adjoining room. Ginny kept her responses short and controlled, this was in some way because of the presence of the child, but I also picked up that she needed to be in control and was afraid to let go of her emotions. I was unable to get her to express

how she was feeling or what her health issues were, she seemed to hesitate when I occasionally asked 'how did that make you feel', and often giving noncommittal answers.

Here Ginny was asked how she felt about being in the refuge.

> *Ginny*: "It's just strange, I think being in a different place and different circumstances and   everything else and I've just got to keep going because I've got three kids".
>
> *Interviewer*: "what do you mean by strange"?
>
> *Ginny*: "I don't know, I don't know how I feel to be honest any more, it's just so much has gone on and so much has happened I don't know. Obviously I'm stressed out because I've got three kids in one room, emotionally I've been with my ex-partner for like ten years and I've gone to sort of not having anyone there, it's just and then just losing the house and losing everything it's just emotional. It's just trying to pick myself back up and start again and just forget everything"

Ginny used the word '*strange'* but when asked what she meant by this, was unable to articulate her feelings, as she reiterates *'I don't know,'* more than once. She felt emotionally shocked by her situation and the loss of her possessions. Ginny felt isolated being on her own with the children, but she focused on the positive and looked towards the future for herself and her children. Ginny reflected more on what this new start meant for her.

> *"Friends, friends for the kids and that, it's just, I know you should start again but it's a horrible thing, to restart and build everything up again, get to know people and it's like the kid's baby stuff, so they had when they came out of the hospital and things like that, because I didn't go through everything and made plans or anything."*

Not only the loss of her home but the loss of friends for her children, Ginny appeared sad about. Ginny seemed to be overwhelmed by the loss of her children's keepsakes from when they were born, loss of a home and its contents and loss of friends; she seems to focus on this loss repeatedly. The inconvenience of only having one room to live in, with three children especially with one child having learning difficulties was explained.

> *"Her learning difficulties have, it's quite difficult because she's eleven but her mental age is of a four or five year old so it's like having three young children in the house, so they're bouncing off each other and she doesn't really, she doesn't understand most things so trying to talk to her to get her to stop winding up the*

other children is just hard work and she doesn't understand why this has happened or why we're here or and then she gets angry then and then she can't cope with being in the same room as the boys."

Ginny felt frustrated in trying to contain her children in one room; she suggested that her daughter was not coping well in this situation. Ginny seemed to be blaming her daughter for upsetting the other two children and using her learning difficulties as the cause. She suggested that her daughter's cognitive ability was to blame, but it was not clear whether Ginny had explained the situation to her daughter. Ginny's sense of loss was also associated with her children's 'ill' health, the loss of 'normal development' as she saw it.

One of Ginny's children had cystic fibrosis; here she discussed her childcare issues.

"It's just hard work with him, cystic fibrosis, going back and fore to hospitals, medications, physio, it is hard work but I suppose you get used to it because its everyday things, the hardest part is going back and fore to hospital, because it's so far. You've got to rely on other people and that because I don't drive myself so, and it takes all day just to get there and then you come back…. I had to take my other two children the night before to my mum's house and got him to his appointment and then by the time I'd got to my mother's house it was about five o'clock, by the time I got back to the refuge it was seven o'clock."

Having a child with a chronic illness can be exhausting and emotionally draining as suggested by Ginny. She felt isolated, as she had to carry the burden of his care herself. For Ginny it felt like a marathon finding care for her other children and transporting them to and fro.

Ginny describes her frustration of healthcare personnel when she was trying to get help and support for her children.

"A bit stressed out because he was ill when I first went into this place, he was ill, so he had to be secondary antibiotics so then I had to get another secondary antibiotics so I went back then to get more medication and I had to wait to see the doctor to get more medication and then I've had to wait then three days for the chemist to get the medication before actually getting it so it was a long time off and if something serious then (son) would have ended up being in hospital".

Ginny expressed her feelings of being powerless when waiting for medication for her son. She acknowledged her increase in stress in view of this situation and the potential of a deterioration in her son's condition.

The negative feelings that Ginny had for other agencies was explored further.

> "They haven't offered my children anything, no services to help me because they've been off school for seven weeks. All they've done is go out and see my ex-partner and make sure his needs are sorted and is he capable of looking after the kids, well he hasn't got the children and I've got the children and they haven't even offered me anything."

Ginny seemed to be dismissive of the support services and felt her needs had been ignored, she referred to '*they*' it was not made clear which professionals she was referring to, possibly social services as Ginny referred to them later in the narrative. She seemed to be irritated by her ex-partner as she felt he was getting all the attention. Ginny was frustrated of the time it took to access services.

> "My youngest son has got behavioural problems that he's picked up so he constantly cries for hours and he hits me and I've asked social services to help me with his behaviour, to get him on like a course or something that could help me control his behaviour and it's been seven weeks and they still haven't sorted that out, nothing."

Ginny suggested that her son's behaviour problems was due to modelling, something he had previously witnessed happening at home before they came into temporary accommodation. Ginny was reticent about discussing why she left her home however, she left her partner of ten years and all her possessions, which meant she left in a hurry, the likelihood there was violence in the home, although I never confirmed this with Ginny. The discussion was rather convoluted; Ginny seemed to feel that she could control her son's behaviour by sending him on a course. Here she was shifting the responsibility onto her son and extricating herself.

Ginny goes on to describe her contact with the health visiting service.

> "A health visitor came out and seen me once where I am now and that's about it…. Because for me from when he was first born he used to be quite a handful and they never gave me any

support or anything. I've asked all of them and they haven't even, all they've come up with is a disability form for activities for the summer holidays, yeah I could afford to pay for them but I don't know how to get there and I don't know where they are, I've asked them can they drop me off to get there and then I'll find my own way back and then I could keep going and going but no-one can help me with that so I'm just stuck basically. They've told me to google it but I don't understand, don't know where the actual place is to get off to google where I've got to go."

Ginny appeared to be unimpressed with the health visiting service she had received currently or previously before she became homeless. Ginny felt the health visitor had not been forthcoming in the information that she required. It was unclear who Ginny was referring to when she used the term '*they'* this could be the health visitor or the refuge staff. Ginny appeared unmotivated and seemed to be reliant on other people finding the information she needed.

> *"No one tells me anything of what information I can get, what support I can get, because everyone is just saying well we can't support you with this and then I go to someone else and they say can't support you with that. So I don't know what actually what they do, do, I can't get help because no one is telling me anything"*

Ginny felt her needs were being disregarded; she referred to '*everyone'* and '*they'* without clarifying whom she was talking about.

> *"I suppose you've just got to do it, I suppose because I thought to be honest I'd have more help than I have now but it just seems that everyone is just don't know, brush it under the carpet I think, I don't know, but they're just."*

Ginny felt let down by the agencies and suggests that they were not interested in her problems.

> *"We applied for social services for seven years and they said we didn't need social services to try and help us with (daughter's) needs, to get her into some kind of clubs or something for children like herself. We've tried to apply for a social work for (son's) needs and they refused us… at the moment they have decided that we are entitled to a disability social worker but they haven't transferred us over seven weeks ago."*

Ginny appeared relentless in her quest for support for her children. She was frustrated in regard to the decisions that had been made and the delay in actioning the support.

Ginny found the loss of her home and possessions difficult to come to terms with. She seemed to blame healthcare services for the difficulties she had encountered so far. Having three children all with health needs and trying to get help and support for them, had been frustrating for Ginny. Although she had only been in temporary accommodation for seven weeks at the time of interview. The refuge environment for Ginny and her children who were mainly confined to one room and gave them the security they needed. Seemed to make the sense of loss greater, they had less privacy within the refuge and this added to their sense of loss.

Table 9: Super-ordinate themes and extracts from the interviews – Ginny

Super-ordinate	Wellbeing	
Sub-ordinate	**Quote**	**Line. No**
Emotional impact	Her learning difficulties have, it's quite difficult because she's eleven but her mental age is of a four or five year old so it's like having three young children in the house, so they're bouncing off each other and she doesn't really, she doesn't understand most things so trying to talk to her to get her to stop winding up the other children is just hard work and she doesn't understand why this has happened or why we're here or and then she gets angry then and then she can't cope with being in the dame room as the boys.	7.1-7.6
Super-ordinate	**Loss**	
Sub-ordinate	**Quote**	**Line. No**
Loss of home	It's just strange, I think being in a different place and different circumstances and everything else and I've just got to keep going because I've got three kids.	3.3-3.4
	It's just and then just losing the house and losing everything its just emotional. It's just trying to pick myself back up and start again and just forget everything	3.7-3.9
Loss of partner	I don't know, I don't know how I feel to be honest any more, it's just so much has gone on and so much has happened I don't know. Obviously I'm stressed out because I've got three kids in one room, emotionally I've been	3.5-3.7

	with my ex-partner for like ten years and I've gone to sort of not having anyone there	
Loss of friends and possessions	Friends, friends for the kids and that, it's just, I know you should start again but it's a horrible thing, to restart and build everything up again, get to know people and it's like the kids baby stuff, so they had when they came out of the hospital and things like that, because I didn't go through everything and made plans or anything.	4.2-4.5

Super-ordinate	Being done to	

Sub-ordinate	Quote	Line. No
Othering	They haven't offered my children anything, no services to help me because they've been off school for seven weeks. All they've done is go out and see my ex-partner and make sure his needs are sorted and is he capable of looking after the kids, well he hasn't got the children and I've got the children and they haven't even offered me anything………. My youngest son has got behavioural problems that he's picked up so he constantly cries for hours and he hits me and I've asked social services to help me with his behaviour, to get him on like a course or something that could help me control his behaviour and it's been seven weeks and they still haven't sorted that out, nothing.	8.9-8.18
	A health visitor came out and seen me once where I am now and that's about it…. because for me from when he was first born he used to be quite a handful and they never gave me any support or anything. I've asked all of them and they haven't even, all they've come up with is a disability form for activities for the summer holidays, yeah I could afford to pay for them but I don't know how to get there and I don't know where they are, I've asked them can they drop me off to get there and then I'll find my own way back and then I could keep going and going but no-one can help me with that so I'm just stuck basically. They've told me to google it but I don't understand, don't know where the actual place is to get off to google where I've got to go.	10.1-10.9

Super-ordinate	Social Exclusion	

Sub-ordinate	Quote	Line. No

Access to healthcare services	They said oh we'll make an appointment for you to see the doctor first and then they didn't make an appointment they said oh you can just leave it and then by the time I needed to get his medicines then, get a repeat, I had to go and make an appointment, wait all weekend for an appointment and then go and get his medication and then I got to the chemist and they didn't have none of the medication and I've had to wait three days for medication on top of that.	7.4-7.9
	We applied for social services for seven years and they said we didn't need social services to try and help us with (daughter's) needs, to get her into some kind of clubs or something for children like herself. We've tried to apply for a social work for (son's) needs and they refused us………….at the moment they have decided that we are entitle to a disability social worker but they haven't transferred us over seven weeks ago.	8.2-8.6
Helpful information	No one tells me anything of what information I can get, what support I can get, because everyone is just saying well we can't support you with this and then I go to someone else and they say can't support you with that. So I don't know what actually what they do, do, I can't get help because no one is telling me anything	9.1 – 9.4
Excluded	I suppose you've just got to do it, I suppose because I thought to be honest I'd have more help than I have now but it just seems that everyone is just don't know, brush it under the carpet I think, I don't know, but they're just.	10.10-10.12
Transport	It's just hard work with him, cystic fibrosis, going back and fore to hospitals, medications, physio, it is hard work but I suppose you get used to it because its everyday things, the hardest part is going back and fore to hospital, because it's so far. You've got to rely on other people and that because I don't drive myself so, and it takes all day just to get there and then you come back…. I had to take my other two children the night before to my mum's house and got him to his appointment and then by the time I'd got to my mother's house it was about five o'clock, by the time I got back to the refuge it was seven o'clock….	5.1-5.9

6.6: Summary

The stories of these women were harrowing and emotional as can be seen by the descriptions of their ordeals. Three of them became homeless for their safety and the safety of their children; the other two women were because of adverse events. The loss of their home and possessions were traumatic and the stress of living in temporary accommodation subjected them to loneliness and isolation. The health issues for them and their children were sometimes hindered by the inaccessibility of healthcare services. The attitudes of healthcare personnel and other agencies contributed to the women feeling stigmatised and excluded. Communication between healthcare personnel and the women and across organisations often led to the delay in accessing services or support. Many of the experiences identified were shared across all or most of the women, in Chapter 7 these the shared experiences will be explored in more detail.

Chapter 7: Shared and Unique experiences

7.1: Introduction

The previous chapter explored the descriptive experience of each of the participants. This chapter will explore the similarities across participant cases and include the unique experiences of one participant. See Table 10, for a list of the shared sub-ordinate themes. When the interviews took place all the women had been in temporary accommodation although, three of the women were in permanent accommodation. The women discussed here have all become homeless and resided in temporary accommodation; at no time were they living on the streets.

In rearranging and grouping the themes into clusters and identifying a new name for each cluster produced sub-ordinate themes as discussed in detail in Chapter 5. The superordinate themes were identified using abstraction by putting like with like and developing a new name as can be seen in Table 10. Subsumption was used as can be seen by the use of the term 'loss' where a series of related themes of loss was brought together. In identifying connections between emergent themes, the narratives of events experienced of the women such as accessing primary care services, attitudes of practitioners, isolation, social exclusion demonstrates contextualisation. In using these different processes, by grouping of the emergent themes as discussed, led to the development of super-ordinate themes, which are 'Wellbeing, Loss, Being done to and Social exclusion.

