‘Hard-to-Reach’ or ‘Hardly Reached’? Underservice, Marginalisation and Inequity in Care

JACKSON, Debra <http://orcid.org/0000-0001-5252-5325>, BOND, Carmel <http://orcid.org/0000-0002-9945-8577>, WATSON, Adrianna and CLEARY, Michelle <http://orcid.org/0000-0002-1453-4850>

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'Hard-to-Reach' or 'Hardly Reached'? Underservice, Marginalisation and Inequity in Care

Debra Jackson[1] | Carmel Bond[2] | Adrianna Watson[3] | Michelle Cleary[4]

[1]University of Sydney, Sydney, New South Wales, Australia | [2]Sheffield Hallam University, Sheffield, UK | [3]Brigham Young University, Provo, Utah, USA | [4]University of New England, Sydney, New South Wales, Australia

Correspondence: Debra Jackson (debra.jackson@sydney.edu.au)

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ABSTRACT

In mental health care, the term 'hard-to-reach' is frequently used in relation to individuals and populations who have reduced access and engagement with services. While positioned as a neutral term, this term can conceal and minimise the multiple factors influencing access to and engagement with care. It also clearly places the responsibility for disengagement as an individual decision or failing, removing responsibility from services themselves. In this paper, we consider the term 'hard-to-reach' and provide a counter-framing of 'hardly reached' to centre patterns of underservice within mental health services and systems. Using the phenomenon of being unhoused as a lens, we consider how language informs assumptions about people and populations. We propose that the label 'hard-to-reach' operates discursively to redirect attention from service limitations and reinforce deficit-based positioning of marginalised people and populations. Contrary to this framing, the concept of 'hardly reached' refocuses attention back to the ways in which service design contributes to disengagement with care services. We highlight the obligations of mental health services and systems to recognise and effectively address structural barriers. We argue that embracing a 'hardly reached' position provides us with a more ethically responsive and socially just framework for understanding and addressing systemic inequities in mental health care.

1 | Aims

The aim of this paper is to critically examine the use of the term 'hard-to-reach' in mental health contexts, and to advance the counter-framing of 'hardly reached' to foreground patterns of systematic underservice. Using being unhoused as a lens, we critically examine how the term 'hard-to-reach' operates to produce and sustain marginalisation and exclusion within mental health care systems. Drawing on a critical social perspective, our analysis interrogates how the label 'hard-to-reach' shapes assumptions about responsibility, engagement, and risk, while obscuring the structural, organisational and ethical conditions that shape mental health care delivery. In doing so, we reframe engagement as a shared and socially situated process and consider the implications of this reframing for mental health nurses as clinicians, advocates and ethical practitioners.

2 | Background and Conceptual Framing

Mental health nursing has a longstanding commitment to relational care, advocacy and responsiveness to people experiencing vulnerability and social exclusion. People who experience homelessness often present with complex and intersecting mental health needs shaped by trauma, poverty, substance use, physical illness, family violence and repeated encounters with systems that have failed to meet their needs (Hollingdrake et al. 2025). Within mental health and other health services, these populations are frequently characterised as 'hard-to-reach' (Lin et al. 2019).

In health and social research, the term 'hard-to-reach' is commonly used to describe population groups who experience limited or inconsistent engagement with services or research

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initiatives. Yet the concept is applied variably and often without theoretical clarity contributing to inconsistencies in who is rendered visible within the evidence base (Törnävä et al. 2025). Critically, such labels risk obscuring the structural, relational, and institutional conditions that shape access to care, implicitly locating difficulty within individuals rather than within research practices and service systems. As Fry et al. (2023) argue, it may be more accurate to interrogate how researchers and institutions themselves are positioned as inaccessible through methodological, ethical, and gatekeeping processes.

When disengagement is framed as an individual or group characteristic, limited engagement with services can appear to occur in isolation, rather than as a reflection of broader patterns of marginalisation, social exclusion, and the cumulative effects of stigma associated with particular life circumstances and identities. Marginalisation contributes to physical and emotional health inequalities by constraining choices and fostering social isolation (Cleary et al. 2014). Those living on the social and economic margins frequently encounter daily challenges linked to relative or absolute poverty, discrimination, alienation, and victimisation. These conditions indirectly affect health by reinforcing disempowerment and disengagement, leading to lower participation in mainstream mental health services, treatment, and recovery programmes; services that may exist but are not always accessible in practice (Cleary et al. 2014).

