Research Dissertation

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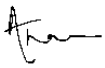
Signed: 

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DOCTORATE IN CLINICAL PSYCHOLOGY

Exploring the Workplace Wellbeing of People Working in Homelessness

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Introductory Chapter

Homelessness is an increasing global public health and human rights crisis (Fowler et al., 2019; Organisation for Economic Co-operation and Development, OECD, 2020; 2021; United Nations Human Rights Council, 2020). Under current policy arrangements in the United Kingdom (UK), for example, homelessness is predicted to increase by one-third from levels in 2019 by 2024 (Watts et al., 2022). The forecasted socio-political-economic impact on local authorities, low-income families, and single people or those deemed intentionally homeless is a particular cause of concern (Watts et al., 2022). This concern considers the established negative association between homelessness with socioeconomic status and health outcomes (i.e., the steepening social gradient and extreme health inequity that persists in high-income countries, e.g., see, Marmot et al., 2020).

A legal definition of homelessness considers a variety of housing circumstances including living in temporary accommodation, overcrowded environments, and insecure housing as well as those rough sleeping on the streets (Public Health England., 2019). Routes into homelessness typically stem from multiple intersecting factors from interpersonal issues to macro-level socio-political-economic influences. For example, homelessness can be associated with adverse childhood experiences, addiction, physical health complications, poverty, discrimination, systems of oppression and social exclusion, and persistent structural violence (Fellitti et al., 1998; Fraser et al., 2019; Giano et al., 2020; Wiewel & Hernandez, 2022). Less explicit influences are psychological distress and trauma, in consideration of the repeated threats of harm people endure (Duncan et al., 2019). Thus, whilst every person's story is unique, a common thread throughout the lives of people experiencing homelessness is an accumulation of stress, vulnerability, and marginalisation (Tickle, 2022), and attempting to navigate such experiences amongst finding solutions to meet their diverse unmet support needs inevitably cause "insurmountable challenges" (Duncan et al., 2019).

Working in homelessness at every level is shaped by the same mentioned systemic-level challenges (Kerman et al., 2022). For example, homelessness commissioning has been described as "traumatising" due to current capacity challenges, lack of 'joined-up thinking' and strategic spending (Pleace, 2020). Inaccessible mainstream and specialist support services also worsen circumstances and workload is increasing along with unrealistic expectations being placed on people working in homelessness. For example, the homelessness support sector (i.e., people working in homelessness) are typically relied upon to meet the diverse unmet needs of people experiencing homelessness, often without adequate professional training or qualifications (McGrath & Pistrang, 2007). Workplace wellbeing is being negatively impacted (Peters et al., 2021; Wirth et al., 2019) and requires urgent improvement, otherwise workplace hazards such as trauma, stress, and burnout will continue to exacerbate and be an increasing detriment to the quality of care provided (Department of Communities & Local Government, 2008; Rios, 2016).

This thesis presents two papers that explore the wellbeing of people working in homelessness. Chapter One is a systematic review that explores the experiences of trauma of people working in homelessness, and Chapter Two is an empirical study, which explores the predictors of the Professional Quality of Life (Stamm, 2010) of frontline workers. Together these two chapters contribute to the rigour of psychological research, which is vital in drawing reliable conclusions and in the dissemination of recommendations in healthcare, policy, and practice.

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Chapter One: Systematic Review

Exploring the Experiences of Trauma of People Working in Homelessness: Mixed Methods Systematic Review

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Article intended for submission to the Violence, Trauma and Abuse Journal for peer review.

Abstract

Objective: Homelessness is a global public health concern which extends to the health and wellbeing of people working in homelessness. Increased exploration of the extent of psychological distress in the homelessness support sector is needed, and this mixed methods systematic review aimed to explore, accumulate, and synthesise the evidence associated with trauma experiences. **Method:** The Substance Abuse and Mental Health Services Administration (2014) definition of trauma was applied to identify the 'events', 'experiences' and 'effects' of trauma. Seven databases were searched from inception until May 2023, including CINAHL, MEDLINE, PsychINFO, Psychology Database, Public Health Database, Web of Science and PubMed. Relevant grey literature was searched via Google. The methodological quality was assessed using the Mixed Methods Appraisal Tool (Hong et al., 2018). Data were synthesised per the Johanna Briggs Institute guidance on mixed-methods systematic review synthesis (Lizarondo et al., 2020). **Results:** A total of 22 papers met the eligibility criteria and were retained for inclusion. Despite some inconsistencies across the literature, the quantitative evidence highlights a significant prevalence of, and factors associated with, experiences of trauma, with some people at risk of severe distress and meeting diagnostic thresholds for Post-Traumatic Stress Disorder. The qualitative findings highlighted themes associated with trauma, resulting in a hypervigilant homelessness support system that can feel physically, emotionally, or psychologically unsafe. **Discussion:** This review discusses the need for psychologically informed practice, to prevent and alleviate trauma experiences across homelessness, along with more nuanced, inclusive, and consistent trauma measures.

Keywords:

People Working in Homelessness, Homelessness Support Sector, Trauma Experiences, Trauma-Informed Care, Systematic Review

1. Introduction

An ecological lens can capture the complexity of homelessness, evidencing how multiple structural to individual-level factors can accumulate and intersect over time and impact health (Luchenski et al., 2018; Sample & Ferguson, 2020). For example, a typical route into homelessness is associated with social risk factors such as poverty and adverse childhood experiences (ACEs; Fellitti et al., 1998; Koh & Montgomery, 2021; Mabhala et al., 2017) which can lead to social exclusion and worsen experiences of addiction, physical and psychological health, multiple morbidities, and lead to early mortality (Aldridge et al., 2018). Compounding this context are challenges in accessing inclusive and equitable primary care and preventive support services to effectively meet the diverse needs of people experiencing homelessness (Aldridge et al., 2018). The outcome is that emergency healthcare use is high, with a predominant focus on presenting problems. However, failing to address wider health and social care needs comes at a financial cost to the NHS and public services, perpetuates poor health outcomes and leads to a fragmented homelessness support system (Luchenski et al., 2018).

Working in homelessness at every level is shaped by these socio-political-economic challenges (Kerman et al., 2022b). For example, current capacity restrictions place considerable pressure on local authorities to deliver their duties (e.g., to provide support for homeless households) under the Homelessness Reduction Act (2017; Watts et al., 2022) and barriers to joined-up thinking and strategic spending has created "traumatising" commissioning conditions (Pleace, 2020). The high demand for support services also reflects the relentless workloads and unrealistic expectations placed on the homelessness support sector (Peters et al., 2021; Wirth et al., 2019a). These factors coupled with insufficient social and emotional support, training and supervision, low wages, workplace discrimination, and difficult team dynamics can reduce workplace wellbeing (Kerman, 2022b, c, d; Levesque et al., 2021; Wirth

et al., 2019a, b). The emotional burden of this work exacerbates with the reality of supporting people who have experienced severe and multiple disadvantage[1]. For example, people working in homelessness (i.e., the homelessness support sector) often responds directly to threat, violence, and overdoses (Kerman, 2022c; Wallace et al., 2018), encounter greater exposure to death (Lakeman, 2011; Valoroso & Stedmon, 2020) and repeatedly hear the trauma accounts of others (Arslan, 2013; Kidd et al., 2007).

Increasingly, research is exploring the psychological impact of working in these contexts. Frontline workers in homelessness have been found to experience high levels of stress and depression (Lemieux-Cumberlege & Taylor, 2019), post-traumatic stress (Schiff & Lane, 2019; Schiff et al., 2019) and secondary traumatic stress (STS; Petrovich et al., 2021; Schneider et al., 2021). Similar outcomes have been reported in research conducted during the pandemic (e.g., Aykanian, 2022; Carver et al., 2022; Kerman et al., 2022c) whilst also highlighting that the pandemic and increasing overdose crisis might exacerbate distress levels. A high prevalence of ACEs and lived experiences of homelessness are also indicated in the homelessness support sector (Aykanian & Mammah, 2022; Kerman et al., 2022c) which might risk increasing levels of distress or traumatic stress responses (Kerman et al., 2022c, d; Rios, 2016; Schiff et al., 2019).

More research is needed to explore the implications of these psychological consequences, however, they are already recognised to contribute to worsening circumstances from reducing workplace wellbeing, compassion satisfaction and the quality of care provided (Benuto et al., 2019; Petrovich et al., 2021), to challenges in retaining and recruiting a workforce with the skills and experience required to practice within such contexts (Levesque et al., 2021). Consequently, the qualitative literature exploring the emotional experiences of

[1] a term coinciding with "complex needs" or "chronic exclusion", used to describe people who experience a combination of challenges such as homelessness, substance misuse, psychological distress, physical health difficulties and offending, and require significant system level support (Bramley et al., 2020; Cornes et al., 2018; Dobson et al., 2019).

people working in homelessness has been drawn together and meta-synthesised (Peters et al., 2021). Important individual, relational and contextual themes emerged concerning workplace wellbeing including, 'building quality relationships', 'negotiating boundaries', 'carrying the emotional burden', 'accessing care and support', 'individual advancement', 'advocating' and 'contextual helplessness', as well as the development of an overarching theory into the internal experiences of this workforce in managing job demands and their own needs. Thus, the current literature adds valuable contributions to understanding the emotional experiences of this sector, its implications, and strategies to improve contexts systemically.