Table 10: Across case similarities

Super-ordinate	Sub-ordinate	Emily	Amy	Julie	Susie	Ginny	Total
Wellbeing	Emotional pain	√					1
	Drinking all the time	√					1
	Mental ill health	√					1
	Emotional impact		√	√		√	3
Loss	Loss of possessions	√				√	2

	Loss of identity		√	√			2
	Security				√		1
	Loss of friends				√	√	2
	Isolation				√		1
	Loss of self-confidence				√		1
	Loss of home	√		√		√	3
	Loss of partner					√	1
Being done to	Being judged	√	√	√	√		4
	Being powerless	√	√	√	√		4
	Negative attitudes		√				1
	Othering		√	√		√	1
Social exclusion	Access to services		√		√	√	3
	Barriers		√				1
	Struggle to build trust		√				1
	Dependent				√		1
	Helpful information				√	√	2
	Transport					√	1
	Excluded					√	1

7.2: Shared Experiences

7.2.1: Wellbeing

Health and wellbeing was a determinate factor for all of the women, whether this referred to their own health or that of their children. Having ill health could be attributed to loss, the loss of wellbeing. Three of the women Emily, Amy and Julie acknowledged they suffered with depression, either as a consequence of living in temporary accommodation or as an outcome of their life prior to losing their home. Both Susie and Amy's children suffered from mental ill health, which possibly resulted from being abused or witnessing domestic abuse. The emotional impact of becoming homeless and living in temporary accommodation seems to be overwhelming at times for these women.

The dependent children from this study were not exempt from the emotional impact of being homeless; they too felt the effects of being in temporary accommodation and the difficulties in getting help and support. When a

neighbour abused Amy's daughter this resulted in them being moved around the country and the help and support that should have been accessed for the daughter at that time was missed. Counselling was not accessed until five years later when they were permanently housed. Amy felt that had her daughter received support earlier the emotional impact would have been lessened. The emotional impact of leaving your home and being temporary housed in a new area away from family and friends, increased the feelings of isolation and exacerbated the emotional impact. The lack of support also impacted emotionally on Julie, during being temporary housed she had a health scare. Although she accessed primary care and secondary care services quickly and effectively for her physical health needs. Julie felt her emotional needs were not addressed and felt unable to ask questions of the GP, but she needed someone to talk to about her fears and anxieties relating to the health scare while waiting for the test results.

Ginny resided in a refuge when placed in temporary accommodation; she shared one bedroom with her three children. The eldest child had learning difficulties and needed her own space at times as she aggravated the other siblings when being constricted to one room. Ginny found the situation emotionally draining as her daughter was unable to understand why they living in the refuge. The impact of living in this way was not conducive to wellbeing for Ginny or her children. It was difficult to determine whether Ginny had any health issues, she refused to get drawn into any discussion around her own health and wellbeing. The interview questions had to be sensitively asked because the child was present. Ginny's responses were short and controlled, it was difficult to get her to express her feelings around some of the points she made. There was hesitation before she spoke, as if she was carefully picking out what she wanted to say. However, Ginny felt the loss of her children's wellbeing, her loss was associated with the 'ill' health of her son and the loss of 'normal' developmental and behavioural aspects of her other two children's health.

7.2.2: Loss

The concept of loss is multidimensional and related to either home, possessions, friends, identity, spatial environment and wellbeing. All of these women experienced one or more aspects of loss. The loss of their home was congruent for all of the women. Their home held many memories for them, it symbolised happy times, the birth of their children, birthdays and so on. Having the ownership of a home and sense of belonging was strongly important to them. The security of putting down roots and making a home as oppose to the insecurity of temporary accommodation.

All the women had lost possessions, some permanently due to a fire, for others, these were left behind when fleeing from their home. The women grieved the loss of these possessions with no expectation that they would get them back. Ginny in particular seemed not ready to come to terms with the loss of her possessions, especially those that evoked memories of her children as babies and was unable to move on.

All of the women voiced the lack of support, they felt isolated, alone and often void of adult conversation. The women agreed that the loss of friends they missed most, the companionship and support that friendships offer. Although Emily had the support of her family while in temporary accommodation, the lack of professional support was identified.

Loss of identity was classified from two distinct entities, the personal identity that comes from within the individual and the social aspect that is a function of relationships. The personal identity of these women changed for three of them, they became single parents after fleeing from their partners, although the role of mother and carer remained. The women concurred that being in temporary accommodation affected their identity and they were excluded by society. Socially they were viewed as being a 'homeless' person and their identity became the same as that of the street homeless.

7.2.3: Being 'done to'

The women agreed that the attitudes of health and social care professionals were judgemental and they felt discriminated against because of their homeless status. With the exception of Ginny who did not feel labelled but found the lack of support she received from healthcare professionals was unacceptable. These attitudes disempowered the women and they disengaged with healthcare services when it came to their own health needs, but these women battled on in getting services for their children.

The stigma associated with living in temporary accommodation was clearly articulated by the women that healthcare personnel were not interested and the women were not listened to. Where appointments were missed because of the high mobility of being in temporary accommodation, there was no offer of help or a solution to the situation. The stigma of having a mental health condition was particularly poignant for Emily, she felt discriminated against because of her diagnosis of bipolar and was marginalised because of it, not receiving the same respect as other patients. The judgemental attitude of healthcare personnel and their lack of understanding of mental health issues in general contributed to the women's lack of trust in healthcare professionals.

The women often felt powerless, this was especially pertinent for four of the women. Amy was evicted from her home by the owner and was not given enough time to find other accommodation. Amy felt powerless in this situation as she was renting privately and was unsure of her rights. Julie had to leave her home due to domestic abuse; it was not safe for her and the children to remain. Julie felt the unfairness as a victim that she had to leave her home and possessions while the perpetrator could remain in the home. Julie felt she had no rights and was powerless as the choice she made was to safeguard herself and her children. In trying to access healthcare services, they felt they were battling against an appointment system that was bureaucratic and inflexible. Health professionals did not seem to understand their situation and the women were either not listened to or it was assumed that the women were making excuses for not attending appointments. This

situation rendered the women powerless in getting appointments for their children.

Women who are homeless and living in temporary accommodation are viewed negatively by society. The women in this study felt they were treated differently by healthcare professionals, they perceived that professionals did not want to communicate with them, did not give eye contact and just wrote a prescription to get rid of them. However, all people attending this particular healthcare service could be treated in the same way and may have nothing to do with being homeless.

People who are homeless are often judged as unreliable or drug and alcohol dependent by society, Julie felt she was judged in this way, in view of this she tried to disassociate herself from this form of identity and made it clear she was only homeless because of domestic abuse. This form of othering where negative values and stereotyping can impact on women's self-worth and identity as identified from the women's stories.

The women perceived that healthcare personnel marginalise everybody who lives in temporary accommodation as they view them as criminals or with an addictive lifestyle. This pattern of stigmatisation and judgemental attitude is alluded to many times throughout the transcript.

7.2.4: Social Exclusion

Accessing healthcare services was particularly harrowing and difficult for these women, not only in light of missed appointments for secondary care services, as often these women had not received the appointment. There were barriers to accessing primary care services. Temporary residents at a primary care practice do not have a named GP and the patient is seen by any GP. The women found this distressing, they had to retell their story over and over each time they saw a different GP. In this way, the women were not allowed to put the past behind them and move on, they had to relive their experiences each time they visited primary care services. Accessing repeat prescriptions were also problematic for these women especially if they were on antidepressant medication. The women were not always believed

regarding their medication, this could not be verified until their medical notes were received by the practice. Often one' week's medication was prescribed at a time, or in the case of Amy who carried a copy of her prescription, was not believed as it was suggested she could have made changes to the prescription copy.

Accessing services for themselves or their children was also challenging for these women. Services were not always available in the area where these women residing in temporary accommodation. Travelling to other areas was not always safe or convenient as in the case of Susie, who needed drug rehabilitation services, which were only available in the town she had previously lived. As Susie was a victim of domestic abuse it was not safe for her to return. The women had to rely on public transport, often this resulted in two to three changes of transport to get them to their destination. Support services were not readily available for the children, such as youth services or counselling. All of the children had differing health needs and needed healthcare services and support, which ranged from physical, mental, emotional, psychological, behavioural and developmental. The majority of these children were failed by healthcare services while they were in temporary accommodation. The only exception was Ginny's son who suffered from cystic fibrosis. Ginny was happy with the services she received for her son from secondary care and stated that the transfer from the one hospital to another was seamless. However, this was not the case for primary care, Ginny had difficulties in getting antibiotics for her son when he needed them, and a delay could have resulted in a serious deterioration of his condition.

7.3: Unique Experience

Julie's experiences of accessing healthcare was unique because of the health needs that she endured at this time. Julie had two consultations with a GP; the first consultation was for her low mood and possible depression. Julie perceived that the GP displayed indifference towards her, showed a lack of understanding of her situation and did not listen to her. Julie understood the dilemma for GP's in trying to see as many patients as

possible, but felt she deserved the same respect as everyone else. Her observations were that she was being treated more negatively by the GP and practice staff and she thought this was because of her temporary accommodation status.

On the second occasion when Julie visited primary care services, she had a breast lump and feared a cancer diagnosis. However, the news was good the lump was not malignant. Julie's opinion of the consultation with the GP was that medical jargon was used rather than the GP communicating in a more patient friendly way. She felt unable to ask questions or ask for clarification, as her perception was that the communication was not conducive to this.

The lack of explanation and clarity of the information given to Julie was viewed negatively by her. The anxiety and distress in finding a breast lump and the fear of a cancer diagnosis was heightened, she wanted some reassurances and support.
Julie views the doctor, patient relationship as unequal, where the doctor as a professional is always right and is to be trusted without questioning. From this understanding of the patient doctor relationship, Julie does not think she can challenge the doctor or asked questions about her breast lump. Although she desperately wants someone to talk to and ask questions.

7.5: Summary
Women, who live in temporary accommodation and became homeless for a variety of reasons, suffer the emotional loss of their home, possessions and friends. These women and children have poorer health outcomes, incurring the instability of being in temporary housing and suffering the loss of their home and possessions. Loss affects people differently, for these women the loss of a home and possessions can have emotional repercussions, which can have a lasting effect even after they have been re-homed permanently. A person's identity changes when they become homeless, they lose their valued placed in society and are viewed differently because of their homeless status.

In addition, they have to deal with their own health issues and that of the children, some of which has been exacerbated by being in temporary accommodation. The battle in trying to get healthcare services when being mobile, never staying in the same place long enough to access appointments, becomes frustrating and emotionally charged for these women. The lack of understanding and judgemental attitudes by healthcare personnel and society make homeless women feel marginalised and social excluded. The difficulties in gaining access to services because of homeless mobility and the inflexibility of services, coupled with communication and collaboration between professionals causes additional barriers for homeless women. Julie's unique experience of accessing healthcare services and her perception of the patient/doctor relationship adds an interesting contrast compared to the other women's experiences.

The next Chapter will explore the themes that transpired from the descriptive aspect of IPA, from a more interpretative life world perspective through the concept of loss.

PART THREE: LOCATING THE THESIS IN THE WIDER CONTEXT

Chapter 8: Discussion: Locating the thesis in the wider context

8.1: Introduction

The aim of this study was to gain an in-depth understanding of how women with dependent children make sense of homelessness, the lived experience of homelessness and the barriers in accessing healthcare services. The purpose was to consider each participant's experience individually and then to identify similarities and unique experiences across the participants. This process was undertaken by adopting themes, these were constructed by regrouping of the emergent themes that was identified in chapter five. In identifying superordinate themes, the processes for grouping of these themes differed. By grouping themes and putting together those that were similar, (abstraction) was used for the superordinate themes of 'Wellbeing, Being done to and Social inclusion'. The theme of 'Loss' was identified by adopting the emergent theme as a superordinate theme, (subsumption). Therefore four superordinate themes were developed, these being; 'Wellbeing, Loss, Being done to and Social Exclusion.' (Table 10) These four superordinate themes will be used to structure the discussion.

After analysing the data, a second literature review was undertaken, additional themes and information alongside more recent research was transposed into the literature review which included elements identified in the analysis, particularly that which related to the superordinate themes. It became evident that, 'Wellbeing, loss, being done to and social exclusion' impacted on these women's accessibility of healthcare services.