Beyond shaping patterns of service engagement, marginalisation functions as a direct mechanism of psychological harm. Social disconnection, including isolation, exclusion from meaningful social roles, and stigmatising or low-quality relationships, exerts independent and, in some cases, causal effects on mental health outcomes. Effects have been shown to persist even after adjustment for socioeconomic status, physical health and baseline mental illness, indicating that social disconnection and marginalisation create a distinct pathway to psychological morbidity (Holt-Lunstad 2024). Thus, people experiencing homelessness can enter cycles in which marginalisation both worsens mental health and is intensified by it, further constraining recovery, maintenance, and sustained engagement with systems of care.

Groups most commonly described as ‘hard-to-reach’ include people experiencing homelessness, those who use particular substances and individuals engaged in sex work. These populations are not absent from society but are positioned at its margins, where poverty, unstable housing, criminalisation and unmet mental health needs disrupt sustained engagement with services (Lin et al. 2019). Framing these populations as ‘hard-to-reach’ risks shifting attention away from institutional practices and service design, while subtly positioning disengagement as an individual failure. Language in health care does not merely describe reality; it actively shapes how issues are understood, where responsibility is located, and which responses are considered legitimate (Koerber and Renshaw 2021). Labels such as ‘hard-to-reach’ function discursively, shaping assumptions about engagement, risk and ethical care, while leaving the limitations of services largely unexamined.

In this paper, we adopt the counter-framing of ‘hardly reached’ to redirect attention from presumed individual disengagement to patterns of systematic underservice within mental health systems. Using homelessness as a lens, we critically examine how the term ‘hard-to-reach’ operates to produce and sustain marginalisation and exclusion within care. We consider how this reframing reshapes understandings of engagement, responsibility and ethical practice, and consider the implications for mental health nurses as clinicians, advocates, and ethical practitioners working within structurally constrained environments. While critiques of the term ‘hard-to-reach’ exist, this paper extends that work by offering a sustained ethical and nursing-focused analysis of how language, risk practices, and service design interact to produce systematic underservice in mental health care.

3 | Design

This perspectives paper contributes a critical discursive analysis of a commonly used term in mental health practice, demonstrating how language shapes ethical responsibility, service expectations, and patterns of exclusion in care. It is informed by a critical social perspective. In this paper, we do not present empirical data or a systematic review; rather, we offer a critical analysis of how the term ‘hard-to-reach’ operates within mental health contexts and advance the counter-framing of ‘hardly reached’ to illuminate patterns of marginalisation, underservice, and ethical care, with particular relevance for mental health nurses. While homelessness is used here as an illustrative lens, the analysis has relevance for populations routinely positioned as ‘hard-to-reach’ within mental health systems.

4 | Method

In this paper a critical social lens is used to examine how language, policy contexts, and organisational arrangements shape understandings of engagement, responsibility and care. The analysis focuses on the discursive function of the term ‘hard-to-reach’, and the counter-framing of ‘hardly reached’, and their implications for marginalisation, underservice and ethical responsibility rather than on evaluating specific interventions or service models.

5 | ‘Hard-To-Reach’ and Hardly Reached: A Discursive Reframing

The term ‘hard-to-reach’ is widely used in health services to describe populations who experience barriers to sustained engagement with care. On the surface, it appears neutral and pragmatic, signalling complexity rather than blame. However, as a discursive label, it does important work. It frames disengagement as a characteristic of particular groups rather than as a relational or systemic outcome, and it subtly positions services as the default norm against which individuals are measured.

Empirical evidence also suggests that labels and shorthand descriptors can shape clinicians' interpretations and actions in real time, contributing to disparities in assessment and responsiveness for people experiencing homelessness (Martineau Jackson et al. 2025). In this way, ‘hard-to-reach’ can function less as a neutral description than as a cue that normalises reduced expectations of care, drawing attention away from how services are organised, accessed and, at times, effectively withheld within health systems.