However, although experiences of trauma are mentioned in this review under the theme 'carrying the emotional burden', experiences of trauma are not explored in significant depth, and are combined with the trauma experiences of people experiencing homelessness and with other emotional experiences such as burnout. It is well established that trauma is a different experience to other emotional experiences, such as burnout. Traumatic stress has an adverse neurobiological effect on the human nervous system (Kolacz et al., 2019) and can be detrimental to many aspects of wellbeing (Substance Abuse and Mental Health Services Administration, SAMHSA, 2014). It is also known that working with trauma specifically can directly impact therapeutic work (Sutton et al., 2022). As mentioned, the literature indicates that this sector experiences trauma, directly and indirectly, and attention has been drawn to the unknown impact of personal histories of trauma within these workplaces (Kerman 2022c, Schiff et al., 2019). Despite the existing literature, insight into the extent of these experiences is unclear. Therefore, a systematic review is required to explore, accumulate, and synthesise the quantitative and qualitative evidence of the trauma experiences in this sector. The outcomes of this review will deepen current understandings regarding implementation of Trauma-Informed Care (Hopper et al., 2010; SAMHSA, 2014) and Psychologically Informed

Environments (Keats et al., 2012; Johnson & Haigh, 2010) to improve the wellbeing of this sector and, in doing so, those they support.

1.1 Defining Trauma

"Trauma is not what happens to you, it is what happens inside of you, as a result of what happened to you" Dr Gabor Maté (2022).

The construct of trauma is not a new phenomenon. It's meaning has become multifaceted across context and time, having been speculated upon within cultures globally for millennia (Emerson, 2015). Identifying its nuances is vital in attaining an applicable and objective definition of trauma when exploring experiences in this sector. This is to ensure an appropriate balance between reliability and construct validity. Therefore, the below sections provide a review of the existing literature in defining trauma. It is important to note that the existing literature is considerably associated with diagnostic categories, however, the definition of trauma drawn upon in this review is more holistic and inclusive of all the below mentioned diagnostic categories (as detailed in section 1.1.4 Systematic Review Definition).

1.1.1 Post-Traumatic Stress Disorder.

Since the 1800s (for a historical review, see, e.g., Emerson & Hopper, 2011; Van der Kolk et al., 1994), the construction of the term Post-Traumatic Stress Disorder (PTSD) has enabled the classification of trauma-related distress as a treatable, psychiatric diagnosis within the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, APA, 2013). Broadly, PTSD can be diagnosed following exposure to a single event that is experienced as threatening and unexpected. Three core elements indicate PTSD including, 're-experiencing' (i.e., vivid intrusive memories, flashbacks, and thematically related nightmares), 'avoidance' (i.e., of thoughts, memories, or external circumstances reminiscent of the event) and 'persistent perceptions of heightened current threat' (i.e., hypervigilance and constantly seeking safety). These experiences impact a person's ability to

function within important areas of their life such as in their relationships and at work (DSM-IV; APA, 2013; International Statistical Classification of Diseases and Related Health Problems, ICD-11; World Health Organisation, WHO, 2022).

1.1.2 Complex Post Traumatic Stress Disorder and Complex Trauma.

Despite decades of debate and several iterations, both diagnostic manuals have supported significant advances in understanding trauma. However, there are limitations to applying the diagnostic construct of PTSD in clinical practice due to the predominant and rigid focus on its symptoms, rather than the associated enduring contextual circumstances people experience (Emerson & Hopper, 2011). For example, Herman (1992) explored the relational and longitudinal nature of trauma. Experiences of different symptoms to the DSM-III classification of PTSD were noted and Complex Post-Traumatic Stress Disorder (CPTSD; Herman, 1992) was coined. Despite CPTSD not being recognised in the DSM-IV (instead, it can be categorised under 'unspecified trauma-and stressor-related disorders 309.9 [F43.9]'), the ICD-11 defines the concept as meeting all diagnostic requirements of PTSD, as well as experiencing three more core elements. These include, 'problems in affect regulation' (e.g., self-destructive behaviour and dissociation), 'beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event' and 'difficulties in sustaining relationships' (Luxenberg et al., 2001; WHO, 2022).

Defining trauma in the context of relationships (e.g., abuse of power) is complicated as several constructs within the literature overlap considerably. For example, there are similarities between 'Disorder of Extreme Stress Not Otherwise Specified' (DESNOS) and CPTSD, although, DESNOS was constructed to support the understanding of the impact of chronic interpersonal trauma particularly experienced during critical developmental stages (Błaż-Kapusta, 2008; Cook et al., 2005). Developmental Trauma Disorder (DTD) also overlaps with CPTSD, although recognised to align with a transdiagnostic framework to describe the

experiences of children (Ford et al., 2022). The experiences of DESNOS and DTD are associated with ACEs (Felitti et al., 1998) which are understood to involve both experiences of 'Capital-T Trauma' (e.g., abuse, neglect, racism, and oppression) and 'Small-t Trauma' (e.g., bullying and emotional needs being unmet; Maté, 2022). The ACEs literature repeatedly evidences the detrimental impact of early relational trauma on human beings throughout their life. For example, as the number of ACEs increases, the risk of experiencing poorer health and harmful relationships increases (Bellis et al., 2014; Howard et al., 2015). Considering the adaptations in the lexicon of relational trauma, the term Complex Trauma has been used to encompass all these constructs and represent their interrelatedness (Emerson, 2015).

1.1.3 Indirect Trauma.

Indirect trauma has been described as "contagious" (Boulanger, 2018) and theorised to occur following circumstances where people feel 'empathetically stressed', such as when hearing accounts of another's traumatic experience (Rauvola et al., 2019; Sutton et al., 2022). It is associated with three main constructs; STS (Bride et al., 2003; Figley & Kleber, 1995; Stamm, 1995), Compassion Fatigue (CF; Figley, 1995) and Vicarious Trauma (VT; McCann & Pearlman, 1990). Although cited interchangeably within the literature, there are clear distinctions within their theoretical foundations which are important to highlight.

The construct of STS stemmed from the acknowledgement that PTSD symptoms can be experienced by "bearing the distress of others" (Figley & Kleber, 1995). Thus, STS symptoms overlap with those defined in PTSD and are understood to be a natural stress reaction caused by repeated and indirect exposure to human suffering (Figley, 2013; Sutton et al., 2022). Joinson (1992) originally constructed CF to describe experiences of burnout, however, Figley (1995) considers CF to be a less stigmatising term to describe STS. CF is also commonly understood as a construct comprising two dimensions; burnout and STS (Stamm 2010).

McCann and Pearlman (1990) constructed VT to understand the experiences of people working with survivors of childhood sexual abuse. They documented "profound alterations in cognitive schemas leading to an enhanced awareness of the fragility of life and feelings of helplessness". They drew upon object relations, self-psychology, and social cognition theories to develop a constructivist self-developmental theoretical framework (McCann & Pearlman, 1992). This framework explains that VT experiences are shaped by the clinician's personal belief systems that are influenced by their history. The exposure to others' traumatic experiences permanently disrupts the clinician's internal experience (i.e., their beliefs regarding themselves, relationships, and the world in areas such as safety, trust, independence, esteem, intimacy, power, and control; Pearlman & Saakvitne, 1995).

1.1.4 Systematic Review Definition.

The generation of multiple classifications has created variances in how trauma is conceptualised, measured, and interpreted (Van der Kolk et al., 1994; 2014). Therefore, limiting a definition of trauma to one classification would be, fundamentally, reductionist. The SAMHSA's (2014) definition of trauma is therefore drawn upon in this review. This is because it is inclusive, applied across health and social care, and has supported the development of national trauma-informed care programmes (e.g., see, the Scottish Government, 2021). The SAMHSA (2014) define trauma as "*an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being*". All three 'E's (i.e., 'event', 'experience', and 'effects') are thought to be present to experience trauma. 'Event' relates to the actual or perceived threat to harm or survival and can be a single or repeated event. 'Experience' is related to the unique meaning assigned to the event, which determines whether it is experienced as traumatic. Lastly, 'Effects' are associated with symptoms that have an adverse impact on the person's functioning

and wellbeing. It is important to note that the theoretical underpinnings of neuroscience are also acknowledged within this definition. For example, the effects of traumatic stress on the brain (Bremner, 2022; MacLean, 1977) and nervous system survival responses, such as those described by Polyvagal Theory (Porges, 2011).

1.2 Review Aims

There is currently limited synthesis across the literature specifically exploring trauma experiences of people working in homelessness. This review aims to draw upon the SAMHSA's (2014) definition to explore and synthesise the relevant qualitative and quantitative literature to date. In relation to the three 'E's, the quantitative data answers (a) what is the prevalence of trauma experiences? (b) what are the factors associated with trauma experiences? The qualitative data answers (c) what are the experiences of trauma? This review will not only consider trauma experienced in the occupational role, but also personal experiences of trauma outside of the work setting (e.g., ACEs). By answering these questions, implications will support future research in line with the implementation of Trauma Informed Care and Psychologically Informed Environment principles.

2. Method

2.1 Search Strategy

A preliminary literature search was conducted to explore the existing quality and quantity of evidence available in the general research area. These scoping searches were performed to enable careful consideration when constructing the different components of the systematic review questions, and to identify the most suitable search terms to establish an adequate balance of sensitivity and specificity throughout the search (Bramer et al., 2018). There were three research questions as defined above. The systematic review was registered on PROSPERO (ID: CRD42023380413). The full search terminology is shown in Table 1.