8.2: Returning to the Literature

The initial review of the literature for this thesis identified the more common aspects of homelessness that have been discussed in chapter three. A return to the literature was essential after the analysis of the interviews was completed. Wellbeing in relation to women's and children's health was reviewed in the initial literature review incorporating mental ill health. However, the emotional impact of homelessness was not considered. The
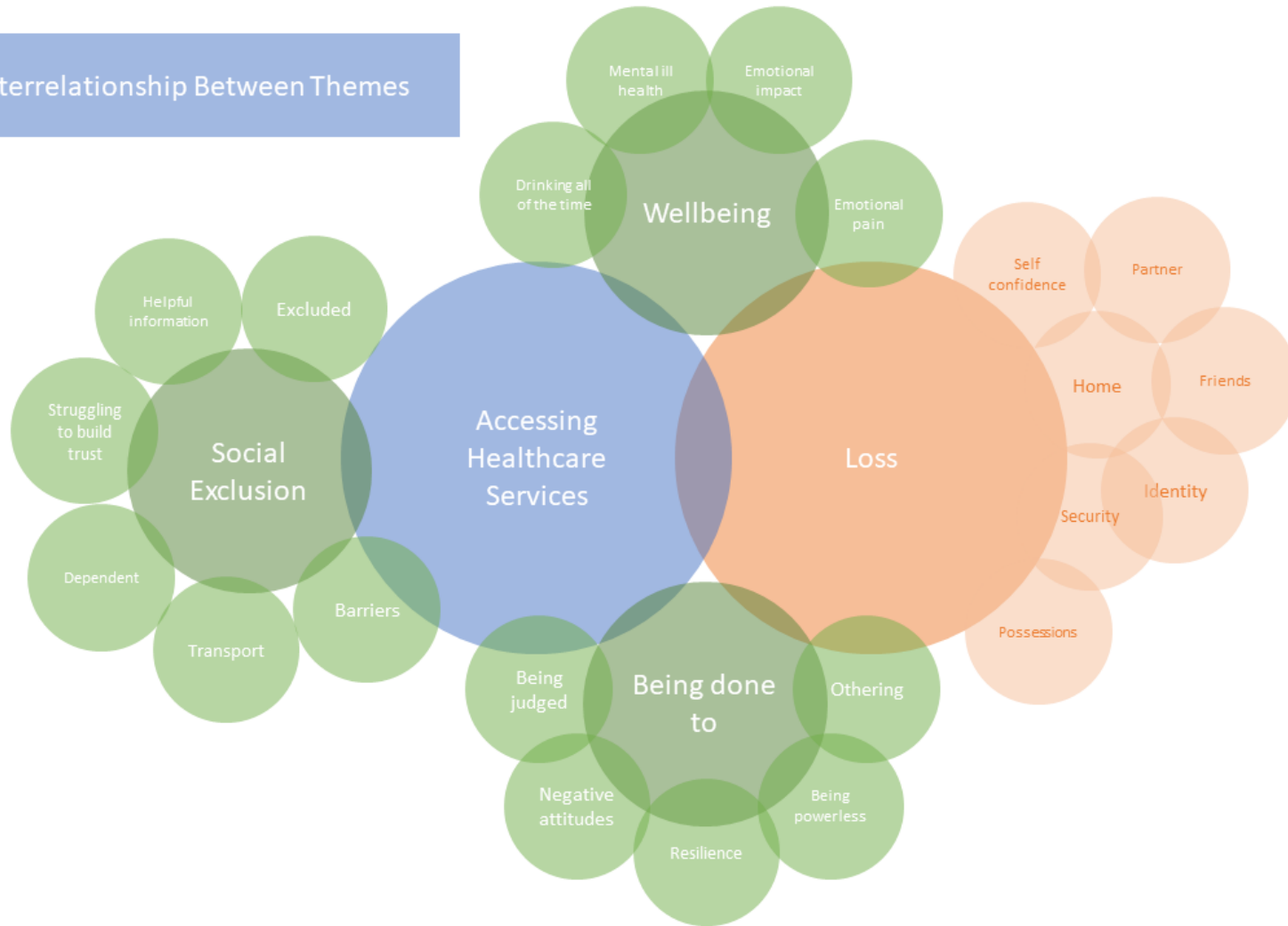
aspect of 'loss' of possessions, home, friends and identity was a theme that emerged from the interviews that was not initially expected. Although one study relating to loss of identity in single homeless people (Riggs and Coyle 2002) was identified in the initial search, 'loss' was not replicated in other studies. Therefore, identity was not included in the initial literature review. It became clear from the analysis of the interviews that tangible aspects of loss as well as loss of identity was an important consideration for this thesis. Another superordinate theme that emerged was 'Being done to', which included the subordinate themes of 'othering', 'being powerless' and 'being judged' although, the latter has been picked up in attitudes and perceptions within the review.

The four superordinate themes of 'wellbeing', 'loss', 'being done to' and 'social exclusion' and their corresponding subordinate themes identified in table 10 on page 108, are expanded upon in this chapter. The subordinate themes are not identified by the use of subheadings in this chapter to prevent duplication of discussion, as there is some crossover between the different subordinate themes. Figure 1 identifies how the themes were developed by demonstrating the link between the subordinate themes and superordinate themes. The size of the superordinate themes within the graph represents the weighting, 'accessing healthcare services' and 'loss' are equally weighted, but larger than the other themes of 'being done to', 'social exclusion' and 'wellbeing'. The subordinate themes are represented by the smaller spheres again demonstrating the weighting of these themes. The overlap of the themes shows the relationship between the higher order and the lower order themes.

Figure 1

Interrelationship Between Themes

- Wellbeing
  - Mental ill health
  - Emotional impact
  - Drinking all of the time
  - Emotional pain
- Social Exclusion
  - Helpful information
  - Excluded
  - Struggling to build trust
  - Dependent
  - Transport
  - Barriers
- Accessing Healthcare Services
- Loss
  - Self confidence
  - Partner
  - Home
  - Friends
  - Security
  - Identity
  - Possessions
- Being done to
  - Being judged
  - Othering
  - Negative attitudes
  - Being powerless
  - Resilience

8.3: Wellbeing

Mental health issues have been cited by numerous studies in the literature review in chapter three as inherent in homeless people (Tischler et al 2000; Vostanis 2002; Schanzer et al 2007; Tischler et al 2007; Tischler and Vostanis 2007; Savage et al 2008). The literature suggests that being homeless affects the emotional wellbeing of individuals and may in turn lead to mental health issues, which was particularly pertinent to three of the participants in this study who admitted to suffering from depression. The emotional rollercoaster that the women have been subjected to have at times intensified their feelings of despondency and self-worth. The literature suggests that poor mental health impacts on self-esteem and coping, which may affect the parenting role of the mothers in positively caring for their children (Chambers et al 2014). Emily who suffers from bipolar disorder, believes her condition deteriorated since being in temporary accommodation. The study supports the findings of existing research by Zabkiewicz et al (2014) who found that multiple stressors affects the instability of mental illness, the more stressors the greater the impact on mental ill health. Another interesting finding from this study was that the stress of extended homelessness impacted more on women with dependent children than women without children. This study reviewed women with dependent children and found similarities regarding mental ill health but these were not compared against single women without children.

The participants in my study felt a lack of control over their situation, they had no control over their accommodation whether they were placed in a refuge or a house and for how long. This was particularly evident in the women who were depressed, they had difficulty coping. Coping is defined by Folkman and Lazarus (1980, p223) as

> "*The cognitive and behavioural efforts made to master, tolerate or reduce external and internal demands and conflicts.*"

This early source has been considered by (Schanzer et al 2007; Zabkiewicz et al 2014) is seminal text and often referred to in later literature. The action of coping in this definition is associated with the behaviour of the individual to

overcome the difficulties they are encountering. Finfgeld-Connett (2010) implies that poor problem-solving skills and an inability to cope are exacerbated by feelings of vulnerability, resentment and a sense of injustice. The circumstances surrounding these women who were homeless, the additional stress of supporting their children and battling to get healthcare services, resulted in a reduced ability to cope. Coping is adversely influenced by additional stressors and becomes a '*loss spiral*' (Krohne 2002 p. 5). Emily took this to the extreme and remembers being in the kitchen looking at a knife and wanted to hurt herself. Johnson et al (2017) suggests that coping with stress alongside mental illness can affect people's capability to act rationally. Emily thought that she could have control over her body by inflicting physical pain on herself, whereas she felt a complete lack of control over her emotions.

Barriers to accessing mental health services by homeless women suggests that the needs of these women are not being addressed adequately (Chambers et al 2013). The access to medication is one such example, where the need to continue with medication already prescribed for these women is essential. Amy had no control over accessing her medication, as she was a temporary resident at the GP practice in view of her homeless status. In Amy's situation the GP wished to confirm the drug had been previously prescribed before writing a repeat prescription, which would be accepted as good practice, as doctors need adequate knowledge of a patient's health before prescribing or repeat prescribing (GMC 2013). This resulted in a delay in Amy receiving her medication. Homeless people are often highly mobile, as was the case of Amy, who moved around the country 28 times over a period of five years. Notes get lost or missing when moved from one location to another especially if these notes are not electronic. The participant's experience of obtaining repeat prescriptions was a continual battle and often the women were challenged and misbelieved, when requesting a repeat prescription.

"Oh well we haven't got your notes, are you sure those are your tablets you're taking. In the end I used to take a photocopy of the prescription and carry it around with me"

Even providing a previous copy of a prescription was not proof enough of their honesty, there seems to be mistrust between the health professional and the women. Although there are studies on homeless women and mental illness, the issue of repeat prescribing has not been previously identified therefore, this is a new finding from my study. Even though these women with children are housed in temporary accommodation, they are marginalised due to their homeless status and labelled the same as street homeless. Hwang et al (2010) compared single homeless with homeless women with dependent children and found that the latter were more in need of healthcare. The barriers in this study to accessing healthcare were mistrust of professionals and access to primary care provider. Although Hwang's study did not include access to prescriptions, the elements of mistrust and access are similar.

The accumulation of stressors and the additional effects of mothering on mental health previously considered by Zabkiewicz et al (2014) found there was an increase in mental illness for those women who had dependent children. Four out of the five participant's in my study acknowledged they had mental ill health, and all had dependent children. In essence, the findings from my study reflects the findings from Zabkiewicz et al (2014). For Emily who had bipolar disorder, her mental health deteriorated during the time she was in temporary accommodation. The lasting effects of emotional stress and her bipolar disorder led to her withdrawal from society. Although Emily was now permanently housed, she suffered from panic attacks and a fear of leaving the house, the feeling of insecurity never left her.

The children of the participants were also affected by their change in circumstances and suffered from mental ill health. Three of the participants were victims of domestic abuse. Holt et al (2008) purports that children often witness the abuse and can get caught up and physically abused themselves, Susie's daughter was one such victim. A study by Kernic et al (2003) identified that a high proportion of children who were exposed to domestic abuse were also victims of child maltreatment. The research found these children showed signs of internalised and externalised behaviour. Susie's

daughter began self-harming while in temporary accommodation, the emotional trauma was so great that her daughter attempted suicide.

> "My thirteen-year-old is a self-harmer and we're waiting for out
> of service help because she took, a couple of weeks ago she
> took an overdose so we had to get an ambulance and go to
> hospital."

The effects of the previous (domestic abuse) and present situation (homelessness) may have contributed to her self-harming and suicidal behaviour, as suggested by (Hawton et al 2012). There are many studies on mental health illness and homelessness (Vostanis et al 1998; Karim et al 2006; Vostanis et al 2007), some studies have implied that mental illness in children is an ongoing concern even after a year of being permanently housed (Vostanis et al 1998; Holt 2008). Studies of domestic abuse also suggest that mental ill health in children and adolescents can be a consequence of witnessing domestic abuse (Holt 2008). Therefore, the vulnerability factors such as social and emotional disruptions, homelessness and violent relationships could affect children's mental health (Karim et al 2006). The impact on the mother's emotional wellbeing and parenting can adversely affect children's mental health as was identified in the literature review. The factors identified in the literature above could be associated with the children's behaviour displayed in this study. Susie's daughter as highlighted above was self-harming and attempted to commit suicide. Ginny's youngest son was displaying behavioural problems as indicated in the quote below,

> "My youngest son has got behavioural problems that he's picked
> up so he constantly cries for hours and he hits me."

It is clear that children of mothers in my study suffered behavioural and mental health which may have been aggravated by being homeless. Although it is difficult to make this causal relationship as other factors such as domestic abuse may have impacted on their health and wellbeing. The mental illness that the homeless women suffered from were depression, bipolar disease and anxiety that is often intensified by substance misuse and domestic abuse. Their children were also likely to suffer mental ill health, which predisposed into self-harming and attempted suicide. The sexual

abuse of one of the children and a house fire could have also predisposed to mental ill health.

Being homeless with dependent children and having a mental illness can disadvantage these women when it comes to seeking healthcare services. The women are marginalised and often do not have access to equitable healthcare services because of their situation (Benbow et al 2011). This poses a cycle of powerlessness for these women, they removed themselves from a situation of abuse, became homeless, marginalised by society and unable to receive access to equitable healthcare services. However, these women were no longer passive recipients they showed resilience in fleeing from an abusive relationship with their children. It is evident from the transcripts that these women fought hard to get access to services, for many of them the access only became available once they had a permanent address. What was evident that these women fought for healthcare services for their children, but not so much for themselves. Mackenzie (2014) purports that women in general put their children first over themselves as this is the act of being a mother. This view is supported by Sulik (2007), in that women feel obliged to place children's needs above their own. In putting their own needs first would contradict with their "gendered identity". Similar findings were found in studies by DiGiacomo et al (2011); Joslin and Harrison (2002). The four studies mentioned above have not been undertaken on homeless women but on women with life limiting diseases such as cancer or chronic conditions HIV and cardiovascular disease. What this demonstrates is that women whether they have life limiting, chronic diseases, depression or emotional pain such as the women from this study, all put their children's needs first. These findings have not been identified in previous homeless literature, therefore, this is a new finding gained from this study.

Emotional impact had not been explored in the literature review in chapter three, many of the studies explored aspects of wellbeing. However, emotional impact was not always a principle factor within the reviewed studies. A return to the literature was necessary as this concept was one of

the sub-ordinate themes identified from the interview transcripts. The emotional impact of losing one's home, becoming socially isolated from family, friends and other social support mechanisms, impacts on the added stress of homelessness (Lippert and Lee 2015). A study by Lee et al (2010), suggests that poverty and social isolation were influential factors that affected the emotional stability of homeless people, although poverty may have been a determining factor in their decline into homelessness. Another consideration suggested by Lee et al (2010) related to problems in accessing medical care which exacerbated homeless peoples stress, leading to further emotional distress. Similarly, Johnson et al (2017) suggests that women who are homeless, are more likely to suppress their feelings and be less tolerant of their circumstances, which can lead to greater stress and emotional instability. Johnson et al (2017) further argues that the emotional impact may not be contributed to homelessness alone; it could be as a result of other negative experiences previously endured such as domestic abuse or adverse childhood experiences. It is not only the adults who are affected, the children also suffer emotionally.

Welch-Lazoritz et al (2015) found that women who care for dependent children will often internalise their emotional stress, by supressing their emotions in this way, can lead to a deterioration in their mental health. The dependent children of women who are homeless are not exempt from the impact of emotional consequences. The children will experience multiple sources of stress including greater school mobility, disengagement with education and poorer academic attainment than other disadvantaged children (Johnson et al 2017). Children in situations of homelessness become isolated from friends, peers and other forms of social support, including disruption to family routines and lack of supervision (Grant et al 2013). The adults and children are emotionally affected by their situation, the removal from what is familiar to the unknown, new area, schools and peers. The social isolation and insecurity of being in temporary accommodation impacts psychologically on homeless people.