When people experiencing homelessness are described as 'hard-to-reach', the implication is often that services are available and appropriate, but that individuals are unwilling or unable to engage in expected ways. This framing risks masking the extent to which mental health services are organised around assumptions of stability, predictability, and compliance that are fundamentally misaligned with the realities of lived homelessness. Research on women's experiences of homelessness highlights how pathways into homelessness are often shaped by cumulative trauma across the life course, including abuse, neglect, mental and physical illness, and economic precarity (Phipps et al. 2021). Such histories increase vulnerability while also exposing individuals to stigmatised and stereotyped representations that further undermine access to care. Interventions designed to offer protection or support can themselves become sites of harm when they fail to account for cumulative trauma, autonomy needs, and the lived realities of those they seek to serve (Welker et al. 2025). Well-intentioned service responses may inadvertently reproduce control, surveillance or stigma (Welker et al. 2025), thereby generating new psychological distress or exacerbating existing mental health challenges rather than alleviating them.

The counter-term 'hardly reached' has been used in health services research to shift attention from presumed individual disengagement to the ways services and their boundaries shape who is reached and on what terms (Wallace et al. 2019). Related critiques have similarly reframed so-called 'hard-to-reach' groups as 'easy to ignore' and point instead to 'hard-to-reach services', highlighting institutional design and practice, rather than individual deficit, as variables that determine who is reached and on what terms (MacFarlane and LeMaster 2022). From a 'hardly reached' perspective, then, the problem is less that people fail to engage and more that systems fail to integrate and adapt. Staff in one homeless health service identified service gaps centred on mainstream integration, workforce configuration and organisational governance constraints that shape who can be reached and how (Thompson et al. 2025). For people experiencing homelessness, this configuration means that mental health care is often reliably available at the point of crisis, through emergency departments, police-linked triage pathways or involuntary admission, so that being 'hardly reached' becomes a predictable feature of service design rather than a matter of personal disengagement (McNeill et al. 2022).

Less visible in the 'hard-to-reach' framing are the limits of system capacity and flexibility, particularly within services operating under resource constraint, risk aversion and organisational pressure. Appointment-based systems, rigid eligibility criteria, time-limited interventions and fragmented care pathways shape who is reached and who is not. These patterns are also reproduced at the point of contact, where busy, high-pressure environments amplify reliance on rapid judgements and people experiencing homelessness may be assessed less thoroughly or effectively set aside, despite clinicians' stated intentions to equity and impartiality (Martineau Jackson et al. 2025).

From a critical social standpoint, the language of 'hard-to-reach' can therefore be understood as a form of symbolic boundary-making. It delineates those who fit within dominant models of care from those who do not, while rendering service structures themselves largely invisible. For mental health nurses, working within this discourse can constrain how care is conceptualised and justified, even when nurses recognise its limitations. As a result, exclusion can become normalised within everyday practice, not through lack of care or intent, but through discourses that make some forms of need appear misaligned with what services are able or willing to provide.

Reframing these populations as 'hardly reached' shifts the analytic focus from individualised notions of disengagement to the patterned ways in which mental health systems underserve those positioned at their margins. The term foregrounds how service design, eligibility criteria, risk frameworks and organisational priorities shape access to care, often resulting in delayed, fragmented or absent support. Rather than reflecting distance from care, being 'hardly reached' signals systematic exclusion and helps make the links between language, service organisation, and persistent mental health inequities visible. These inequities are lived as well as structured; qualitative accounts of transitioning out of homelessness describe being 'discarded from everyday life' and struggling to reconnect with society (Hyun et al. 2025), alongside profound invisibility, loneliness and a sense of being unseen within systems intended to provide care (Jackson and Usher 2024; Jackson 2025; Rokach 2019).