Table 1

Table of Search Terms Used in Systematic Review

Variable	Search Terms
Area (Title OR Abstract)	Homeless*
	AND
Sector (Title OR Abstract)	"Key Work*" OR Keywork* OR "Support Work*" OR "Case Work*" OR "Support Assistant*" OR "Support Staff" OR "Case Manager*" OR "Support Sector*" OR "Sector Worker*" OR "Hostel Staff" OR "Shelter Staff" OR "Service Worker*" OR "Front-Line" OR "Frontline" OR "Front Line*" OR Employee* OR "Service Provider*" OR "Professional* OR "Peer Support Worker*" OR Manager
	AND
Trauma Experiences (Title OR abstract)	"Post-Traumatic Stress" OR "PTSD" OR Trauma* OR "Psychological Trauma" OR "Vicarious Trauma" OR "Secondary Traumatic Stress" OR "STS" OR Trigger* OR Helpless* OR "Adverse Childhood Experiences" OR Death OR Dead OR Deceased OR Bereavement OR Overdose

Note. The asterisk symbol allows for the identification of terms with the same stem but with ending variation. The quotation marks enable the match of exact phrases. The Boolean operator 'AND' was used to allow all three variables to be present (and thus focus the search). The Boolean operator 'OR' was used to widen the search.

Three search strategies were used. Firstly, seven databases were searched from inception until May 2023, including: CINAHL, MEDLINE, PsychINFO, Psychology Database, Public Health Database, Web of Science and PubMed. Key words from the relevant literature from the preliminary searches were reviewed and included into the search syntax, and 'controlled vocabulary' on databases were applied to ensure relevant papers were detected. The search strategy details were discussed with an Evidence Reviewer in Mersey Care NHS Foundation Trust and a Liaison Librarian at the University of Liverpool. The second search strategy included hand-searching the reference lists of all included articles and using the 'cited by' feature on Google Scholar. This was to identify any further articles that had not emerged from the database searches. Thirdly, a grey literature search was conducted using Google to search relevant charity and organisation websites. These comprised of Homeless Hub, Homeless Link, FEANTSA, Canadian Observatory on Homelessness, Groundswell, Shelter, SAMHSA Homelessness Resources, St Mungo's, Crisis, and Frontline Network.

Homelessness is an under resourced area which extends to the commissioning of homelessness research. It is not always possible within the context of time and funding for research projects to go through the same rigorous process that reflects peer review. This is especially considering the critical need to respond practically and immediately to secure funding and to directly influence policy and practice (Pleace, 2020). However, despite all constraints, there exists admirable research collaborations and striking innovation, insight and wisdom drawn from lived experience and practice-based evidence (Pleace, 2020). Although the peer review process acts as a verified filter to ensure high quality and valid research (Kelly et al., 2014), it is not without its own bias limitations such as the 'file-draw-effect' (i.e., bias towards publishing positive outcomes, Laitin et al., 2021). Therefore, the decision to include grey literature in this systematic review was to support inclusion and reduce publication bias.

2.2 Eligibility Criteria

To be included, the papers required the following: (1) available in English language unless resources for translation were accessible; (2) an exploration of trauma experiences in line with the SAMHSA (2014) definition where the 'event' relates to the circumstances of working in homelessness, 'experiences' is the meaning assigned to events and 'effects' relate to traumatic stress symptoms; (3) the aim of the paper is on the experiences and emotional impact of working in homelessness; (4) the quantitative focus is on the prevalence or the factors associated with trauma as defined by SAMHSA (2014).

Papers were excluded if they, met any of the following criteria: (1) the participant sample included people who had not experienced homelessness (e.g., veteran or sex worker population); (2) the participant sample focused on working with people considered as refugees or seeking asylum; (3) the research was looking at the consequences of natural disasters; (4) the stated study aims were on the practical elements or service provision, rather than the 'events', 'experiences', and 'effects' of working in this area; (5) where there was none or minimal reference to trauma; (6) CF was mentioned without clear separation from burnout.

2.3 Quality Assessment

Eligible studies were critically appraised by two independent reviewers for methodological quality using the MMAT (Hong et al., 2018a, b; 2019). Disagreements arose between the reviewers on three papers and were resolved through discussion. The MMAT is a 27-item checklist that allows for the quality assessment of quantitative, qualitative, and mixed methods studies and provides methodological quality criteria for different designs, within a single tool. There are two screening questions, and five separate study design categories with five questions included in each. These categories consist of a qualitative, quantitative (either the randomised, nonrandomised, or quantitative descriptive), and mixed methods. When appraising mixed methods studies, three sets of items are assessed (i.e., qualitative,

quantitative, and mixed). Criteria relate to the appropriateness of methodology, data analysis and data collection techniques, sample representativeness, outcome data reliability, and researchers' interpretation of research findings. Each item is rated on a categorical scale ('Yes', 'No', and 'Cannot Tell'). The number of items rated 'Yes' can be counted to provide an overall score, although this is discouraged as scores do not provide sufficient detail regarding individual elements (e.g., aspects that might be problematic). Thus, it is advised to provide a detailed presentation of the ratings of the criteria for sensitivity analysis to consider the quality of studies by contrasting results (Hong et al., 2019).

2.4 Review Selection

The review search process is outlined in The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram within the Results section (see Figure 1; Page et al., 2021). The reference management software Rayyan (Ouzzani et al., 2016) was used for the direct exportation of citations from online databases. The search results were merged, and duplicates were removed. Titles and abstracts were screened for relevance using the eligibility criteria and a second reviewer screened 25% randomly assigned titles and abstracts against the same criteria along with using a screening tool (Appendix A). Full-text articles were retrieved to determine eligibility when it was unclear from the abstract. The same criteria were used throughout the full-article review. Consultation with the research team was sought throughout the final article selection. Discrepancies were resolved via discussion, alongside input from the second reviewer, who assessed 25% of the full-text articles against the eligibility criteria.

2.5 Data Extraction and Synthesis

Three data extraction tools were developed (for descriptive, quantitative, and qualitative analytic data) to systematically extract key information and results. The data extracted included: (a) authors and publication year; (b) location; (c) sample demographics; (d)

main aims; (e) study design/method; (f) outcome measures; (g) data analysis; (h) analytic data and main findings.

This mixed-methods review adopted a convergent segregated approach which initially involved the synthesis of quantitative and qualitative data independently (Lizarondo et al., 2020; Stern et al., 2020). The review question dictated the inclusion of a range of research designs and findings. Thus, the heterogeneous nature of the extracted data meant that statistical techniques (e.g., meta-analysis) were not appropriate for the synthesis of the literature. Quantitative data were therefore narratively synthesised per the Johanna Briggs Institute (JBI) guidance on mixed-methods systematic review synthesis (Lizarondo et al., 2020). Key aspects of the quantitative data across the included studies were categorised under the SAMHSA (2014) three 'Es' definition of trauma (i.e., prevalence and associated factors as detailed in Quantitative Synthesis section 3.4.1). Textual descriptions of the included study findings were summarised and synthesised, outcome data were reviewed for similarities and differences and conclusions across the studies were drawn.

Theoretically flexible and reflexive thematic analytic methods (Braun & Clarke, 2006) were drawn upon to support the synthesis of the qualitative data. Qualitative synthesis methods further aligned with Thomas and Harden's (2008) thematic synthesis methods and the JBI qualitative synthesis guidance (Lockwood et al., 2020). How individuals make meaning of their experiences within their social contexts is central, thus a critical realist epistemological stance (Bhaskar, 2009; Willig, 1999) was adopted. The descriptive and analytic data from each study was extracted comprehensively into data extraction tables and referred to throughout the synthesis, capturing the context of the study in which the data were generated. Thus, considering the meaning of all findings and reducing the risk of placing preconceived ideas on expected findings (Thomas & Harden, 2008). Data were extracted and synthesised in line with the established superordinate themes as defined as 'event', 'experience' and 'effects' of trauma

(SAMHSA, 2014), providing a theoretical structure within which to develop higher-order thematic categories (Thomas & Harden, 2008).

During the first stage, data familiarisation and line-by-line coding was carried out to capture the meaning and context of each sentence, enabling the translation of concepts from one study to another whilst in consideration of the review question. The trainee then generated the codes and repeatedly reviewed them around the contexts in which they were embedded to identify patterns of meaning within the semantic content both within and across studies, aiming towards the generation of 'data-driven' descriptive themes (Braun & Clarke, 2006; Thomas & Harden, 2008). Examples of coding are shown in the Thematic Diagrams presented in Figures 3, 4 and 5. The development of codes and themes was explicitly organised using Microsoft Word computer software whereby tables were created to include reference citations, qualitative data (i.e., initially associated author interpretation and direct quotes) and tentative codes. To ensure consistency of interpretation the primary supervisor also reviewed all codes, checking for similarities and differences between them.

The final stage of synthesis involved ‘going beyond’ the aggregated findings from the primary studies (Thomas & Harden, 2008), inductively developing overarching analytical subthemes aligning with the established superordinate themes as defined as ‘event’, ‘experience’ and ‘effects’ (SAMHSA, 2014) to answer the review question. The trainee completed all stages of the analysis, facilitated by discussions with the wider team throughout. All raw data, data extraction and several analytical tables with notes have been stored as part of an audit trail to increase transparency of the synthesis process (i.e., evidencing the process of refining themes). The narrative summaries of themes, quotation tables with reference to the original papers, and the thematic diagrams highlighting key codes which are all clearly presented in Section 3.4.2 Qualitative Synthesis further increase transparency of the synthesis

process and the provenance of the results, increasing rigour, replicability, and confidence in the review findings.

To be explicit regarding the confidence in the qualitative evidence synthesis a GRADE-CERQual (Lewin et al., 2015) Evidence Profile and Interactive Summary of Qualitative Findings (iSoQ) table has been created (see Appendix R for iSoQ table). Each finding has been assessed using the four criteria (i.e., methodological limitations, coherence, adequacy, and relevance) and the associated guidance. GRADE-CERQual aims to improve the quality and reliability by systematically evaluating the confidence in qualitative findings to ensure rigor and transparency. Its structured assessment enables reviewers to determine the strength of qualitative evidence through the process of rating confidence levels. This approach promotes more informed decision-making and increases the trustworthiness of synthesised qualitative findings. Acknowledgement of reflexivity is included in Section 4. 'Discussion' in this review.