For the women who are homeless, not having a permanent place to live leads to emotional loss. The negative effect of becoming homeless, the uncertainty of the future and the responsibility of parenting impacts their emotional wellbeing. Susie felt isolated and alone,

> *"It was one of the scariest things I've had to do, do you know, it is so scary and socially isolating, you've got to leave everything and everyone behind."*

Emily did not want to show her emotions to the outside world, she would try to hide her emotions.

> *"There were times that as much as I could hide it, nobody else could see it but the kids were with me 24/7 and they'd hear me crying"*

This is often viewed as the 'face to the world' concept as a way of hiding emotions, what is portrayed to the outside world is different to the feelings and emotions that are being internalised. Jung describes face to the world as 'the mask', the side that is presented to people that is outward facing. This is an element of the personality referred to as the 'persona,' the persona is a part of the ego that allows us to interact socially, which enables us to function on a daily basis (Hopwood 2015 p.3). The homeless women wanted to portray that they could function normally and hide their emotional turmoil. Here Emily again hides her emotions,

> *"I got very good at not showing people how I was really feeling the true state of me."*

This showed the women's resilience and hope to survive their time in temporary accommodation, through the women's discourse they exhibit positive attitudes despite their hardships. This positivity was displayed by Susie,

> *"I think that's it, I've come through it, I'm smiling."*

There were times when the women found it difficult to hide their emotions, when the stress and despair became too overwhelming. This led to feelings of instability and insecurity which was often referred to in the narratives. Homeless women with children have to shoulder the parental responsibilities in caring and supporting their children with the devastation of losing their

home (Hausman and Hammen 1993; Friedman 2000; Marcus 2014). Julie feels unable to provide a homely environment for her children, including the insecurity of living in a temporary accommodation coupled with the probability of moving again.

> "*You can't really make it a home because you can be moved at any time*"

The women do their best in trying to support their children while in temporary accommodation. However, the trauma of losing their home and the experiences encountered prior to becoming homeless has an effect on the children's wellbeing.   (Friedman 2000). The women demonstrated a positive attitude, as they battled with healthcare services and displayed a determination and resilience to survive their time in temporary accommodation. The resilience of these women is not always recognised, a view supported by Benbow et al (2011). The women needed to adapt to their environment and their situation, they were still vulnerable but their belief in themselves helped them overcome the negativities that they faced.

The emotional impact of the lived experience of becoming homeless and being temporary housed was overwhelming for one of the participants. Throughout the interview Emily was so overcome with emotions that she would be in tears, constantly wringing her hands. The emotional fallout of becoming homeless, was still apparent even three years after the event. Emily frequently apologised for her emotions, at one point she stated that I was "like her shrink," to this I felt that the telling of her story was therapeutic for Emily. Participants can often find a therapeutic effect when unburdening themselves during the interview process, even when discussing quite emotive issues. Similar findings about the 'therapeutic' value of these experiences have been found in other studies (Lowes and Gill 2006; Taylor et al 2007).

The temporary nature of the accommodation added to the stress that the participants were already feeling. They regularly referred to '*temporary*' throughout the interview, it seems to have an impact on their emotional state.

The permanency of a residence is all important to these women who are in temporary accommodation, not only about ownership of the accommodation but what it represents. The symbolic nature of a permanent address allows them access to primary and secondary care services without being stigmatised, they are accepted by society and not marginalised. The temporariness of the women's situation was the key to their stress and was implicit throughout the narrative. Arguably for Emily it was about the security of having a permanent place to live, an anchor to set down her roots, without the stress of being moved on. The temporary status and loss of ownership felt by homeless women who are in temporary accommodation and the impact on their emotional health is a new finding emerging from this study.

The children were often aware of their mother's anguish and emotional state, as they were present most of time, it was not always easy for the women to hide their emotions from their children. This was apparent for Emily whose two sons were teenagers, she felt that her sons became stressed as a consequence of seeing her stressed, and not as a result of the homeless situation, as she sees it.

"*So they were stressed, I was stressed, they were feeding off me*"

Emily did not feel her sons' emotional wellbeing was affected by becoming homeless, but felt that her distress did upset them. Alcohol and drugs often play a part in the lives of the homeless as depicted in the literature in chapter three. This behaviour can be the cause of becoming homeless or as a way of coping once homeless. In Emily's situation the breakup of her relationship with the father of her children before she became homeless was the catalyst for her substance misuse. Emily reverted back to using alcohol as a coping strategy after she became homeless although this could have had an impact alongside her bipolar disorder. Research by Marcus (2014) suggests that often people do not seek help for their mental illness, but self-medication by using alcohol or illegal drugs to relieve the emotional pain.

<u>8.4: Loss</u>

The concept of loss was not identified within the literature review in chapter three therefore, a return to the literature was undertaken.

Loss is perceived in different ways and can affect people differently, for homeless people the loss of a home, possessions or identity can have emotional repercussions for some individuals. These emotions can lead to feelings of grief for the things that have been lost. There are a range of different models of grief that are usually associated with bereavement. These are Bowlby's attachment theory (1973), Kubler Ross five stages of grief (1969), Stroebe and Schut dual process of coping (1999; 2010). Bowlby (1973) identifies four stages of mourning these are "numbing, yearning and searching, disorganisation and reorganisation". Bowlby argues that attachments are formed early in life, when these attachments are damaged such as a bereavement, the individual becoming distressed, resulting in anxiety and anger. Kubler-Ross (1969) implies that grief is a healing process that brings comfort; the loss referred to is personal, such as the death of a loved one. The five stages of grief are denial, anger, bargaining, depression and acceptance, or sometimes called adaptation. The process of grief is flexible, individuals will move back and forth from one stage to another and may even miss a stage. Lastly, the dual process model by Stroebe and Schut (1999; 2010) focuses on loss orientation and restoration, they suggest that the individual will concentrate on the restoration activities when the loss becomes too difficult for them to bear. The views and theories suggested above, all offer processes that individuals are likely to work through when coming to terms with loss. Although death is the ultimate traumatic experience that individuals will face, other forms of emotional trauma can lead to the same grief response, especially if these challenges are encountered for the first time (Thompson 2016). Any of the examples of the different stages of grief discussed could be adopted and used in this thesis however, Kubler-Ross (1969) is the model of choice, this theory of grief and loss has been adapted and used in other studies that are not aligned to bereavement. These are management and leadership studies (Friedrich and

Wustenhagen 2015); and grieving due to worksite closure (Blau 2008). Therefore, these stages are adapted within this thesis.

Sabar (2000 p154) defines bereavement as "to be robbed or deprived of something valuable". So in essence this definition could be attributed to any form of loss and not just to the loss of a loved one or family member. Therefore, any loss is personal to that individual even the loss of a home or possessions. Loller (2010) in her narrative describes the loss of her home due to a fire, she reflects on her experience of grief following this loss of her much loved home and all their possessions. The endurance of pain over possessions, although some of these possessions could be replaced, many were unreplaceable and difficult to bare at times. For Loller "the house fire was a form of death" and the grieving process allowed her to come to terms with her loss and finally move on (Loller 2010 p270).

Freeman (1999) defines loss as being the loss of someone or something of value that is perpetuated by grief. The emotional impact of losing one's home and its contents can be compared to the stages of grieving, denial, anger, bargaining, depression and acceptance as previously commented on (Kubler-Ross 1969). This model of loss and grief has been included in a variety of loss situations relating to injury, divorce, work, unemployment and identity. Although there is much controversy around the use of this model, the stages can be utilised around the experience of loss per sae. Where there is a change of experience such as a loss of a home, personal items or identity, firstly what occurs is denial or ignoring the situation. If these feelings persist then a battle ensues to either prevent or reverse the structural change. Where prevention is unlikely then bargaining protects what is most valued. Through a period of hopelessness change becomes inevitable then acceptance is likely. Acceptance and adaption occurs where the experience of loss becomes more positive and there is a willingness to move on (Kubler Ross 1969). Therefore, Kubler-Ross's theory of grief could apply to any loss including the loss of home and possessions.

Homelessness can pose a threat to a person's identity; their valued place in society before they became homeless no longer exists. Society's view of homeless people is idealised by the media and reflects the street homeless. Riggs and Coyle (2002) in their study of homeless youths found that self-esteem, distinctiveness and self-efficacy was difficult to maintain after they became homeless. Similar findings were identified by Davies in (2011) homelessness threatens their former identities and it becomes more difficult for homeless people to accept this change. Identity is very much encapsulated with how society views homelessness, including the perception and attitudes of others who encounter homeless people.

The loss of a home and possessions can involve a complex set of emotions, grief and sometimes guilt. Home is not seen as just a physical space but a place of identity and belonging, a place where events transpired and memories made social (Moore 2007). The concept of a home and the meaning of homelessness is subjective and can be idealised in different ways according to individual experiences as discussed in chapter two. According to Husserl, the lifeworld is embodied, and shaped by human experience, including how people relate to the world and situations (Hemingway 2011). For these women who have lost their home, their experiences resonate with one of the elements of the lifeworld namely spatiality (Todres et al 2006) of living in a temporary environment and the experiences of living in this different environment.

The women in this study expressed multiple and diverse feelings of loss, not just the loss of their home, but loss of possessions and companionship. Their loss symbolises what Loller (2010); Jarrett (2013) describes in that a home is not just a structure but what it represents, the memories and events that have taken place. Emily felt that a house was not a home unless it was a permanent place to live, a feeling of belonging.

> "*all my belongings were there, what I'd managed to take, you know, with me, nothing was mine, it didn't feel like mine, I never said let's go home, it was let's go back to the house, it wasn't home, it was a house because it wasn't mine*".

Riggs and Coyle (2002 p13) refers to this sense of home versus a house as

a "*sense of hearthlessness because it lacked a home-like quality.*" Although it is argued the loss of a home is in relation to place attachment (Moore 2000). For example, the attachment to a home that could be associated with the length of time spent in the home, and socialisation with friends and or groups. For the women in this study, a consequence of losing their home there seems to be a combination of place attachment and hearthlessness. Julie describes what home represents for her,

> "*It's the little things that you miss as well and it's just having your own, especially being in a refuge just like not having your own four walls, it plays quite a big part in your life you know, your home is everything, when you lose it you kind of realise what it meant to you*".

The women felt they had lost a part of themselves when they left their home and came into temporary accommodation. People respond to these type of losses in different ways, it can invoke feelings of grief as previously discussed by Kubler-Ross and Kessler (2005). Individuals move in and out of these stages in accordance with how they react individually to their grief and emotions. Ginny felt overwhelmed by her emotions and the need to move on with her life.

> "*it's just and then just losing the house and losing everything it's just emotional. It's just trying to pick myself back up and start again and just forget everything*"

Three of the women were victims of domestic abuse and so fled their home to get away from their abusive partner. Both Julie and Ginny as seen in their quotes above had feelings of loss of their home. What is interesting is the negative experiences that the women suffered in these homes seemed not to affect their feelings of loss of their home. For these women it is more about what the home represents the positive events, birth of their children and a source of identity. Moore (2000 p212) suggests that home can be a place of security and affection but can also be a place of fear and confinement. The latter is true of people who are the victims of domestic abuse. There appears to be no studies based on the experiences of loss of home associated with victims of domestic abuse who have fled their home and became homeless. Some studies have explored the positive aspects of the meaning of home

however, these were not attributed to homelessness (Jarrett 2013; Freeman 1999). Therefore, this is a new finding from this study.

The loss of losing a home for whatever reason is associated with so many other variables such as loss of personal possessions, familiarity with the neighbourhood, friends and schools. The loss for these women goes beyond the home to their valued possessions. This was pertinent for all the women who fled their home and having to leave possessions behind. As Jarret (2013) suggests a home can be seen as a repository for memories, in losing possessions the vital link to memories can be lost. However, for Ginny and Emily it was especially poignant. Ginny felt the trauma of losing her children's belongings from when they were born was overwhelming and she grieved for the loss of memories that these objects symbolised.

> *"I know you should start again but it's a horrible thing, to restart and build everything up again, get to know people and it's like the kid's baby stuff, so they had when they came out of the hospital and things like that, because I didn't go through everything and made plans or anything".*

Ginny loss was symbolised in terms of memories that was invoked by possessions she cherished, and were now lost to her. These items were irreplaceable; if they are replaced; they would not have the same significance as the lost item as the new item is devoid of meaning (Berry 2012). Emily lost her possessions during a flood while in temporary accommodation.

> *"During the Christmas period the pipes in the house I was in froze and burst in my kitchen. I was staying with my sister for a week over Christmas with the kids… when I opened my front door I was two feet deep in water, it ruined everything. I lost everything downstairs"*

Belk (1988); Ferraro et al (2010) indicates that possessions are an extension of the self and therefore the loss of these possessions and the grief that is experienced, threatens the person's self-identity. Where the possession in question is unique, something that is of particular relevance to the owner, as considered by Ferraro et al (2010 p2) as being an "identity marker". Where the identity marker is lost a part of the self is damaged and can be interpreted as a "symbolic form of death" leading to deep negative outcomes. Therefore, the negative reactions are greater where the possession when

lost is more a symbolic representation of self. Similar findings were found by Loller (2010); Jarrett (2013) regarding possessions as the extended self and sense of identity. People grieve for the loss of these possessions, because of the feelings and memories that they represent.

The homeless women experienced material loss such as the loss of possessions, loss of a home through eviction, fire and relationships. The emotional loss affected their sense of self, their identity, belonging and the memories of previous happy events. In turn the emotional pain that often results from the loss could have affected their mental wellbeing.

8.5: Being 'Done To'

The focus of this section is to explore identity formation in relation to becoming homeless and the effect this had on the women. The change of identity that these women feel is shaped by people's attitudes and judgements towards them. Both these factors are congruent in diminishing self-esteem and confidence, which then lead to the women feeling powerless in their battle to access healthcare services. Although being judged and attitudes of professionals was considered within the literature review in chapter three, the concept of othering was not found in the studies reviewed on homelessness. Therefore, returning to the literature was fundamental to identify how othering is defined and review any studies pertaining to homelessness.