6 | When Systems Are Hard to Access

Reframing the issue as one of systems that are hard to access rather than people who are 'hard-to-reach' shifts attention to structural and organisational dimensions of care. Mental health services are often designed around assumptions of stable housing, reliable professional communication, recovery-oriented person-centred care, collaboration and consistent patterns of attendance. For people experiencing homelessness, these assumptions rarely hold. Instead, everyday life is often dominated by the exhausting and consuming work of securing safety, shelter and basic survival, alongside the management of constant threats, leaving little capacity for navigating complex (and siloed) health systems. Stigma, discrimination and communication barriers, including a lack of phones or stable contact details, can further complicate engagement. Eligibility thresholds based on acuity, substance use or perceived risk can exclude individuals with complex but fluctuating needs. Access to care may be effectively crisis-gated, with service capacity constraints and long waiting times disrupting continuity and limiting sustained engagement (Ferris-Day et al. 2025).

Intersectional considerations also need to be examined when considering unmet needs (Graells-Sans et al. 2025). Gender, age, culture, sexuality, disability and dual diagnosis can all influence how language (and subsequent care) is used, which can disempower individuals, amplify stereotypes and perpetuate stigma. This can lead to shame and exclusion, further increasing risk. For example, when a woman experiencing homelessness encounters discrimination, it cannot be attributed to a single factor, as her experiences of care and treatment are also shaped by the intersection of multiple identities and circumstances, such as gendered assumptions, socioeconomic status, culture and stigma around homelessness, which interact to create systemic forms of disadvantage and bias. These identities can intersect with her housing insecurity, shaping how she is perceived and treated. For instance, medical misogyny might lead healthcare providers to dismiss her symptoms as emotional (Jackson et al. 2025), while racial stereotypes and socioeconomic bias further influence the quality of care she receives.

These systemic features are not neutral; they actively shape patterns of engagement and disengagement. When services are inflexible, individuals must adapt to systems rather than systems adapting to people. The label 'hard-to-reach' can then function as a shorthand that normalises this misalignment, deflecting attention away from critical reflection on service design. Evidence from a specialist Homeless Health Service shows that 'access problems' are often produced by service design and system fragmentation, particularly weak integration with mainstream health services and the need to adapt existing models of care (Thompson et al. 2025).

Mental health nurses are often acutely aware of these constraints yet may have limited capacity to alter them (Cleary 2025). Recognising systems as potential barriers rather than neutral providers helps reframe disengagement as a shared outcome of structural conditions rather than individual failure, opening space for ethical reflection, advocacy and resistance to deficit-based narratives. Thompson et al. (2025) also highlight that even when nurses are positioned to provide wraparound, preventative and crisis-oriented care, their capacity to do so depends on workforce development, clearer specialty pathways and governance processes that manage risk without defaulting to exclusion. This is where mental health nursing advocacy becomes indispensable: nurses can (and arguably must) contest policies, throughput logics and risk frameworks that institutionalise underservice, and advocate for service models that make sustained, relationship-based care possible.

7 | Risk, Control and Ethical Tensions in Practice

Risk occupies a central place in mental health care, shaping decisions about admission, treatment and discharge. In the context of homelessness, risk assessments are often heightened, with concerns about self-harm, substance use, violence and vulnerability intersecting in complex ways. Within risk-averse organisational cultures, these concerns are frequently managed through practices that prioritise containment, surveillance and control over relational engagement and sustained care. For people experiencing homelessness, encounters with mental health services may therefore be characterised by surveillance, coercion or conditional care (Kerman et al. 2023). Involuntary admissions, compulsory treatment and discharge to unstable environments raise significant ethical questions about autonomy, beneficence and justice. While such decisions are commonly justified as necessary for safety, they can also reinforce mistrust, deepen disengagement and reproduce the very risks they seek to manage. When viewed through a 'hardly reached' lens, these risk-saturated encounters illustrate how people may be seen in moments of acute risk yet remain structurally underserviced in the ongoing 'relational' care that may prevent future crises from reoccurring (Martineau Jackson et al. 2025).

Mental health nurses frequently find themselves navigating these ethical tensions at the frontline of care. They are tasked with balancing professional commitments to care and advocacy with organisational expectations around risk management and throughput. Within this context, the language of 'hard-to-reach' can obscure these tensions by framing disengagement as a patient characteristic, rather than as an outcome of ethically complex, risk-saturated practice environments. Viewing these dynamics through a critical social lens highlights how power operates within mental health systems and how ethical responsibility is distributed. It also makes visible the moral labour undertaken by nurses who must enact care within systems that simultaneously demand control, efficiency and risk minimisation. In such contexts, being 'hardly reached' is not an unintended consequence of risk management, but a predictable outcome of systems in which safety is prioritised over care and control over connection.