Following independent synthesis, the quantitative and qualitative data were integrated. A configuration analysis was conducted via a meta-aggregation which involved a simultaneous comparison of the quantitative and qualitative findings. Themes were generated in line with the prevalence and associated factors explored in the quantitative studies and experiences explored in the qualitative studies to organise the evidence into a line of argument (Lizarondo et al., 2020; Stern et al., 2020). No data transformation was carried out.

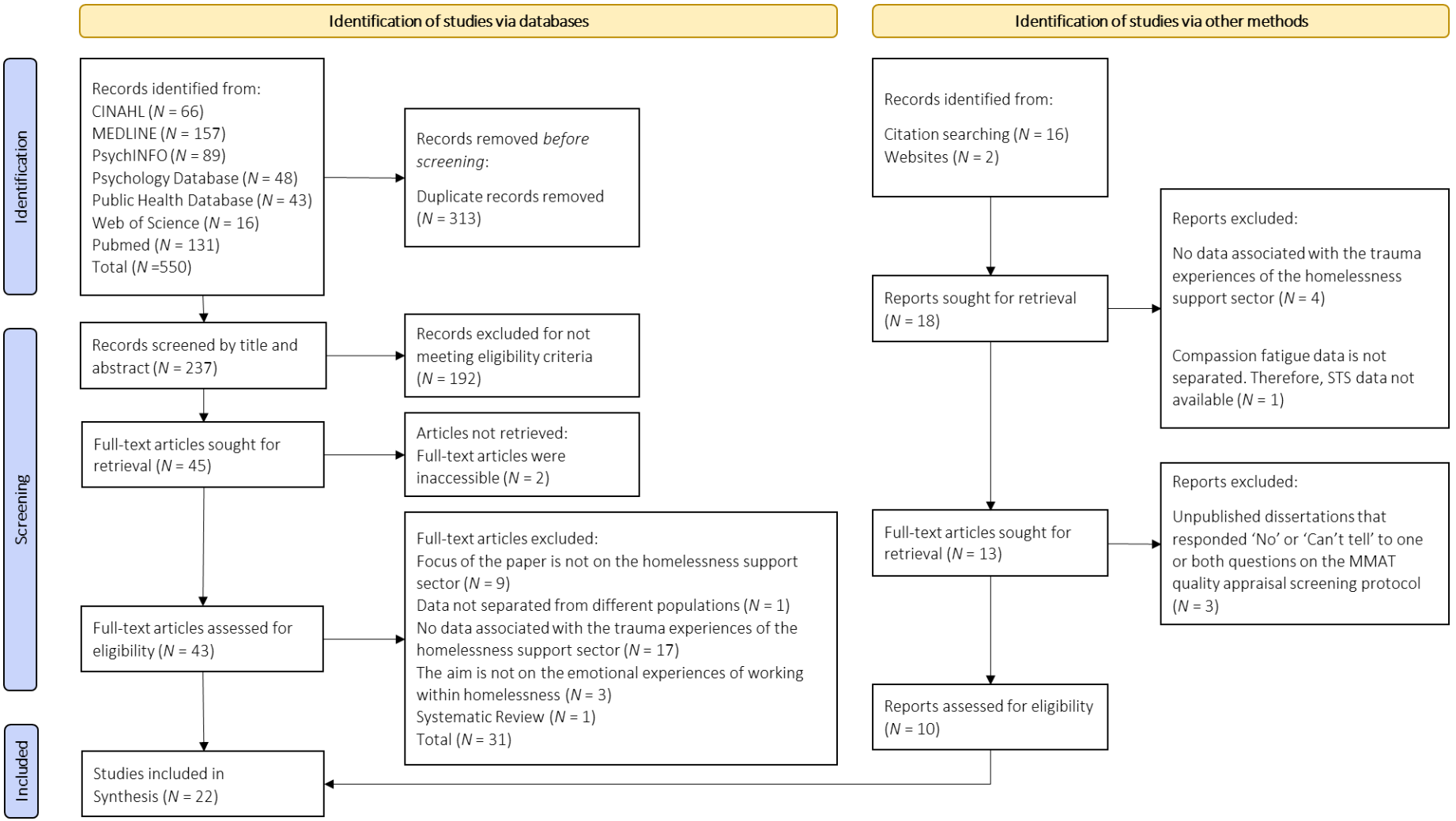
3. Results

3.1 Search Results

The PRISMA guidance (Liberati et al., 2009; Page et al., 2021) was used to guide the process of identification, selection, and critical appraisal of research for analysis and synthesis. A flow diagram of the study selection process is shown in Figure 1. Electronic and hand searches identified 568 citations which, once duplicates were removed, left 255 citations to be screened for inclusion. Their titles and abstracts of these were screened for relevance and a further 192 records were excluded for not meeting eligibility criteria. Common reasons for exclusion at this stage related to irrelevant study aims, population samples and topic areas. It was not possible to translate and retrieve the full-text of two citations, therefore, 61 full-text citations and reports were obtained. Further, following removal of duplicates (N = 313), titles, abstracts, and full-text articles were reviewed by the author. To ensure that inclusion and exclusion criteria were followed, a second reviewer reviewed 25% of the titles and abstracts and full-text articles. There was agreement on the inclusion and exclusion of 74 out of the 79 titles and abstracts, and five were omitted for inclusion following discussion, whereby they were agreed to not meet eligibility criteria. A list of the full-text articles was reviewed and reasons for exclusion can be found in Appendix B. A total of 22 articles proved to fulfil the eligibility criteria and were retained for inclusion. Twelve studies contributed to the quantitative component and 13 contributed to the qualitative component. Three mixed methods studies contributed to both components of this review.

Figure 1

PRISMA (2020) Flow Diagram of Study Selection Including Searches of Databases and Other Sources (Page et al., 2021)



3.2 Methodological Quality

All papers were subjected to an initial screening (to be included in the appraisal for all articles) using the first two questions of the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018a, b; 2019). The answer to these two questions indicates whether the study quality is an appropriate level to be assessed using the MMAT. The three included unpublished dissertations indicated significantly low quality which eliminated them from further appraisal in accordance with the MMAT protocol. In further reading and discussion in supervision, the decision was taken to therefore exclude unpublished theses from the review (as shown in the PRISMA diagram in Figure 1).

As shown in Tables 2, 3, 4 and 5, each study was quality assessed using either one of the MMAT (Hong et al., 2018a, b) quantitative (i.e., nonrandomised, or descriptive) or the qualitative categories. Mixed methods studies were assessed via quantitative, qualitative and the mixed methods category. Across the quantitative methods (see Tables 2 and 3) the representativeness of the study samples was uncertain in consideration of sampling methods. Most variables across the studies were clearly defined and accurately measured with reliable and valid outcome measures, however, reliability and validity queries were present regarding specific measures across eight studies. Across all studies, almost all the participants contributed to at least 80% of the measures, indicating complete outcome data (Thomas et al., 2004). The approaches taken across the qualitative studies were appropriate to answer the research questions. As indicated in Table 4, the qualitative data collection methods were not always reported in adequate depth to ascertain study quality, nor clear integration between the data sources, collection, analysis, and interpretation. Due to minimal information in two studies, determining whether analysis methods were adequately derived was not possible. Potential divergences and inconsistencies between qualitative and quantitative findings may not have been fully reported or explained in two of the mixed methods studies, as indicated in Table 5.

Table 2

Quality Assessment of Quantitative Non-Randomised Studies

Study	Author(s) and Publication Year	3.1. Are the participants representative of the target population?	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	3.3. Are there complete outcome data?	3.4. Are the confounders accounted for in the design and analysis?	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?
2	Aykanian (2022)	CT	Y	Y	Y	CT
5	Kerman et al. (2022a)	CT	Y	Y	N	CT
7	Kerman et al. (2022c)	CT	CT	Y	N	CT
8	Kerman et al. (2022d)	CT	CT	Y	Y	CT
10	Lemieux-Cumberlege et al. (2023)	CT	CT	Y	N	CT
11	Lemieux-Cumberlege et al. (2019)	CT	CT	Y	Y	CT
14	Petrovich et al. (2021)	CT	Y	Y	CT	CT
15	Schiff et al. (2019)	CT	CT	Y	CT	CT
16	Schneider et al. (2021)	CT	CT	Y	CT	CT
20	Waegemakers-Schiff et al. (2019)	CT	Y	Y	CT	CT

Note. All studies answered 'Yes' to both screening questions (i.e., 1. Are there clear research questions? 2. Do the collected data allow to address the research questions? Y = Yes. N = No. CT = Cannot Tell

Table 3

Quality Assessment of Quantitative Descriptive Studies

Study	Author(s) and Publication Year	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?
3	Aykanian and Mammah (2022)	Y	CT	CT	Y	Y
18	Twis et al. (2022)	Y	CT	Y	Y	Y

Note. All studies answered 'Yes' to both screening questions (i.e., 1. Are there clear research questions? 2. Do the collected data allow to address the research questions?). Y = Yes. N = No. CT = Cannot Tell.