Chaturvedi (2014) proposes that negative values and stereotyping portrayed by society on homelessness can impact on the homeless person's self-worth and identity. A descriptive phenomenological study by Martins (2008) interviewed 15 homeless adults on the healthcare they had recently received. The findings suggest that the participants felt they were treated as second class citizens because they were homeless. They felt their care was compromised and they were disrespected by the staff, that animals were treated better then they were. The participants were ignored and were made to feel as if they were invisible to healthcare. This study was based in the

USA and many of the homeless attend a free clinic for treatment. It is possible that other people attending this clinic who are not homeless receive similar service. Similar findings were found by Parkinson (2009) in their systematic review of the literature. The findings suggest that homeless people receive negative attitudes from nurses, of not being listened to, in view of this become disempowered. These negative attitudes can act as a barrier to accessing healthcare services.

For homeless people, identity is often inflicted upon them especially by the news media as suggested by McCarthy (2013). The messages society sends, places values on homeless people, these messages often have negative connotations for the homeless. Their identity is constructed in a way that considers them objects of discourse and homelessness is seen as a characteristic of that discourse. McCarthy (2013) suggests that being labelled in this way is predictive of why homeless people take on this identity.

Othering defined as the process of identity formation through disapproval and denigration of the 'other' (Gabriel 2012). These identities are often positioned within a social context as is the case of homelessness (Jenson 2011). Gabriel (2012) argues that western society dehumanises and degrades people such as homeless women by denying them a voice, offering judgment by importing views and opinions regarding these women. Amy felt that she was disadvantaged when trying to get appointments because of her temporary accommodation status.

> *"They don't bother finding out why, they just assume that you haven't bothered to turn up and the number of times I'd phone them and say but I've moved so I didn't get the letter and our GP should have written to you. Oh well we haven't received anything so it's your fault".*

The women felt they were not listened to because of their temporary status and the reasons behind their homeless situation was not of interest. Therefore, the assumed change of identity for these women that was endorsed by people and society, from being a partner and mother in permanent accommodation, to being a homeless mother in temporary accommodation. Identity is about who we are, our sense of self, gender,

race, ethnicity and religion. It locates us in the social world, affecting what we do, feel, say and think (Boydell et al 2000). Therefore, in understanding of ourselves based on observation, how others view us, how we evaluate ourselves is perceived by Stets and Burke (2003) as an important self-concept. The loss of a home, possessions, how the homeless women were regarded by society was posed as a threat to their former identities, as foreseen by the women in this study. Homelessness had an impact on the women's sense of identity, Julie saw her personal identity from being different to the other residents within the homeless refuge.

> *"my situation is a bit more different because obviously I've come in to refuge, I've got no like issues, other women who are alcohol dependent, drug dependent, who've got numerous medical sort of things……. I'm literally just there to be safe and to keep my children safe"*

Julie refers to the phenomena in question as the norm for homeless residents or as she sees it. Stets and Burke (2000) suggests that people see themselves as defined by social structure, so for Julie, homelessness is the embodiment of that social structure. Merleau-Ponty suggests that experiences are shaped by our interpretation of the world, if we are well and feel comfortable with our bodies, we feel secure. When an event happens such as the loss of a home, disequilibrium occurs which disrupts the familiar world (Smith et al 2009; Shaw et al 2016). Julie does not accept a change to her identity since becoming homeless, she disassociates herself from society's view of homelessness. The refuge for Julie was a place of safety for herself and her children. Research undertaken by Boydell et al (2000) equates with this premise that participants do not wish to be acknowledged the same as other homeless people, they create what Boydell calls "*an identity hierarchy*" (p132) as they see themselves as better or different. The role of being a mother is the only identity that Julie associates herself with at this time and not as a homeless person. She views being homeless as a temporary situation that was necessary to keep herself and her children safe.

Amy has similar views to Julie in how society views homeless people regardless of their reasons for being homeless, she refers to being,

> *"Clumped together, all down and out druggies and alcoholics."*

These women felt like they are viewed the same as single homeless people living on the streets, sleeping in doorways, on park benches or under bridges as depicted by the media.

This castigation by society, the media and organisations marginalises the homeless women and diminishes their self-worth and causes barriers when seeking healthcare services. In a study by Riggs and Coyle (2002) the participants were young homeless people who were in temporary accommodation, their experience was similar to the women in this study. Society viewed them as being no different to the media's portrayal of street homeless. These young people over time lost their former identities the more socially excluded they became, which resulted in them taking on the identity and behaviour that was expected of them by society.

McCarthy (2013) argues that homeless people not only lose their home, but also their social identity and can cause a loss of their sense of self. In the case of Julie, the GP practice made her feel inhuman, 'just another number.' The individualisation that each person is different and the acknowledgement that people have different needs was not apparent. There was no opportunity for Julie to discuss her current situation.

> *"It's like they just sort of rush you and that's what really annoys me and I just think okay well you know, because they don't really want to look at you or communicate with you they just want to write you a script and that's it."*

A similar position is argued by Goffman (1963), in referring to the sense of self and how people are viewed by others, he purports a person's identity is reliant on the acceptance of the wider community and not just by the individual, in this case the homeless person. The homeless women were discriminated in different ways, based on homelessness, mental illness, temporary residence and other social identities such as drug and alcohol misuse. Another of the participants felt being in temporary accommodation left her feeling isolated and a sense of not belonging. The lack of place attachment that homelessness offers can result in low self-worth, social exclusion and isolation (Riggs and Coyle 2002).

Throughout the women's stories there appears to be a thread running through around powerlessness and the insecurity that these homeless women feel. Women who are victims of domestic abuse, showed great courage in fleeing from their abusive partners and making themselves homeless. The participants in choosing homelessness over abuse, to protect themselves and their children, also demonstrated their resilience through disempowerment. Susie raised an interesting point that, women who are victims of domestic abuse become drug and alcohol users by default, as a means of coping with the situation they were in. However, as in the case of Susie, her partner controlled her drug taking habit.

> *"I just think that women, a lot of women in the situation that I've been in were drug and alcohol dependent because that's the only way that we can be controlled, is to have our brains turned to mush."*

This form of control disempowers women (Hayes 2015), making them unable to think, act or make decisions while under the influence of drugs. Incidentally, victims of domestic abuse have a greater tendency towards drug and alcohol addiction as reported by Busch and Valentine (2000). The women did not want to be controlled either by their partner or by misusing drugs. In breaking away from this controlling environment they were taking control and the women that were misusing drugs rehabilitated to wean themselves off the drugs. Mosedale (2005) purports where control and domination over women was exerted such as in domestic abuse, male dominance is especially endemic. Although it is acknowledged that men are victims of domestic abuse too however, the incidence is much smaller. Busch and Valentine (2000) proposes that for women who are victims of domestic abuse to be empowered they must regain control of their environment.

The children also feel powerless, they have no control over their environment and are dependent on the care of their parent(s). The dependent children in this study displayed powerlessness in a variety of situations. Susie's daughter tried to intervene when her mother was attacked.

"One day he was strangling me while my baby was in his arms and my fourteen-year-old daughter come in the bedroom and tried to save the baby and he hit her out of the way."

Susie's daughter tried to safeguard the baby by trying to remove her from the situation, which resulted in her being physically assaulted, she was powerless to help any further. Hester et al (2000); Holt et al (2008) states that older children will try to intervene or prevent the abuse from happening, often adopting care taking roles and responsibilities for siblings. For the older child this can be empowering by having something to be in control of as was the case for Susie's daughter (Stanley et al 2012).

It is important that Children have a voice, Article 12 of the United Nations Convention on the Rights of the Child promotes that every child should be heard and listened to on all issues that affect them (Lansdown 2011). Children are dependent on their parent(s) to care for them and advocate for them within the healthcare service. The women in this study felt powerless when attempting to access healthcare services for their children. Susie's daughter began self-harming while in temporary accommodation, Evans et al (2005) suggests that adolescents who have a tendency to self-harm mainly confide in friends about their problems. The children from the study, who resided in temporary accommodation attended new schools, had possibly only known their peers for a short while. Therefore, would be unlikely to openly discuss their worries.

"My children were trying to just fit in but we worked through it and we got through it but it might have been easier if they were allocated their own youth worker or someone just to talk to"

For these children they had no one outside of the family unit to talk to and therefore did not have a voice or someone to listen to them.

The women in this study felt excluded from having equal access to healthcare services. It was as if these women or their problems did not exist, they became invisible to organisations especially health organisations (May et al 2007). They were perceived as unlikely to turn up to appointments. Homeless people are often stigmatised against, excluded and powerless and have greater health inequalities (Benbow et al 2011). Amy felt powerless in her struggle to get healthcare services for her two children. The constant

moving to different addresses and regions complicated her situation, appointments would be missed, as letters were not forwarded to the new address, this was a similar scenario for most of the women. Cooper (2015) emphasis that institutional temporalities can negatively affect homeless women's experience of self and to preserve their sense of self, homeless women may opt out or refuse healthcare services.

> "*I just can't do this anymore, I cannot fight any more because I just seem to be fighting against everything and everybody and just getting shoved back all the time*"

Amy felt that the healthcare organisations did not understand her situation and were not interested in her reasons why she failed to attend appointments. They failed to consider that being in temporary accommodation meant that these families would be highly mobile and move around. The attitudes of healthcare personal also contributed to the feelings of powerlessness by the women in this study. On one occasion, it caused Amy to become so distressed that she was left in tears

> "*To have that sort of pushed at you all the time, and the number of times I broke down, you know you don't know me, so how dare you place judgement on me*"

Amy felt demoralised and her self-esteem and self-worth was undermined. In a study by Wen et al (2007) the findings suggest that deleterious attitudes by nurses resulted in homeless people feeling disempowered, and treated as objects rather than human beings. This dehumanisation attitude of healthcare staff had affected Amy's sense of self and a strong character is not always an effective barrier. This demonstrates the fragility of the state of mind through constant dejection.

Although there were instances where the women became empowered. The women in this study showed determination and strength in fighting against the powerlessness they often felt when accessing services, they wanted a better future for themselves and their children. Mosedale (2005) describes, that women become empowered by believing in themselves, raising their confidence and self-esteem rather than succumbing to 'learned helplessness'. Amy's response demonstrates how empowered she became.

> *"Fortunately, I'm the sort of person that doesn't give up, I tend to fight especially when I know it's needed and especially if it's for my children, I will fight and I did."*

These findings are consistent with those of Benbow et al (2011) who found that homeless women's resilience enabled them to fight for a better future for themselves and their children, this being a permanent home and access to healthcare services. Although what should not be forgotten is that living in temporary accommodation can be detrimental to the health of homeless people. Therefore, domestic abuse, mental health and homelessness can impact on health not only in the short term but long into the future.

Society often marginalise individuals according to their status and social structure, for homeless people society often denies a homeless person's right to exist (Chaturvedi 2014). The homeless are often stereotyped as being unreceptive, idle, disempowered and disaffiliated as identified in a study by Boydell et al (2000). The participants in the current study perceived they were disbelieved by practice staff, this was interpreted by the body language and facial expressions of the practice staff in communication with the homeless women. Emily felt she was being judged every time she accessed GP services,

> *"they made everything feel worse you know, to sit there and have somebody you know, the eyebrows go up and yeah alright, whatever, and I thing how the hell do you know how I feel, how can you sit there and judge me"*

The participants felt their self-worth was being challenged, they were judged by healthcare personal because of their homeless situation, without any inquiry on how or why they became homeless. Goffman (1963) argues that where individuals or groups do not conform to social norms then they are stigmatised by society. This study confirms the views of Parker (2012) who found that the dignity of homeless individuals is often violated through being unfairly treated, or in receipt of a poor service. These women felt rejected by society, their self-worth was linked to how they were viewed and treated by others.

The reaction of healthcare personal affected the participant's confidence levels and they become subservient and reluctant to ask questions, as stated by Julie,

> "*They don't really want to look at you or communicate with you they just want to write you a script and that's it.*"

Judgements were made by healthcare personal when referring to homelessness, the reason for being homeless was not considered. The women felt stigmatised because of their situation (Chaturvedi 2014), felt they were treated differently to other patients who were not in temporary housing, felt they were not seen as a priority and were treated unfairly and not listened to. Amy's opinions were not valued she was deemed to be making excuses for missing appointments.

> "*How many times are you going to use this as an excuse? It's not an excuse, it's the truth, you know we moved 28 times in five years, not through any fault of our own*"

Judgmental attitudes by healthcare personal whether through body language or spoken did not go unnoticed by these women and for Emily and Julie it resulted in them not accessing healthcare when needed.

Moral judgement is another consideration; the participants were made to feel guilty because they were in temporary accommodation and were deemed to be unfit mothers in view of their homelessness. According to Glaser and Strauss (1964) people are valued according to their social status. Both Amy and Julie felt guilty about their inability to access services for their children, even though they tried tirelessly to get appointments. Their own feelings of guilt were further exacerbated by healthcare personal judging them not to be good parents.

> "*They used to make me feel pretty awful, when speaking to them, you know it was always oh well if you were, you get the impression well if you were a better mother you'd make sure you got the appointments wouldn't you.*"

Healthcare professionals use victim blaming techniques when they deem the patient is at fault (Hill 2010). The surveillance of parents can be seen as an act of judgement on parenting abilities. Julie was certain that her actions were being monitored when she attended baby clinic. In view of Julie's

circumstances as a victim of domestic abuse, the anxiety that Julie was experiencing could be exaggerated by her home situation (Benbow et al 2011). The participants lost confidence and trust in healthcare personal and reacted negatively when dealing with them. In an early study undertaken by Roth (1972) and supported by Hill (2010) suggests although healthcare personal made a conscious attempt to be non-judgemental, women were labelled by their addresses before they arrived for appointments. The women in this study assumed that the healthcare personal would find fault in their actions and feared that their children would be removed hence it appears that little has changed since 1972.