8 | Engagement as a Shared and Social Responsibility

Dominant discourses in mental health care often conceptualise engagement as an individual responsibility (Salmon and Hall 2003), linked to insight, motivation and compliance. From this perspective, disengagement signals a lack of readiness for care. A critical social reframing challenges this assumption, positioning engagement as relational, contextual and socially produced, rather than as a fixed attribute of individuals. Engagement is shaped by trust, past experiences of care, material conditions and the responsiveness of services. For people experiencing homelessness, engagement may look different from what services expect. It may be episodic rather than continuous, pragmatic rather than therapeutic, or focused on immediate needs rather than long-term recovery goals. Recognising these forms of engagement requires flexibility and attentiveness, rather than deficit-based judgements about motivation or compliance. In health services targeting people experiencing homelessness, staff describe the central challenge as system integration and model-of-care limitations, conditions that make people 'hardly reached' rather than inherently 'hard-to-reach' (Thompson et al. 2025).

In practice, reframing engagement as a shared responsibility opens space for critical reflection on language use, practice norms and ethical priorities. It invites consideration of how services might adapt to better meet people where they are, rather than expecting individuals to conform to service expectations that may be unrealistic or exclusionary. Such a reframing also legitimises advocacy, self-determination, flexibility and relational work as core dimensions of ethical mental health care and nursing practice, rather than as discretionary or exceptional practices.

9 | Conclusions

The use of the term 'hard-to-reach' in the mental health context with people experiencing homelessness reflects more than descriptive convenience; it reveals underlying assumptions about responsibility, normality and care. We argue that the use of this language risks obscuring the structural and organisational factors that shape engagement, while placing the burden of disengagement on individuals who are already socially marginalised.

Reframing the issue as one of systems that are difficult to access, and of engagement as a shared and socially situated process, allows for a more ethically attuned understanding of care and responsibility within mental health systems. This perspective does not deny the challenges inherent in working with people with complex needs, nor does it diminish the constraints faced by nurses. Instead, it offers a way to make the ethical tensions embedded in everyday practice visible and to resist narratives that individualise structural failure, while reaffirming care, advocacy and relational engagement as ethical imperatives rather than optional extras.

10 | Relevance for Clinical Practice

For mental health nurses, adopting a critical social perspective on language and engagement may support more reflective and ethically responsive practice. Attending to how terms such as 'hard-to-reach' shape thinking and decision-making can prompt critical examination of service assumptions, risk practices and documentation norms. This may include deliberately avoiding deficit-based descriptors in clinical documentation, advocating for flexible engagement pathways or making system barriers visible during multidisciplinary decision-making.

Recognising engagement as relational and context-dependent may also legitimise flexible, creative and advocacy-oriented approaches to care, particularly when working with people who are routinely and systematically 'hardly reached' by existing services. For mental health nurses, this involves recognising that language is never a neutral description but a form of everyday clinical practice in its own right, one that can either reproduce deficit-based framings (hard to reach) or foreground the structural and organisational barriers (hardly reached) in documentation, handovers and multidisciplinary discussions.

At a broader level, this reframing highlights the importance of organisational and policy contexts in shaping what care is possible. Mental health nurses are well-positioned to contribute to critical conversations about service design, equity and ethical responsibility, particularly in relation to populations experiencing homelessness and others who are marginalised within mental health systems. Engaging with these issues aligns with nursing's longstanding commitment to care, social justice and responsiveness to those at the margins.

Author Contributions

All authors contributed substantially to the conception and design of the work or the acquisition, analysis or interpretation of data; drafted the work or revised it critically for important intellectual content; approved the final version to be published; and agreed to be accountable for all aspects of the work, ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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The authors declare no conflicts of interest.

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Data sharing was not applicable to this article as no datasets were generated or analysed during this study.

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