Table 4

Quality Assessment of Qualitative Studies

Study	Author(s) and Publication Year	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?
1	Aykanian (2018)	Y	Y	Y	Y	Y
4	Campbell et al. (2022)	Y	Y	Y	Y	Y

6	Kerman et al. (2022b)	Y	Y	Y	Y	Y
8	Kerman et al. (2022d)	Y	Y	Y	Y	Y
9	Lakeman (2011)	Y	Y	Y	Y	Y
12	Levesque et al. (2021)	Y	Y	N	Y	CT
13	Peters et al. (2021)	Y	Y	Y	Y	Y
14	Petrovich et al. (2021)	Y	Y	Y	Y	Y
17	Theodorou et al. (2021)	Y	Y	Y	Y	Y
18	Twis et al. (2022)	Y	Y	Y	Y	Y
19	Valoroso et al. (2020)	Y	Y	Y	Y	Y
21	Wallace et al. (2018)	Y	Y	Y	Y	Y
22	Webb (2015)	Y	Y	Y	Y	Y

Note. All studies answered 'Yes' to both screening questions (i.e., 1. Are there clear research questions? 2. Do the collected data allow to address the research questions?). Y = Yes. N = No. CT = Cannot Tell.

Table 5

Quality Assessment of Mixed Methods Studies

Study	Author(s) and Publication Year	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
8	Kerman et al. (2022d)	Y	Y	Y	Y	CT
14	Petrovich et al. (2021)	Y	Y	Y	CT	CT
18	Twis et al. (2022)	Y	Y	Y	CT	N

Note. All studies answered 'Yes' to both screening questions (i.e., 1. Are there clear research questions? Do the collected data allow to address the research questions?). Y = Yes. N = No. CT = Cannot Tell.

3.3 Characteristics of Included Studies

The following information regarding study characteristics can be found in Tables 6, 7 and 8, including (a) study number, (b) author(s) and publication year, (c) location, (d) sample information, (e) method, (f) measures, and (g) analysis approaches for the quantitative, mixed methods, and qualitative studies. All included articles were published between 2011 and 2023. The studies were conducted in North America (n = 9), the United States of America (USA, n = 5) and the UK (n = 8). The total number of participant samples range from N = 7 to N = 701 across the studies, which involved a diversity of roles across the homelessness support sector, including frontline work (such as support worker roles) to management and executive directing roles. The majority of participants across samples were White, female and the average sample ages ranged from 35 to 54 years. All quantitative data were gathered via cross-sectional survey methods exploring the prevalence of trauma experiences and associated factors. The constructs that were measured included STS (n = 6), post-traumatic stress (n = 6), potentially traumatic life events and experiences (n = 5) and psychological distress and wellbeing factors associated with trauma experiences (n = 5). Essential approaches to quantitative data analyses were correlational and regression (n = 10) and descriptive statistics (n = 2). Across all qualitative data, in-depth, semi-structured interviews (n = 9) and focus groups (n = 4) were conducted, using a variety of approaches to qualitative data analysis.

Table 6

Characteristics of the Quantitative Studies Included in the Narrative Synthesis

Study	Author(s) and Publication Year	Location	Sample	Method	Measure	Analysis
2	Aykanian (2022)	Texas, USA	*N* = 132 78 working primarily in direct service roles and 54 primarily in managerial roles. Female 70% White 75% 42 years	Cross-sectional	ProQOL (Stamm, 2010)	Multiple Linear Regression
3	Aykanian and Mammah (2022)	Texas, USA	*N* = 136 78 working primarily in direct service roles and 58 primarily in managerial roles. Female 70% White 75% 42 years	Cross-sectional	Adverse Childhood Experiences Checklist (Felitti et al., 1998)	Univariate statistics and bivariate approaches (correlations, ANOVAs, t-tests)
5	Kerman et al. (2022a)	Canada, North America	*N* = 701 280 working in small/remote community services, 197 in supportive housing, 102 in community health services, 75 in harm reduction programmes and 47 'other'.	Cross-sectional	ProQOL (Stamm, 2010) PCL-6 (Lang & Stein, 2005)	Hierarchical Multiple Regression

			Female 80% White 88% 39 years			
7	Kerman et al. (2022c)	Canada, North America	*N* = 701 280 working in small/remote community services, 197 in supportive housing, 102 in community health services, 75 in harm reduction programmes and 47 'other'. Female 80% White 88% 39 years	Cross-sectional	A modified list of 'chronic stressors' and 'critical events' by Seto et al. (2020) PCL-6 (Lang & Stein, 2005) DASS-21 (Lovibond & Lovibond, 1995)	Hierarchical Multiple Regression
10	Lemieux-Cumberlege et al. (2023)	Edinburgh, Scotland	*N* = 201 Frontline workers homelessness services (*n* = 139) Third sector organisations (*n* =152) Female 68% White 92%	Cross-sectional	Trauma exposure count list of 15 possible distressing workplace events CERQ (Garnefski et al., 2002) PCL-5 (Weathers et al., 2013b)	Correlational Hierarchical Regression Conditional process analysis

					ProQOL (Stamm, 2010)	
11	Lemieux-Cumberlege and Taylor (2019)	Edinburgh, Scotland	*N* = 112 16 health/social care professionals, 18 managers, 23 practitioners, 8 senior support workers, 42 support workers, 5 did not disclose. Female 65%	Cross-sectional	ProQOL (Stamm, 2010) DASS-21 (Lovibond & Lovibond, 1995)	Correlational
15	Schiff et al. (2019)	Canada, North America	*N* = 312 100 worked in shelters, 106 in permanent housing, 44 in transitional housing, 62 provided residential support. Female 74% 39 years	Cross-sectional	ProQOL (Stamm, 2010) PCL-C (Wilkins et al., 2011) The Life Events Checklist for DSM-5 (Weathers et al., 2013b)	Correlational
16	Schneider et al. (2021)	Cardiff, Wales	*N* = 184 93 support workers and assistants, 21 staff with managerial responsibilities, 21 support staff, 21 team leaders, 6 area heads and 14 senior managers. Females 63% 40 years	Cross-sectional	ProQOL (Stamm, 2010) WEMWBS (Tennant et al., 2007) ARTIC-10 (Baker et al., 2016)	Correlational

20	Waegemakers Schiff and Lane (2019)	Canada, North America	*N* = 472 Homelessness Support Sector	Cross-sectional	ProQOL (Stamm, 2010) The PCL-6 (Wilkins et al. 2011)	Correlational and Hierarchical Multiple Regression

Note. Female = Gender. White = Ethnicity. Years = Average Age. ProQOL = Professional Quality of Life. PCL = Post-Traumatic Stress Disorder Checklist. DASS = Depression, Anxiety, and Stress Scale. CERQ = Cognitive Emotion Regulation Questionnaire. WEMWBS = The Warwick-Edinburgh Mental Well-being Scale. ARTIC-10 = Attitudes Related to Trauma-Informed Care Scale.

Table 7

Characteristics of the Mixed Method Studies Included in the Narrative Synthesis and Thematic Synthesis

Study	Author(s) and Publication Year	Location	Sample	Method	Measure	Analysis
8.	Kerman et al. (2022d)	Canada, North America	Survey (*n* = 130) Female 82% White 78% 38 years Interview (*n* = 14) 8 working in direct service roles, 5 team lead/coordinators, 4 program managers and 1 in a senior leadership role Female 79% White 93% 35 years	Cross-sectional survey Semi-structured interviews	A modified list of 'chronic stressors' and 'critical events' by Seto et al. (2020)	Binary logistic regression Univariate and multivariate models Thematic analysis Saldaña (2013)
14	Petrovich et al. (2021)	Texas, USA	Survey (*n* = 122) Focus groups (*n* = 21) 107 direct service providers and 15 program managers	Cross-sectional survey Focus group semi-structured interviews	STSS (Bride et al., 2007)	Descriptive statistics Conventional content analysis (Hsieh & Shannon, 2005)

			Female 78% White 59% 40 years			
18	Twis et al. (2022)	Texas, USA	Survey participants (n = 10) Focus groups (n = 16) 6 case managers, 1 case worker and 3 not identified Female 80% White 60% 38 years	Cross-sectional survey Focus group semi-structured interviews	STSS (Bride et al., 2007)	Descriptives statistics Concurrent nested approach for mixed methods analysis Conventional content analysis (Hsieh & Shannon, 2005)

Note. Female = Gender. White = Ethnicity. Years = Average Age. STSS = Secondary Traumatic Stress Scale.

Table 8

Characteristics of the Qualitative Studies Included in the Thematic Synthesis

Study	Author(s) and Publication Year	Location	Sample	Method	Analysis
1	Aykanian et al. (2018)	New York, USA	N = 8 8 homeless service providers	Semi-structured interviews	A three-step coding process (Miles et al., 2014)

4	Campbell et al. (2022)	Canada, North America	*N* = 42 16 program directors, 15 executive directors, 2 chief executive officers, 1 chief financial officer and 7 department managers and coordinators Female 69% White 71% 49 years	Semi-structured interviews	Deductive and inductive (Bingham & Witkowsky, 2021)
6	Kerman et al. (2022b)	Canada, North America	*N* = 40 18 direct service providers, 9 team lead/coordinators, 7 program managers and 6 in senior leadership roles Female 73% White 76% 37 years	Semi-structured interviews	Grounded theory-informed (Corbin & Strauss, 1990)
9	Lakeman (2011)	Dublin, Ireland	*N* = 16 16 participants outreach workers in emergency shelters, high-support hostels, and residential alcohol and drug treatment facilities 40 years	Semi-structured interviews	Grounded theory (Glaser & Strauss, 1967)

12	Levesque et al. (2021)	Canada, North America	*N* = 15 15 executive directors in interview sample White 84% 54 years	Semi-structured interviews	Interviews were recorded, transcribed, and coded using NVivo
13	Peters et al. (2021)	Cardiff, Wales	*N* = 11 11 support workers, with varying levels of responsibility and specific job roles Female 54%	Semi-structured interviews	Constructivist grounded theory (Charmaz, 2014)
17	Theodorou et al. (2021)	Edinburgh, Scotland	*N* = 19 19 assertive outreach service providers Female 85%	Focus groups	Thematic analysis (Braun & Clarke, 2006)
19	Valoroso et al. (2020)	Plymouth, UK	*N* = 8 5 support workers, 3 in leadership roles Female 63% White 100% 40 years	Semi-structured interviews	Interpretative Phenomenological Analysis (Smith & Osborn, 2015)
21	Wallace et al. (2018)	Canada, North America	*N* = 49	Focus groups	Interpretive description (Thorne, 2008; 2016)

			23 shelter residents and 13 harm reduction shelter staff Female 66% 43 years		
22	Webb et al. (2015)	Worcestershire, UK	*N* = 7 7 hostel staff working in palliative care	Semi-structured interviews	Descriptive phenomenological (Giorgi, 2009)

Note. Female = Gender. White = Ethnicity. Years = Average Age.