> *"It feels like you don't want to open up to them, you know, or you feel like if you do something wrong then you know, like, would social services be called in, you've always sort of got that worry"*

Healthcare personal prophesise in being non-judgemental in their approach to patients however, the evidence from this study suggest that this theory is flawed. These women are harmed by the attitudes of healthcare personal, the findings from this study supports this ideology.

The participant stories are infused with the frustration that the women feel in trying to get access to healthcare services with the added un-cooperation from healthcare personal and support. Similar findings were identified in a USA study by Martins (2008), where participants were treated differently if they were homeless. The nurses disbelieved and mistrusted the explanations provided by the homeless patients, the homeless patients felt they were always treated inferior to non-homeless patients. Similar experiences came from this study; Amy was instantly judged as soon as she mentioned temporary accommodation

> "*As soon as you mention the word temporary accommodation you can sort of almost see the shutters coming down"*

Emily also had the same experiences,

> *"you don't see the same doctor every time and they all look at you like you're making it up and then you're constantly re-telling the same story so it's easier to avoid th*em"

The findings from Martins study has similar connotations to the findings of this study in relation to healthcare personal's attitudes towards homeless people. The evidence provided from this study supports the findings from other studies (Neale and Kennedy2002; Cosgrove and Flynn 2005; Nickasch and Marnocha 2009; Parkinson 2009; Rae and Rees 2015).

The perceived high turnover of staff within a social care service led to an inconsistent approach to care according to Amy. Although this cannot be foreseen, the outcome had a significant effect on Amy's daughter. The daughter had mental health issues, which Amy felt was the consequence of the delay in getting help after they became homeless.

> "*Whereas I think if it had been dealt with at the time she'd have been able to move on and probably wouldn't be in the state she's in now.*"

Children who have lived experiences of abuse and breaches of trust are especially guarded about the trust they place in adults (Pinkney 2013). The consequences of these events led to Amy's daughter finding it difficult to continually build trusting relationships with the professionals and subsequently refused to attend appointments. Pinkney (2013) argues that the development of trust takes time, there should be continuity between the professional and the child and a commitment to listen. This child was failed by health and social care services, it took five years to secure an appointment for counselling because of the mobility of being homeless and missed appointments. The negative effects of this failure resulted in more serious mental ill health in adolescence.

8.6: Social Exclusion

Women who are homeless often exhibit comorbidities as identified by the literature in chapter three. The main health issues are depression (Slesnick et al 2012), drug and alcohol addiction (Vostanis 2002; Tischler et al 2000; 2007) and physical health problems underpinned by poverty (Weinreb et al 2006). Not forgetting that some of these women are also victims of domestic abuse. These findings are consistent with the findings from this study. The

participants and their children have required healthcare services for a range of mental and physical health needs. With the constant demand on NHS services, a diminishing budget and an increase in waiting lists is both frustrating and harmful to health (Murrey 2016). These facts are the same across the wider population regardless of social status unless you are able to pay for private treatment.

The participants in this study were aware of these restraints on the NHS but felt they were disadvantaged further because of the temporariness of their accommodation. A key factor from this study for these homeless women is the bureaucratic systems within the NHS around the appointment system. In constricting the flexibility of obtaining appointments when a temporary resident and highly mobile exacerbates the problem, resulting in added stress for these women. In obtaining appointments the women in the current study had a constant battle, Amy consistently fought for services for her children over a period of five years while in temporary accommodation.

> *"Trying to get a doctor, because we didn't have as such a permanent address because we didn't know how long we were going to be anywhere they wouldn't take us on as patients."*

Amy's situation differed from the other participants; they were constantly moved from one temporary accommodation to another which resulted in them being moved 28 times. This perpetual movement was a barrier to registering with a GP practice and getting appointments. As previously discussed, the attitudes that these participants were subjected to, could also have been a barrier in accessing appointments (Martins 2008). The Welsh Government is aware of the disadvantages the current appointment system is having on patients. They have set out recommendations to give patients more control in managing appointments through a digital technology system. Exactly how this will work is not clear at present (WG 2018b).

The participants wanted continuity of care when accessing GP's. In view of their temporary status the women perceived they were not allowed to see the same GP on more than one occasion. However, this situation is not restricted to just temporary residents. Many patients receive a similar

service, however, the women in this study that had a permanent address when interviewed, stated they now have access to the same GP.

> *"Like now I can phone up and ask to see the same doctor each time"*

The increased mobility of these women and children will have contributed to this situation plus the multiple problems that homelessness creates. The re-telling of their previous situation exacerbated the distress the women in this study suffered, as identified here by Amy,

> "*It meant that you never get to see the same doctor so you'd have to explain everything time and time again which was just as distressing for me having to go over it constantly.*"

Each time the women attended the GP practice, they were subjected to repeating their harrowing stories of homelessness, domestic abuse and ill health. This, in itself, was a barrier for the women and determined whether continuation of accessing healthcare services was an option. Amy made the decision to disengage with primary healthcare services.

> *"What's the point, you know there is no point because going there it's making me more upset than if I didn't bother and so in the end I tend to not go."*

There was no therapeutic advantage in doing this and the re-living of their experiences could be harmful. Julie felt the consultation with the GP was rushed and there was no opportunity to discuss her concerns. Arguably, this could be the same for all patients in this particular GP practice and not just for Julie.

> *"When you do go you're like literally, you're so rushed you can't even have like time to talk to a doctor about anything"*

The homeless women became increasingly frustrated when healthcare personal failed to communicate adequately with them regarding their children's health issues.

This invoked a feeling of being ignored, their needs not seen as a priority and a failing in the system. A recent policy 'Healthier Wales: our plan for Health and Social Care (WG 2018b) recommends that healthcare personal have better communication with patients regarding their care. This policy was developed from the Parliamentary Review (WG 2018a), which recommends

there needs to be a culture change within healthcare, where shared decision making is adopted between healthcare personal and patients.

Ginny's experience was particularly concerning, her son has cystic fibrosis and she needed emergency antibiotics for him.

> *"I needed to get his medicines then get a repeat, I had to go and make an appointment, wait all weekend for an appointment and then go and get his medication and I got to the chemist and they didn't have none of the medication and I've had to wait three days for medication on top of that"*

The length of time waiting for a GP appointment and another few days before the pharmacy were able to obtain the medication, could have had serious consequences for the child. There were no reassurances from either the GP or the pharmacist regarding the delay in getting the medication. Communication is not always forthcoming for these women regarding healthcare services. The women living in temporary accommodation are new to the area so information regarding the whereabouts of GP surgery, dentists, pharmacy and schools are important. Without this information engagement with healthcare services is unlikely.

> *"I thought the doctors was just down the road from where I was because it said medical centre so I kept going there every day and trying to catch them on the day but they'd moved and not told anyone."*

This basic information should be a priority for hostel's refuges and organisations that house people in temporary accommodation. Leaflets or a notice board containing this form of information will be a recommendation. Helpful information in regard to available health or social care services and support is another area that improvements could be made. This lack of communication creates a barrier for these women accessing healthcare services. Susie felt let down by professionals when she needed support.

> *"No one tells me anything of what information I can get, what support I can get, because everyone is just saying well we can't support you with this and then I go to someone else and they say can't support you with that. So I don't know what actually they do."*

Susie seemed unsure of what resources were available and whether she could access other services, maybe information was not clearly articulated.

Healthcare personal need to be clear what services can be offered by whom and communicate clearly the reasons why some resources are not available. The marginalisation of these women by healthcare personal and the poor service availability possible affected the health of these women and children, which in the long term will incur additional costs to the already depleted health service. There is a lack of UK literature on the barriers to accessing healthcare services however, a few early studies consider accessing healthcare services but their findings do not replicate this study, other more recent studies are either American or Australian. In view of the difference in Health Services accessibility in these countries compared to the UK, the findings could not be generalised. Two UK studies Wright and Tompkins (2006); Neale et al (2008), identifies appropriate services and interventions for homeless people, but do not consider the barriers in accessibility of services.

8.7: Summary

The research questions set out at the beginning of the study refers to how women with dependent children who live in temporary accommodation, access healthcare services and what are the barriers that affect the uptake of services. This study has explored how women with dependent children who were living in temporary accommodation make sense of their situation, the difficulties in accessing healthcare services when living in temporary accommodation and the barriers that hinder uptake of services. These women not only lost their homes, friends and possessions, but also their sense of self. The emotional impact of this loss was akin to the stages of grieving, especially the loss of treasured objects that held memories of the children's birth. Being in temporary accommodation, having a roof over their head did not compensate for losing their home. The accommodation did not feel like home, the women had a sense of not belonging, there was no ownership of the property. The accumulation of these losses caused additional emotional stress for the participants in this study. There was a deterioration of the women and children's health especially mental ill health.

Some of the participants previously suffered from mental illness whereas other participants developed depression either as a result of domestic abuse or becoming homeless. The children also had health needs, some displaying mental ill health and others with physical health needs.

The emotional impact of being in temporary accommodation took its toll on the health of the women, they showed great determination and resilience to overcome the isolation and negativities that they faced on a day to day basis. The participants on becoming homeless forfeited their previous identity, although they were still parents to their children and role models, becoming homeless changed the way they were viewed by society. The powerless nature of being a victim of domestic abuse, the stigma associated with homelessness, the attitudes of healthcare personal and marginalisation by healthcare providers added to the emotional trauma for these women. Many of the findings in this study have been replicated previously, some barriers facing women in temporary accommodation accessing healthcare services has not been previously identified These being the battle in getting appointments when highly mobile, not allowing these women to access the same GP on more than one occasion and the difficulty in accessing repeat prescriptions. These are new findings from this study.

In chapter three engagement with the existing literature through a sociological perspective was undertaken. Some of the literature used in this section was not presented in the original review, this was a result of emerging themes that were not anticipated in the literature review. The Welsh Government is trying to address some of these issues stated above, in 2018 they undertook 'A Parliamentary Review of Health and Social Care in Wales' (WG2018a) followed by 'A Healthier Wales: our plan for health and social care in Wales' (2018b). These policies set out changes in healthcare delivery, including a new digital system for making appointments, shared decision making between healthcare personal and patients and improved communication between healthcare personal and patients regarding their care. Although the policies do not directly relate to homeless families, they do refer to vulnerable groups in society.

Chapter 9. Conclusion and Recommendations

This chapter provides a summary of the research in context and its implications for practice. The quality of the study has been explored using Yardley's (2000) dimensions of quality as a framework. Limitations are considered and the chapter ends with recommendations for practice and areas of further research.

9.1: Summary of the study

The aim of this study was to explore homelessness and the barriers to accessing healthcare services for women and their dependent children who were living in temporary accommodation. IPA was the chosen method to examine the lived experiences of these women. The sample of five women all with dependent children were interviewed. These interviews took place in two different environments, two women were interviewed in their homes and three women were interviewed in the charity's offices. All interview recordings were transcribed verbatim and analysed according to IPA methodology. Four super-ordinate themes were developed, Loss, Wellbeing, Being done to and Social exclusion, by funnelling down of the emergent and sub-ordinate themes.

What became clear from the participants was the emotional impact and feelings of loss that were experienced by these women. The embodiment of losing their home, possessions and identity was significant to them. The sense of grieving for what they had lost was epitomised within the interviews where they repeatedly talked about the loss of possessions especially newborn artefacts that held so many memories. Although some of these women were residing in three bedroomed houses albeit temporary, the houses to them were referred to as hearthless. Riggs and Coyle (2002) define hearthless, where a house has no home like quality or feelings of belonging. They grieved for the home they had lost, as one participant stated that 'you don't know how much your home means to you until you lose it'.

The stages of grief by Kubler Ross and Kessler (2005) was used to explain these feelings of grief and loss that the women were feeling. Although these stages were initially developed in relation to the loss of life, subsequently this theory has been used to support other aspects of loss similar to that experienced by the homeless women in this study.

This study provides evidence that the health of women and children who are living in temporary accommodation is compromised, especially their mental health. Four of the women interviewed suffered from mental ill health which seemed to be exacerbated by their homeless situation. It could be argued that their mental ill health could have been a barrier to them accessing healthcare services. The emotional turmoil that the women experienced also had negative repercussions for their children. The difficulty in accessing healthcare services especially when living in temporary accommodation, such as access to primary care services and repeat prescriptions added to their stress and emotional upset. Other barriers to accessing healthcare which were perceived by the women, related to how society perceived them. The women felt they were labelled the same as single street homeless and there was a lack of understanding of the homelessness situation. The perceptions of the women were that healthcare professionals judged them, were not caring and disbelieved their explanations for missing appointments. The women felt disempowered by these attitudes towards them however, they also showed some resilience in their persistence to gain healthcare services for their children.

This is only one interpretation of the outcomes of this study and further interpretations could be developed within other discourses. The integrity of this thesis will be underpinned by the use of Yardley's dimensions of quality.

9.2: Dimensions of quality

To uphold the quality of an IPA study, Smith (2009) recommends using the dimensions of quality by Yardley (2000). The four areas of this framework as discussed below.

9.2.1: Sensitivity to context

This study establishes sensitivity to context from the beginnings of the researcher's experiences as a health visitor working with homeless families in practice. I had a good knowledge of the health needs of homeless families and could empathise with the women when undertaking the interviews. I was used to working with vulnerable women and tried to put the participants at ease by listening intently and showing I was interested in their experiences. One of the participants made a comment, '*you're like my shrink*', I took this as a positive comment, that she felt comfortable in discussing her journey through homelessness and was not embarrassed when she became emotional as she retold her story. The same participant at the end of the interview confided that some of the information she disclosed had never been disclosed to anyone else. Therefore, the sensitive nature of how I conducted the interview is testament to the openness of this participant. Homeless women and their children are vulnerable because of their circumstances, without a permanent place to live, often living in poverty prior to and after becoming homeless. Consequently, this vulnerability can make them defensive and unwilling to share information. Four out of the five women were open during the interview however, one participant was quite guarded in her responses. This could be due to her child sitting alongside her and she felt unable to discuss her experiences in more depth, or she did not feel at ease discussing them with me. There was a further factor that may have contributed to her unease, as the interview was conducted in the Charity's offices.

As a health visitor I was experienced in interacting with vulnerable women including victims of domestic abuse. Three of the participants were in this category and I was sensitive in the prompts I used to gain a deeper

understanding of their experiences. In using a sociological framework to set the study in context and additionally using Kubler-Ross's five stages of grief (1969) to offer a further theoretical perspective, also supports the sensitive nature of this study.

9.2.2: Commitment and Rigour

As a novice researcher, in applying IPA methodology and the process of systematically exploring the descriptive, linguistic and conceptual elements of the analysis constitutes rigour as suggested by Smith et al (2009). The length of time in recruiting participants for this study was a long drawn out process. The difficulties were not with the participants agreeing, but with the organisations in recruiting participants on my behalf. Perseverance and determination were conducive to gaining an additional three participants, which was imperative in having a credible sample for this study and in line with IPA. As supported in chapter 4, the handling of data and participants conformed to ethical standards. Using open-ended questions allowed the participants to relay their experiences with occasional prompts in relaying their personal experiences of how they became homeless, their health issues, life, before and after homelessness. This method of collecting the data helped to demonstrate the rigour of this study.

9.2.3: Transparency and coherence

The connection between the research questions and aims and objectives, the development of subordinate and superordinate themes as evidenced in chapter 5, demonstrate transparency and coherence. The transparency of using IPA within this study and its systematic process allows an audit trail, which again demonstrates transparency. The arguments raised based on the themes within this thesis, the interpretation and writing up of the study demonstrates the coherence and transparency of this study.

9.2.4: Impact and Importance

The importance and impact of a study is determined by how it is judged, the impact and usefulness to research. In essence it is ensuring that these

women's voices are heard, that healthcare services are aware of the barriers that affect uptake of services and are sensitive to the needs of homeless families and other vulnerable groups. As opposed to a culture of stigmatism, disempowerment and low self- esteem. From a social constructivist perspective, sense making is not constructed purely from an individual's experience but socially constructed by interaction with others (Robson 2011). In accordance with IPA, what is important is how they, (the women) perceive their experience and not whether these experiences reflect reality.

9.3: Emergence of New Understandings

Other researchers have studied homelessness from different perspectives, there are a small number of UK studies that have explored access to healthcare services. The majority of these studies are associated with street homeless and not women with dependent children. Two studies were undertaken in Canada (Reid 2005: Hwang et al 2010), the participants were young homeless women living on the streets for Reid's study (2005). The uptake of healthcare services was poor and the main reason was discrimination by healthcare personal. The participants for the other study used single men, single women and women with dependent children. They quoted mistrust of professionals and access to a primary care provider (Hwang et al 2010). However, both of these studies have different health systems and access may be determined by financial implications.
Neale (2008) sample were all injecting drug users, only 10% of the cohort were homeless again the main reason for uptake was attitudes of healthcare personal. This was a UK study however, the attitudes of healthcare staff could be related to their drug taking and not homelessness. In stating this, healthcare personal should not discriminate against drug users. Other UK studies concentrated on mental health and support (Vostanis 2002; Tischler et al 2007). There was a lack of research pertaining to women with dependent children who are living in temporary accommodation.

Although there are some similar findings from these studies such as healthcare personal attitudes towards homeless people, there are also new findings from my study. The participants in my study were all women with dependent children who were living in temporary accommodation therefore the sample was different to other studies. The main findings being, accessing primary care services; consistency in continuity of care; seeing the same GP to follow up rather than causing harm and distress to homeless people expecting them to re-tell their experiences repeatedly. In relation to availability of services, it seems to be a postcode lottery. Where some areas offer a range of services, whilst other areas have very little services for homeless people. Where services exist they may not be coordinated and therefore communication between services maybe poor or non-existent. This presents huge challenges as lack of a permanent address means they may not be registered with a GP practice and therefore be hidden.

The appointment system in secondary care is not as efficient as it could be, the process for notification of appointment is not effective for homeless people who are constantly being moved accommodation. This results in wasted resources for the NHS as appointments are regularly not attended by homeless people. Improvements in information sharing between health and social care services is essential to enable a more seamless service for homeless people. One of the barriers to accessing healthcare services by homeless people is attitudes and perceptions of healthcare personal. Possible lack of knowledge and understanding of the trajectory of homelessness and the influence of the media leads to judgemental attitudes aimed at the homeless population. The majority of the women and some of the children in this study had mental health issues, which could also be a barrier for these women in accessing healthcare services. The participants in this study perceived that they were not listened to, were judged by healthcare professionals and were labelled due to their homeless status. The women felt their self-identity had been changed and were perceived the same as rough sleepers or street homeless. Therefore they felt disempowered and disbelieved by healthcare professionals, once again a barrier in them accessing healthcare services. In accordance with IPA

(Smith et al 2009), this study has explored the women's interpretation of their perceptions and experiences of becoming homeless and accessing healthcare services.

An interesting theme that came out of this study was the feelings of loss that greatly affected these women. The loss was multifaceted in that it related to different forms of loss. The loss of home, possessions, friends and identity. For some the loss of control was difficult to adjust to and for others who had lost control prior to becoming homeless became empowered. The women in this study went through a form of grieving for the loss that they endured therefore, Kubler-Ross's five stages of grief (1969) was an appropriate theory which underpinned the grief process that these women were experiencing.

9.4: Limitations

My lack of experience as a novice researcher was evident when undertaking the interviews with the women. The first interview was a learning experience, trying to concentrate on what the participant was saying, allowing her to tell her story, but trying to lead onto the main points of accessing healthcare services, I did not always pick up on vital language or delve deeper by asking for more information. There were some interruptions with her teenage son's and their friends frequently passing through, which disrupted the flow of discussion. I made notes after the interview on observations around body language and emotions of the participant, including improvements on my interview technique. The first two interviews although were pre-arranged the participants was either not at home or was not feeling up to being interviewed, so alternate dates and times were agreed.

I made a decision not to inform the participants that I was a health visitor by profession, I felt this may hamper the participant's honesty regarding healthcare services and professional attitudes. I wanted the participants to open up regarding their lived experiences of accessing healthcare services regardless of professional identity. I did not want the participants to be on

their guard and impede the flow of the interview. I therefore introduced myself as a researcher and lecturer at the University and did not go into any other detail and was not asked for information regarding this. Although I have worked with women who have resided in temporary accommodation, I have not experienced being in temporary accommodation myself. The advantages of having insider knowledge can inform more meaningful questions and the ability to read non-verbal skills. Therefore, from an insider perspective, I have some preunderstanding of knowledge, insights and experience of homeless women, I could draw on these experiences in asking questions and follow up on replies to obtain richer data (Brannick and Coghlan 2007). The disadvantages of being an insider during the interviewing, may fall back on previous knowledge and not follow up or probe as much as if I was an outsider. Further difficulties of being an insider is the positioning of one self within the analysis, being objective, not making assumptions and the importance of maintaining subjectivity (Greene 2014). To overcome the insider perspective, I used a reflective journal and wrote down my observations after each interview not only in relation to what I observed, but my own reflections on how I conducted the interview and how I could improve by listening more and not trying to think like a health visitor, but be impartial and remember I am a researcher.

Although, this does not guarantee that the women would be entirely honest during the interview and open up. One of the participants was very guarded in her discussion and was not willing to discuss her health issues or her reasons for becoming homeless. This may have been because she did not trust me, or because she had her son sitting with her and was careful what she discussed in front of him.

There was a time lapse between the first two interviews and the subsequent three interviews. The charity that recruited the first two interviews were unable to find any other families. I then contacted three local authorities, one of which seemed interested and invited me to a meeting. After months of emailing the housing officer at this local authority there was agreement for

me to interview families however, nothing materialised. I became increasing despondent, at the lack of participants.

Through a chance meeting with representative from another charitable organisation three more participants were recruited. However, the organisation in question insisted that the interviews take place in their offices, they would book the date and times of the interviews and have a support worker to care for the children. The interviews were booked at one hour intervals, I felt having the interviews in the offices was distracting for the participants, one of the participants seemed nervous and was mindful of what she said, and it was difficult to draw out information when using prompts. This could have been because she had her youngest son with her in the room, or she may have thought the interview could be overheard. The interviews felt rushed, I did not have time in between to gather my thoughts or write up my notes.

The sample of women recruited had different homelessness characteristics, they all experienced the same phenomenon, in living in temporary accommodation and accessing healthcare services. Two participant's narratives of their experience of homelessness was due to recall, these women had been permanently rehoused for two years or more. The recall account of the women's experiences may have been over-emphasised due to factors that have not been identified.

When undertaking the analysis of the interview transcripts I found it difficult in letting go of my pre-suppositions, namely being a health visitor. Without realising, I would adopt this stance frequently through the interpretation. Therefore, I revisited the transcripts making sure the participants interpretations of their experiences came through. In being mindful of the word count of this thesis, I had to be selective with the information taken from the transcripts. I used information relating to my research questions, however other interesting information can be written up separately to inform practice.

As a novice researcher and not experienced enough to draw out the women's experiences to help them develop personal interpretation. The small sample size is a limitation, the experiences of a small homogenous group of women were used for this study. A larger study using women from other cultures and a comparison across Health Boards may address this limitation. Two participants had been permanently housed two to three years prior to the interview, therefore the information is dependent on recall. The information of the experience maybe embellished and their reflection could have been on hindsight rather than how it was at the time. However, for one of these participants the emotional journey was quite harrowing and the interview was paused many times to enable her to recover. Lowes and Gill (2006) suggests that talking openly and freely about their situation can be therapeutic. As a single researcher the collection and interpretation of the data may be biased.

9.5: Recommendations

In consideration of the limitations previously discussed, some recommendations have emerged from the study these have been addressed in more detail below. The recommendations will be divided into three categories, macro (Government), meso (Healthcare service) and micro (health and social care professionals).

Macro

The accessibility of health and social care services for homeless women, as an area for improvement by the Welsh Government has been identified (WG 2018a). Recommendations from their Health and Social Care Policy (WG 2018b) considers the development of a seamless service where health and social care would be combined in one system allowing for a more integrated primary and community care approach. This approach would include all community services such as GP's, dentists, social care, community nurses, health visitors, community psychiatric nurses and other services working together. A

Neighbourhood Care Network Strategic Plan has been developed in the area where my research study was undertaken. The purpose of the plan is to deliver integrated care of high quality to meet the future health and social care needs of the population. These networks will be representative of public health, secondary care, primary care, housing, local authority and third sector organisations. This model will coordinate services from primary care and interface with other services as previously mentioned. These policies need to be implemented into practice to enable a more accessible and seamless service for homeless women.

Public Health Wales have set up a group to help shape Public Health Policy, they have recently published their research on homelessness and adverse childhood experiences and resilience. I have recently had meetings with the group regarding my research and hope my findings will also help to shape Public Health Policy. Although the Welsh Government and Health Boards have gone some way in addressing the accessibility issues, if the suggested recommendations are put into practice, I believe there is more that Government could do in addressing access to health and social care services. The findings from my research could influence future policy on homelessness including access to services across health and social care.

Meso

Training for health and social care professionals in the difficulties homeless women and their children face in accessing health and social care. It is important that health and social care professionals are aware of the barriers these women face when accessing health and social care services. Therefore, training to increase knowledge and understanding of these barriers recommended. An important factor here is helping to change beliefs and attitudes towards this vulnerable group of women, to enable better communication channels to allow easier access to services. An identifier on the electronic

system such as a tracker to enable a more flexible approach in relation to appointments setting and recall for these women.

Micro

Key worker to coordinate services between the woman, professionals and agencies. To act as a link between these professionals so there is continuity for the women and her children. The findings identified the barriers faced by the women when trying to access health and social care services, such as missed appointments because of their high mobility therefore a key worker could coordinate these appointments between the health and social care service and the woman. Signposting the women to available services as soon as they are placed in temporary accommodation would help them access services more timely and prevent access to outdated information. The women and their children often need an advisor to discuss problems and someone to advocate on their behalf. The key worker would be the ideal person to be their advocate or signpost them to another service if deemed necessary. Often the women want someone to talk to, who is willing to listen where they can voice their concerns therefore, the role of the key worker would be beneficial in this respect.

A designated health visitor for the homeless women with pre-school dependent children is a recommendation. The health visitor for these women could be the key worker and could coordinate the children's health and social care needs alongside the women's this would be more cost effective and efficient use of resources. A health visitor for the homeless would have expertise in working with these families and signpost them to other agencies and professionals. Their role would be more specialised rather than generic and they could support these women and children more effectively. Women with older children could have a key worker as discussed in recommendation 1 above.

To address the limitations of this study and explore the outcomes more widely for practice, it is recommended for further research to be undertaken. Therefore, this research could be expanded across a range of areas or Health Boards in Wales and comparisons made to identify if the barriers to accessibility are similar across Wales.

It would be interesting to undertake a more in-depth study on homeless people's experiences of Loss. The sample would not be contained to homeless women in temporary accommodation but other homeless individuals.

This study is my interpretation based on the women's interpretations of their experiences, there could be different interpretations and perspectives.

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Appendix 1.

Cardiff School of Nursing and Midwifery Studies
Head of School and Dean Professor Sheila Hunt
Ysgol Astudiaethau Nyrsio a Bydwreigiaeth Caerdydd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt

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2 October 2012

Lorraine Joomun
SONMS
Room 418
EastGate House
Cardiff

Dear Lorraine

A participants narrative: accessing healthcare services for women with dependent children who are in temporary homeless accommodation.

Thank you for submitting your proposal to the SONMS Research Review and Ethics Screening Committee for:

- scientific review;
- ethics screening;

The Committee has now had the opportunity to review your proposal and is unable to approve your application until it has received a satisfactory response to the points made below. When you have considered RRESC's comments, please submit a revised version of your proposal accompanied by a covering letter outlining your responses to this review. Please also include a bullet point list of the changes made.