3.4 Findings of Systematic Review

3.4.1 Quantitative Synthesis

A narrative synthesis of the included quantitative data was conducted in line with the SAMHSA (2014) definition. The prevalence of trauma experiences (section 3.4.1.1) predominantly relates to 'experience' and 'effects' concerning the meaning assigned to experiences (i.e., recognising experiences as traumatic) and the exploration of traumatic stress via outcome measures. Factors associated with trauma experiences (section 3.4.1.2) mainly relate to 'events' and 'effects' concerning the associated threat of harm, and the outcome of circumstances.

3.4.1.1 Prevalence of Trauma Experiences.

Nine studies explored the prevalence of trauma experiences. When measuring STS, mixed results across the literature were highlighted (see Table 9 for reported levels across samples), with 0% to 75% of participants experiencing high to severe levels of STS. Prevalent STS symptoms reported were numbing, trouble sleeping, intrusive thoughts about clients, trouble concentrating, increased annoyance with clients and difficulty recalling client information (Petrovich et al., 2021; Twis et al., 2022). Across four participant samples 23% to 42% reported experiencing high levels of post-traumatic stress, indicative of meeting the PTSD diagnostic threshold.

Table 9

Percentage of High to Severe Levels of Traumatic Stress Experienced Amongst Samples

Study No.	High to Severe Levels of Traumatic Stress %	Construct (Measure)
2	1.5	STS (ProQOL)
5	1.7	STS (ProQOL)
10	27.0	STS (ProQOL)
11	0.0	STS (ProQOL)
15	21.0	STS (ProQOL)
16	63.0	STS (ProQOL)

20	75.0	STS (ProQOL)
14	28.0	STS (STSS)
18	75.0	STS (STSS)
5	42.0	PTSS (PCL-6)
10	23.0	PTSS (PCL-5)
15	33.0	PTSS (PCL-C)
20	41.0	PTSS (PCL-C)

Note. 'High to Severe' levels are defined by the cut-off levels in the individual studies. STS = Secondary Traumatic Stress. PTSS = Post-Traumatic Stress Symptoms. ProQOL = Professional Quality of Life. STSS = Secondary Traumatic Stress Scale. PCL-C = Post-Traumatic Stress Disorder Checklist for Civilians.

The experience of potentially traumatic events was explored across four studies. The prevalence of ACEs (Felitti et al., 1998) amongst this sector in Texas was found to be higher than in the general population (Aykanian & Mammah, 2022). Most participants (81%) reported experiencing at least one ACE and 39% reported four or more. The most reported ACEs were parental separation, emotional abuse, substance abuse and psychological distress within the home. Schiff et al. (2019) found that 95% of participants experienced at least one traumatic incident in their lives and 88% experienced three or more, with 56% experiencing some of these events at work.

In line with Schiff et al., (2019), Lemieux-Cumberlege et al. (2023) and Kerman et al. (2022c) explored the prevalence of workplace traumatic events. Exposure to one or more events in the workplace was reported by 89% of participants (Kerman et al., 2022c), with 33% of participants in Lemieux-Cumberlege et al. (2023) experiencing at least three events in the past six months. The most reported experiences were threats or verbal aggression (89% to 96%), responding to self-harm, suicide, or near-fatal attempts (56% to 83%) and overdose (61% to 81%), physical assault without injury (71%), threat of death or serious injury to self or someone close to them (46% to 66%), witnessing death (52%) and significant relationship breakdowns with a colleague or manager (35%).

3.4.1.2 Factors Associated with Trauma Experiences.

Across seven studies factors associated with trauma experiences were explored. Secondary Traumatic Stress was significantly positively associated with psychological distress and burnout, and negatively associated with general wellbeing (Lemieux-Cumberlege et al, 2023; 2019; Schneider et al., 2021). Workplace trauma exposure and "maladaptive" coping strategies were found to predict PTSD, STS (Lemieux-Cumberlege et al., 2023) and psychological distress (Kerman et al., 2022d). More time in direct contact with clients was significantly associated with greater exposure to trauma experiences (Kerman et al., 2022c). Post-traumatic stress symptoms were found to be significantly positively associated with more frequent exposure to traumatic stressors, lived experience of behavioural health problems, the amount of direct service work (i.e., 76-100% of the time), age and negatively associated with organisational and peer support (Kerman et al., 2022a, c; Waegemakers Schiff & Lane, 2019).

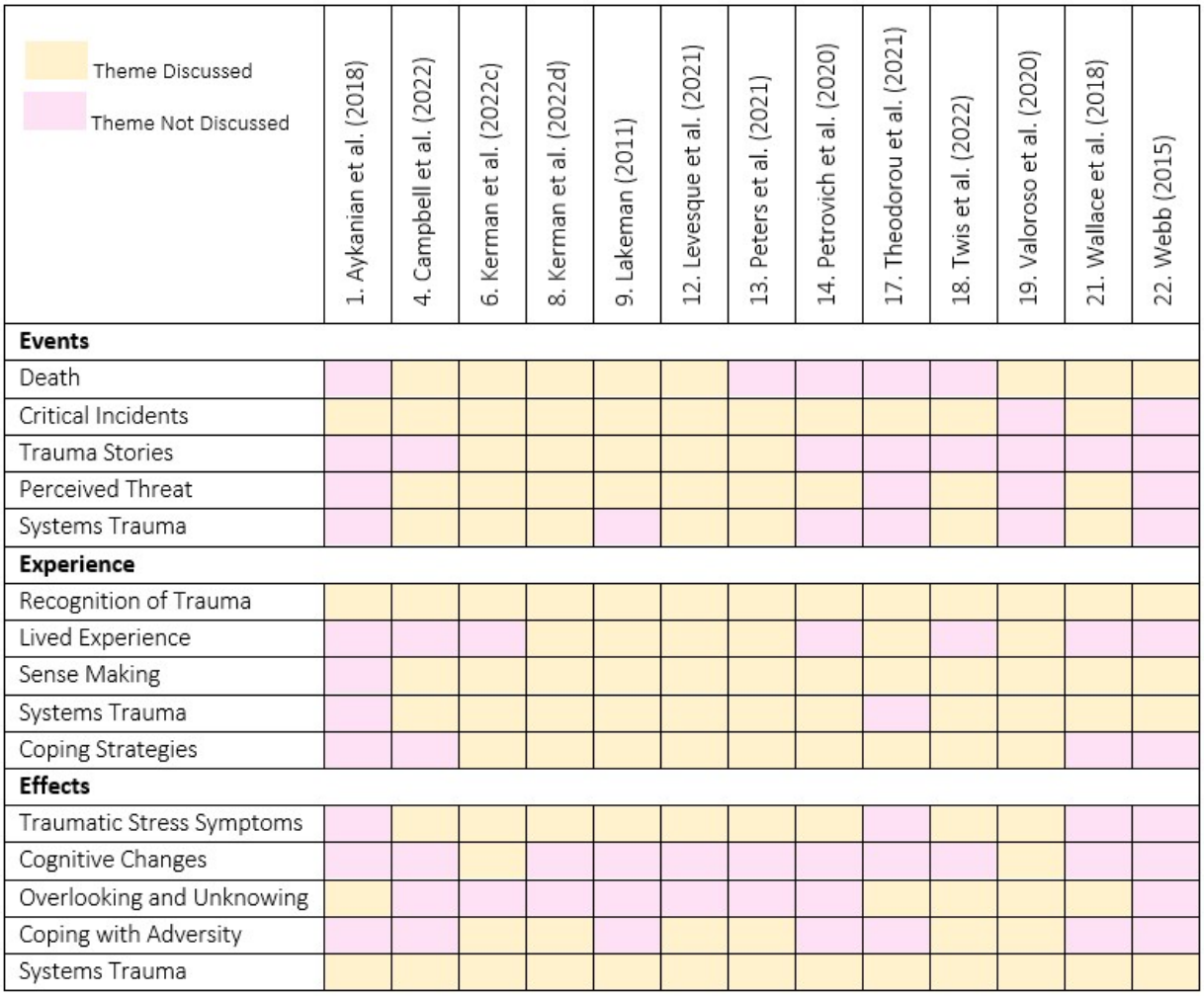
However, despite similar symptoms to post-traumatic stress, STS was not found to be significantly associated with access to organisational support in Lemieux-Cumberlege and Taylor (2019) or managerial or peer support in Waegemakers Schiff and Lane (2019), and although organisational culture and Compassion Satisfaction have been found to be protective against burnout, they were not strong predictors of STS and post-traumatic stress when explored by Lemieux-Cumberlege et al. (2023). Participants with higher STS were also found to hold less favourable attitudes towards trauma-informed practice and more negative perceptions of safety in workplace housing projects (Schneider et al., 2021). Inconsistent associations between experiences of trauma and Compassion Satisfaction are presented. For example, Compassion Satisfaction is significantly negatively associated with STS (Lemieux-Cumberlege et al., 2023; 2019) and post-traumatic stress (Waegemakers Schiff & Lane, 2019), however, no relationship between Compassion Satisfaction and STS has also been identified (Schneider et al., 2021).

3.4.2 Qualitative Synthesis

Synthesis of the included qualitative data was conducted, and subthemes were generated and organised under the SAMHSA constructs of trauma: ‘events’, ‘experience’, and ‘effects’. Tables 10, 11 and 12 demonstrate subthemes for each superordinate theme and include some of the original quotes across the studies to highlight participants’ voices. Theme occurrence across the included papers is shown in Figure 2. To improve the transparency, quality, and reliability, and to assess the confidence in each finding and the conclusions drawn from the qualitative synthesis, the GRADE-CERQual methodology was applied. The iSoQ table can be found in Appendix R. Overall, across all 15 findings, six findings presented as moderate confidence and nine presented as high confidence. These results indicate that there is moderate to high confidence that all the findings are a reasonable representation of the phenomenon of interest being explored (i.e., the trauma experiences of the homelessness support sector as per definitions presented in this review).

Figure 2

Occurrence of Subthemes in the Included Studies



3.4.2.1 Events.

Five subthemes were synthesised across the literature associated with 'events' that risk experiencing trauma. Subthemes included being exposed to or responding to 'death', 'critical incidents', 'trauma stories', 'perceived threat', and 'systems trauma' (see Figure 3 for a thematic diagram). As displayed in Figure 2, eight papers discussed circumstances where participants witnessed or were responsible for responding to the death of the people experiencing homelessness for whom they care. Circumstances ranged from single to repeated events including homicide, suicide, overdose and working in palliative care (as illustrated in direct quotes found in Table 10). At times, confronting death was reported to involve violence, injustice, and indignity, and the increased responsibility in responding to overdose was noted as a particular cause of concern (Lakeman et al., 2011; Wallace et al., 2018). Encountering 'critical incidents' including violence, abuse, property destruction, substance misuse, self-harm, and health complications were emphasised within 11 studies.

These 'events' are surrounded by the unpredictability of threat and danger, as emphasised by nine studies, explaining how staff feel "*unsafe*" as risks cannot be appropriately mitigated (Wallace et al., 2018). Despite all studies mentioning systemic-level implications, seven highlighted how a broad range can intersect and impact potentially traumatic events by creating increased uncertainty and threat and result in "*a vicious cycle of trying to grasp at straws*" (Kerman et al., 2022b). 'Systems trauma' (consistent across all superordinate themes) can relate to limited resources which push people into overworking and feeling unsupported, a lack of collaboration within and between services which can increase levels of resentment amongst teams, and discrimination and stigma (i.e., everyone is "*painted with the same brush*", considering that homelessness is a stigmatised area; Kerman et al., 2022b). The Covid-19 pandemic was also reported to influence this context, raising unpredictability and the actual or perceived threat to harm (Campbell et al., 2022).

As shown in the iSoQ table in Appendix R, the GRADE-CERQual results indicate that there is a high confidence in all five findings across the 'Events' superordinate theme. This is because very minor concerns were raised throughout the structured assessment regarding methodological limitations, coherence, adequacy, and relevance. The 'Events' subtheme included descriptive data (such as providing clear descriptions of death and overdoses), meaning that the synthesised data closely aligned with the original study findings. This differs from the 'Experiences' superordinate theme, which involved higher levels of interpretation due to the subjectivity involved in personal experience, as shown below in section 3.4.2.2.

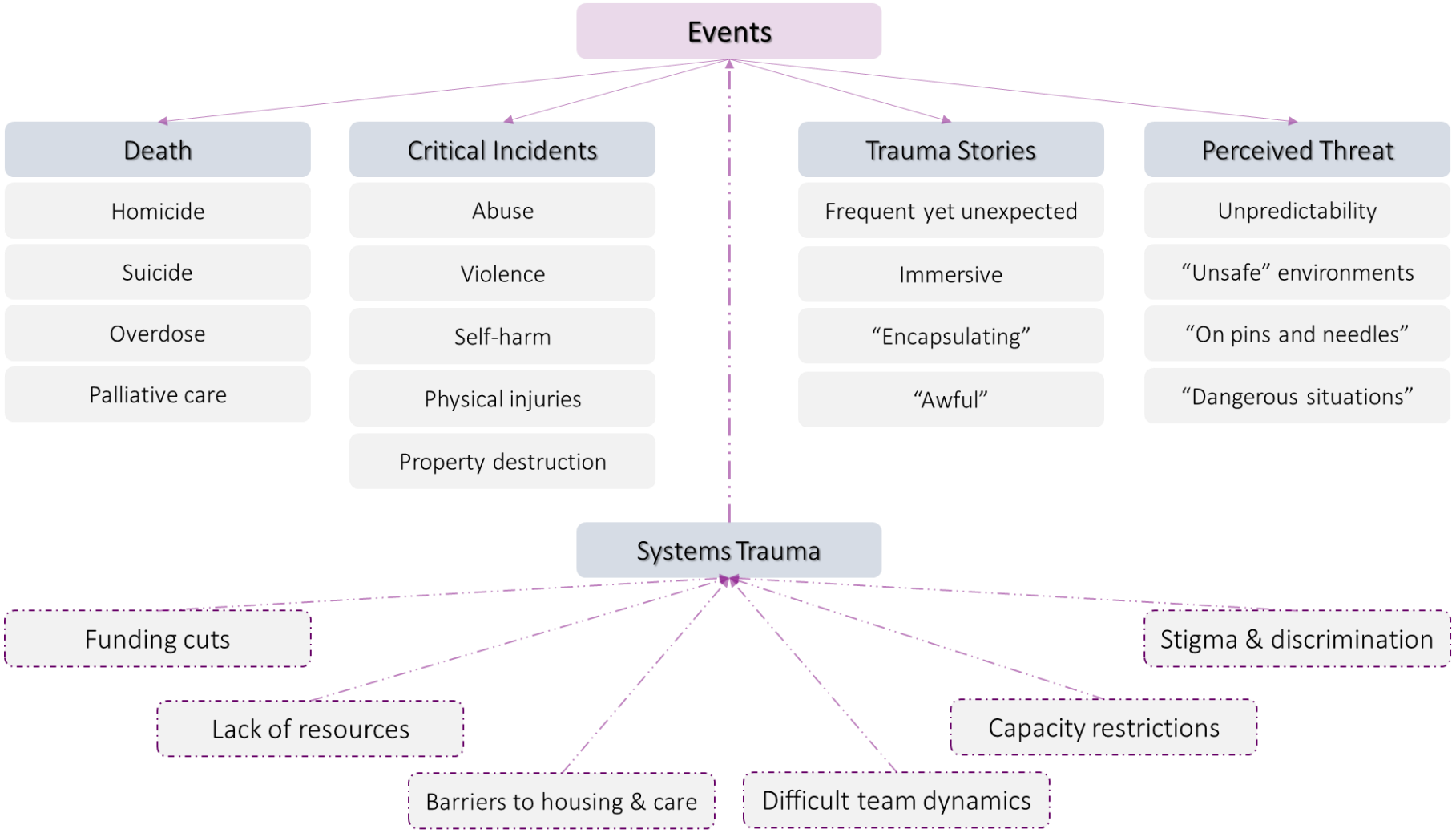
Table 10

Synthesis of 'Events' Themes and Direct Quotes from Papers

	Direct Quotes
Events	
Death	"*I've responded to multiple hangings…cut people down"* (Paper 6, pp 6). *"I lost seven clients in a month with the fentanyl crisis"* (Paper 6, pp 4). *"Overdoses a lot... found clients deceased…had to give CPR*" (Paper 8, pp 11). "*We care, we're supporting that person…and [they're] on the floor almost dying*" (Paper 21, pp 87).
Critical Incidents	*"…someone standing in front of you with bandaging, black eye, cut up in the face"* (Paper 8, pp 11). *"…seeing people with chronic health conditions…broken bones…open wounds…people lose their teeth…"* (Paper 8, pp 11). *"…she used to cut quite badly…it was quite shocking to see…I found myself in an…alien situation…* (Paper 13, pp 5).
Trauma Stories	*"… here's my awful story…you might not be quite prepared for it"* (Paper 6, pp 4). *"…really immersed in these stories…it's very challenging…maintaining boundaries… not becoming immersed and…encapsulated…"* (Paper 8, pp 11). *"[Colleagues] 'sliming' people with their own… vicarious trauma that they picked up from clients"* (Paper 6, pp 6).
Perceived Threat	*"…not knowing if you're going to get woken up at 3:00am…because someone's dead"* (Paper 6, pp 4). *"…[Staff] have been spat in the face…pushed through a window"* (Paper 13, pp 5). *"…we put ourselves in…dangerous situations. You call safety [security staff], I don't know how long it's going to take them to get there."* (Paper 18, pp 29). *"…we're already on pins and needles"* (Paper 18, pp 29).
Systems Trauma	"*…people have the highest needs… we don't have 24-h support*" (Paper 6, pp 3). '*I'm overworking…said to my boss like, "This isn't all right."* (Paper 8, pp 9). "*Poverty pimps…capitalizing off of poverty…doing this work to get money*" (Paper 6, pp 4). "*…clients using racial slurs towards staff…. accusations of discrimination between different ethnic groups in our staff*" (Paper 12, pp 73).