The Committee has also determined that your proposal will need to be submitted for approval through NHS research governance and ethics review procedures. Further information can be found in the 'Research ethics guidance for staff and students' document, which can be downloaded from the RRESC website.

Yours sincerely

R.C.Williams

Rosemary Williams
EO: Research Administration

Committee Comments

This is a proposal for a Prof Doc study, in which interviews will be conducted with homeless women with dependent children, and with health professionals. The focus of the project is on establishing reasons for difficulty in accessing health care.

Appendix 2

Cardiff School of Nursing and Midwifery Studies
Head of School and Dean Professor Sheila Hunt
Ysgol Astudiaethau Nyrsio a Bydwreigiaeth Caerdydd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt

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17 May 2013

Lorraine Joomun
SONMS

Dear Lorraine

Re: 'Using interpretative phenomenological analysis to understand the experiences of accessing healthcare services by women with dependent children who are homeless and living in temporary accommodation.

Thank you for submitting your proposal to the SONMS Research Review and Ethics Screening Committee for:

- scientific review
- ethics screening;

The Committee has now had the opportunity to review your proposal and is happy to approve your plans, please see comments below.

Please remember that this committee (RRESC) is *not* a research ethics committee (REC), and is therefore not able to give you a favourable ethics opinion. In the view of RRESC your proposal will need to be submitted for approval through NHS research governance and ethics review procedures. Further information can be found in the 'Research Ethics Guidance for Staff and Students' document, which can be downloaded from the School's Peer Review and Ethics website [http://www.cardiff.ac.uk/sonms/research/peerreview/index.html]. Please note that if your project is then classified as 'not research' within the NHS (eg, if it is described and treated as a 'service evaluation'), *but* that you are presenting it as 'research' in other contexts (eg, for academic award purposes) then you should submit your project for approval through the School REC. Information on the School REC is also available on the School's Peer Review and Ethics website (URL given above).

Yours sincerely

R C Williams

Rosemary Williams
EO: Research Administration

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Appendix 3

CARDIFF
UNIVERSITY

PRIFYSGOL
CAERDYⱰ

25 October 2013

Cardiff University
Ty Dewi Sant
Heath Park
Cardiff CF14 4XN

Lorraine Joonum
School of Healthcare Sciences

Tel Ffôn +44(0)29 20687552
E-mail E-bost harmerl@cf.ac.uk
Prifysgol Caerdydd
Ty Dewi Sant
Mynydd Bychan
Caerdydd CF14 4XN

Dear Lorraine

Application for School Research Ethics Committee approval

Your project entitled "**How women with children who live in temporary accommodation access health care services**" has now been approved by the School's Research Ethics Committee of Cardiff University and you can commence the project. This approval is based on version 3 of your proposal sent to the REC dated and submitted on 23 October 2013.

You will also need to provide Liz Harmer Griebel (harmerl@cf.ac.uk) with an electronic copy of the letter from SOLAS confirming that you have permission to access the potential research participants.

If you make any substantial changes with ethical implications to the project as it progresses you need to inform the REC about the nature of these changes. Such changes could be: 1) changes in the type of participants recruited (e.g. inclusion of a group potentially vulnerable participants), 2) changes to questionnaires, interview guides etc. (e.g. including new questions on sensitive issues), 3) changes to the way data are handled (e.g. sharing of non-anonymised data with other researchers)

All ongoing projects will be monitored every 12 months and it is a condition of continued approval that you complete the monitoring form.

Please inform the REC when the project has ended.

Yours sincerely,

Dr Ben Hannigan
Co Chair of the School of Healthcare Sciences Research Ethics Committee

Cc Dr Dianne Watkins – Supervisor

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Appendix 4

CONSENT FORM

Title of Project: How women with children who live in temporary accommodation access health care services

Name of Researcher: Lorraine Joomun

Please initial box

1. I confirm that I have read and understand the information sheet dated
   .... for the above study. I have had the opportunity
   to consider the information, ask questions and have had these answered
   satisfactorily.

   ☐

2. I understand that my participation is voluntary and that I am free to withdraw
   at any time without giving any reason, without my medical care or legal rights
   being affected.

   ☐

3. I understand that relevant data collected during the study, may be
   looked at by research governance staff from [*Cardiff University*],
   where it is relevant to my taking part in this research. I give permission
   for these individuals to have access to my records.

   ☐

4. I understand the interviews will be audio recorded and I give permission
   for verbatim quotes to be used within the written report.

   ☐

5. I agree to take part in the above study.

   ☐

Name of Participant   Date   Signature

Name of Person   Date   Signature taking consent

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

Participant Information Sheet

How women with children who live in temporary accommodation access health care services

I would like to invite you to take part in my research to enable me to understand your experience of accessing health care services. Before you decide whether to take part I would like you to spend five minutes reading this to understand why the research is being done and what it would involve for you. Please contact me if there is anything that is not clear.

I will ask you for your written consent to take part in the study.

Talk to others about the study if you wish

What is the purpose of the research?

Very little is known about why families living in temporary accommodation have difficulty in accessing health care services. This research will find out some of the reasons and may help to find ways of making services more accessible.

Why have I been invited?

You have been invited because you are currently living in temporary accommodation. For this study I need to interview six women with children who live in temporary accommodation. If more participants consent to be interviewed, I will choose the first six participants.

Do I have to take part?

Whilst your contribution would be valuable, it is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

You will be contacted by myself to arrange a convenient date and time for the interview.

What will I have to do?

The interview could take one hour or possibly longer, according to how much information you want to give. The interview will be tape recorded and this will be written up. The written report will be given to you to read to confirm this is an accurate account. When the final research report is written, you will be allowed to read it if you wish. Your anonymity will be maintained at all times.

What are the possible disadvantages and risks of taking part?

There are no known risks. However, if you feel sad or upset during the interview, the interview will be stopped and reconvened at a later time at your convenience or will be permanently discontinued. I would encourage you to discuss the issues that have caused the upset with someone else if you wished to do so and I could refer you to support services if you would like to speak to someone else.
If you disclose any information that identifies your child/children being at risk of harm, I will share this information with the appropriate professionals.

What are the possible benefits of taking part?

I hope this study may help improve the accessibility of health care services for women with dependent children who are homeless.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to myself. If you wish to express concern to someone not involved in this research, you should contact my supervisor.

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

The interview can be stopped at any time; all recordings will be destroyed unless you agree that the information you have already given can be used in the study.

Will my taking part in this study be kept confidential?

Your identity will be protected. I will follow ethical and legal practice and all information will be handled in confidence. Names will not be used, and all audio taped recordings will be identified with a code. This same code will be used on the written up account of each interview. The audio recordings will be locked in a secure cabinet in a locked room and retained for 15 years in accordance with Cardiff University requirements for data storage (Research

Governance Framework for Cardiff University 2011). I will be the only person to have access to these recordings, other than research governance staff at Cardiff University who may request access as part of routine audit. The written up information will be kept on a file using a coded identification number within the computer that is password protected and any other form of storage such as USB sticks will be encrypted.
No information will be included in any written reports that identifies who you are. The final report will be made available for you to read if you so wish along with any publications that are written up from the research.

What will happen to the results of the research study?

The data and findings will be analysed as part of my professional doctorate. The research will also be published in journals.

Who is organising and funding the research?

The study is an independent study by myself. I am currently a Lecturer at the School of Healthcare Sciences, Cardiff University and a professional doctorate student.

Who has reviewed the study?

The study has been reviewed and approved by the Research Review and Ethics Screening Committee, and the Research Ethics Committee, in the School of Nursing and Midwifery Studies, College of Biomedical and Life Sciences, Cardiff University.

Contact name and number of researcher and supervisor

Researcher: Lorraine Joomun,
School of Healthcare Sciences,
College of Biomedical and Life Sciences,
Cardiff University
Eastgate House
35-42 Newport Road
Cardiff
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Tel. 02920917819

Supervisor: Dr Dianne Watkins,
School of Healthcare Sciences,
College of Biomedical and Life Sciences,
Cardiff University
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Tel. 02920687776

Appendix 5

Interview questions

These questions will be a guide; it is likely that they may need to be changed to reflect the responses of the individual participants. These questions will be used in the interviews with homeless mothers.

- ❖ **So could you tell me a little about yourself, so I can understand your situation?**
  Setting the scene

- ❖ **Do you see yourself as being homeless?**

- ❖ **Can you tell me what place 'health' has in your life at the moment?**
  Prompts:
  How do you feel?
  How do you cope?
  Do you see yourself differently now than before you became homeless?

- ❖ **What health issues do you or your children need help and support with?**
  Prompts:
  How do you feel about the situation?
  How do you feel about yourself?

- ❖ **What healthcare services are you aware of?**
  Prompts:
  How did you find out about these?
  How easy is it for you to get to these services?
  Have you accessed any of them?

- ❖ **What do you think about the health services that are currently offered?**
  Prompts:
  How do you think these will benefit you or your children?

- ❖ **What other health services would help meet your needs?**
  Prompts:
  What health issues do you or your children have?

- ❖ **What may prevent you from taking up health care services?**
  Prompts:
  How long where you in homeless accommodation before you were aware of what health care services were available?
  How do you feel about going out of the refuge?
  What difficulties do you think you will have?

- ❖ **What could be the difficulties or barriers to accessing health services?**
  Prompts:
  What health services have you attended recently?
  How difficult was this for you?

- ❖ **What may help you to access health care services?**
  Prompts:
  What has made it easier to enable you to attend?

- ❖ **What would you like to be put in place that may assist you to access health care services?**
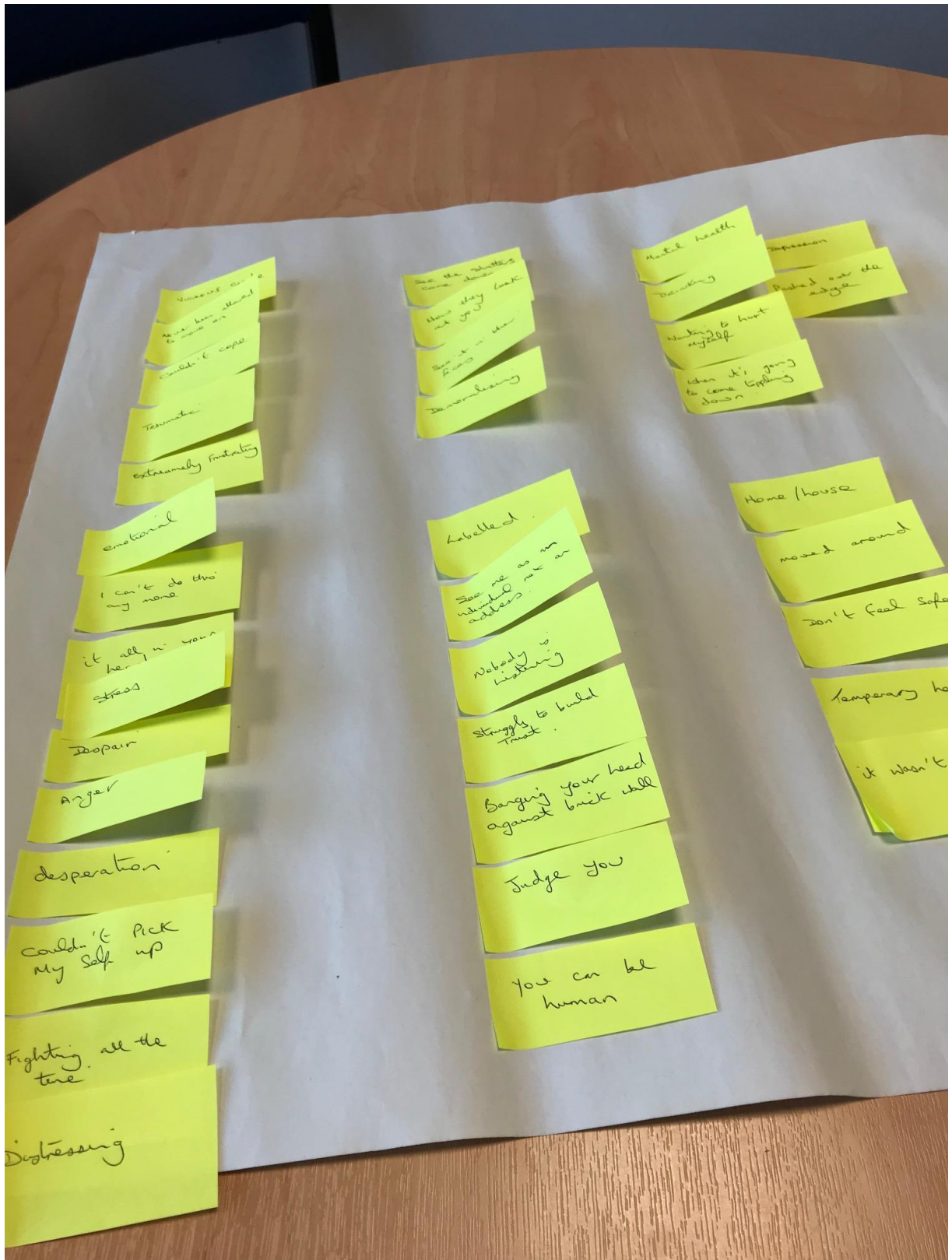 *Prompts:*
  What kind of things is important for you?

- ❖ **What healthcare professionals are you in contact with?**
  Prompts:

<u>Appendix 6</u>

Voices ...
never been allowed to ...
couldn't cope
Traumatic
Extremely frustrating

emotional
I can't do this any more
it all's in your head
stress
Despair
Anger
desperation
Couldn't pick my self up
Fighting all the time
Distressing

See the shutters come down
How they look at you
See it in their faces
Demoralising

Labelled
See me as an individual not a address
Nobody is listening
Struggle to build trust
Banging your head against brick wall
Judge You
You can be human

Mental health
Drinking
Wanting to hurt myself
When it's going to come toppling down
Depression
Pushed over the edge

Home /house
moved around
Don't feel safe
temporary ho...
it wasn't...