Figure 3

Thematic Diagram Depicting Coding for 'Events' Subthemes



3.4.2.2 Experiences.

Five subthemes emerged across 13 studies; ‘recognition of trauma’, ‘lived experience’, ‘sense making’, ‘systems trauma’ and ‘coping strategies’ (see Table 11 and the thematic diagram in Figure 4). Contextual factors (e.g., power imbalance, social and emotional support, and cultural beliefs) and individual differences contribute to how people assign meaning to events which determines whether an experience is traumatic (SAMHSA, 2014).

All papers acknowledged trauma experiences exist following events encountered, and experiences might worsen when “*staff need to support [clients] emotionally while they’re trying to deal with their trauma as well”* (Wallace et al., 2018). Four studies acknowledged the risk of previous trauma experiences being ‘re-triggered’ (e.g., associated with substance use or fleeing domestic violence), resulting in work being “*more psychologically taxing*” (Levesque et al., 2021; Peters et al., 2021). Immediate emotional responses such as feeling a “*full gamut of emotions*” (Lakeman, 2011) and ‘moral distress’ (e.g., felt when not acting per moral decisions) was highlighted to impact experiences (Kerman et al., 2022b).

Moral distress relates to ‘systems trauma’ which further shape potentially traumatic experiences. For example, systemic factors can lead people to feel powerlessness, failure, and ineffectiveness (Kerman et al., 2022b, d), and strain therapeutic relationships (a ‘vehicle’ for fostering positive change and central in shaping trauma experiences, Valoroso et al., 2020). The importance of organisational support (e.g., reflective practice, supervision, debriefing and employment benefits) for acting as a ‘buffer’ against further distress and influencing trauma experiences was highlighted across studies. Those who felt more supported were “*least affected*”, and a lack of organisational support led to resentment, distress, and trauma for some people (Valoroso et al., 2020). Feeling undervalued and unheard by organisations increased feelings of powerlessness, anger, and exhaustion; all of which are theorised to shape traumatic experiences (Kerman et al., 2022b; SAMHSA, 2014).

Several individual-level coping strategies influenced traumatic experiences across nine studies. Self-care, social and emotional support, creating relational boundaries and distance were considered critical in alleviating distress. Strategies included avoidance and suppression of unwanted experiences (e.g., putting disturbing thoughts ‘‘*in boxes*’’). Positive mindsets (e.g., seeing the “*small wins*”, acceptance, positively re-framing, normalising, hope, and compassion) were thought to be protective (Kerman et al., 2022b; Lakeman, 2011; Peters et al., 2021; Theodorou et al., 2021). Some participants searched for deeper meanings (Valoroso et al., 2020), and an element of comfort in certainty was found, such as when following organisational procedures and focusing on what can be controlled (Lakeman, 2011; Peters et al., 2021; Twis et al., 2022).

In terms of GRADE-CERQual, whilst there is high confidence in ‘recognition of trauma’, there were minor concerns regarding coherence in Lakeman (2011), as the recognition of trauma is presented as author interpretation (i.e., witnessing death can be experienced as traumatic) rather than direct quotes from the participants, however, this paper still meets inclusion criteria. Also, the complex intersection between grief and trauma must be considered with caution, in that it is difficult to separate the two emotional experiences. Moderate confidence in the theme ‘sense making’ was highlighted due to minor concerns regarding the adequacy and relevance. For example, the supporting synthesised data is thinner, being derived mostly from Kerman et al. (2022b). Moderate confidence was also highlighted for the ‘lived experience’ subtheme as there were minor to moderate concerns across the structured assessment. For example, in terms of adequacy, only two papers (i.e., Levesque et al. 2021; Peters et al., 2021) contributed direct quotes from participant samples which contributed to the synthesis, however, other studies (i.e., Theodorou, 2021; Valoroso, 2020) also supported the context of this finding via author interpretation. The ‘systems trauma’ also presented as moderate confidence which is discussed more in the limitations under the ‘Discussion’ section

of this review. The 'coping strategies' presented as high confidence. See the iSoQ table in Appendix R for more information.

Table 11

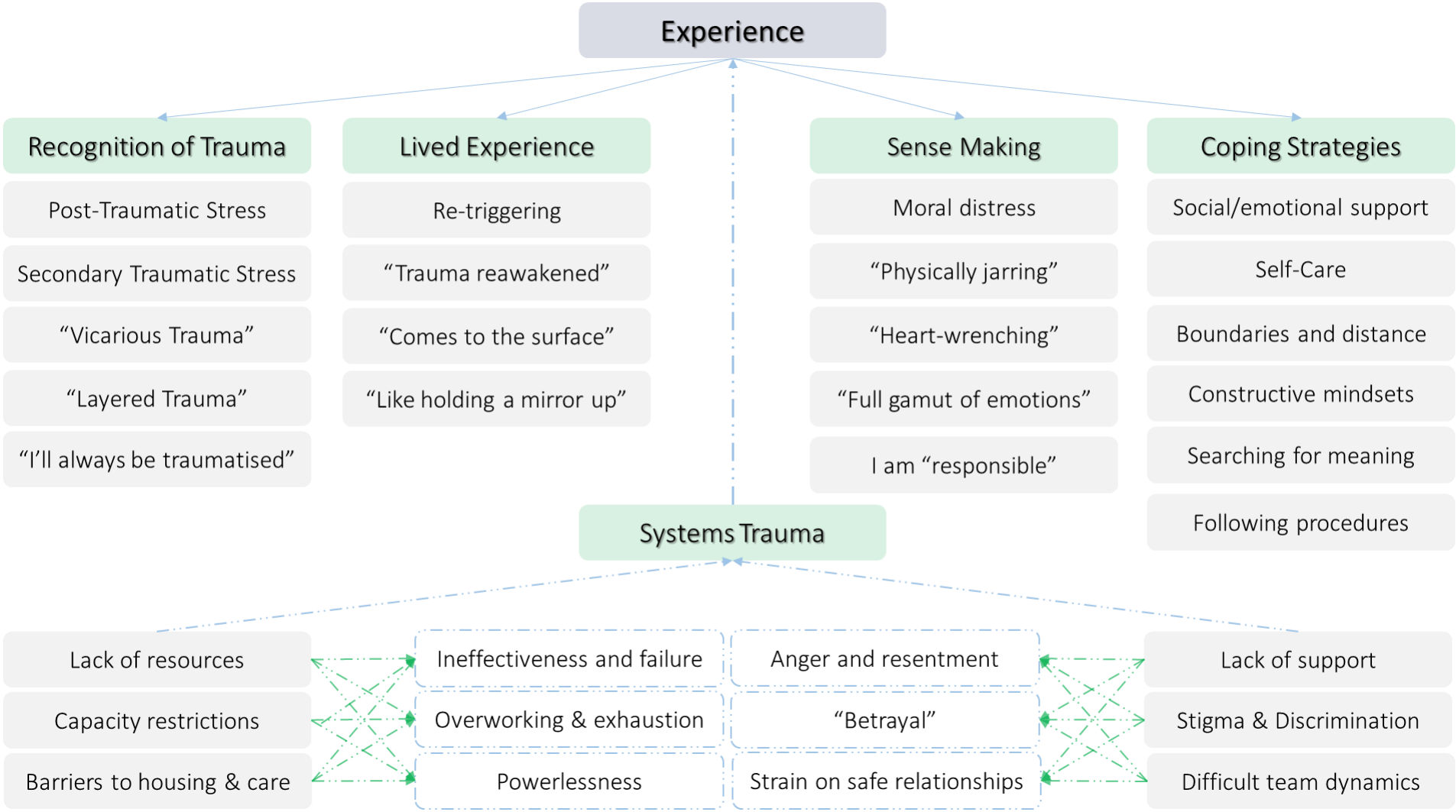
Synthesis of 'Experiences' Themes and Direct Quotes from Papers

	Direct Quotes
Experiences	
Recognition of Trauma	*"…layered trauma…dealing with things in a crisis mode"* (Paper 4, pp 9). *"…it's that vicarious trauma… I'm traumatized by their trauma"* (Paper 8, pp 11). "*…the most distressing thing that I've ever dealt with…seen in my life. It'll never leave me. I'll always be traumatised by it*" (Paper 19, pp 220). "*It was horrendous…traumatised me in a way I didn't expect*" (Paper 19, pp 220).
Lived Experience	*"…emotional toll that it takes on people to have their trauma reawakened…working with people who are also living their trauma"* (Paper 12, pp 70). *"... if [lived experience is] fairly recent, particularly… it does bring anxiety and issues…anyone with lived experience… has struggled* (Paper 12, pp 71). *"…those can be the very tough cases…a bit like… holding a mirror up to yourself, that's really…difficult"* (Paper 13, pp 4).
Sense Making	"*…heart-wrenching*" (Paper 6, pp 6). *"…physically jarring"* (Paper 8, pp 11). *"If you panicked…administering naloxone…you would feel responsible for that person's death"* (Paper 21, pp 87). "*To climb into bed after you've just covered somebody up…in 20 [degrees Celsius] with a tarp… it's pretty tough"* (Paper 6, pp 5). "*It's very depressing as hell …although you've saved someone's life… you're sending them out back into the streets…it's very unpleasant to put it mildly*" (Paper 6, pp 6).
Systems Trauma	*"…makes me feel very little, like there's nothing that I can do for this person [to obtain housing] …it's frustration and sadness*" (Paper 6, pp 4). "*If we ban someone…[it's] an arrest sentence…there's nowhere [to go] …that's inhumane"* (Paper 6, pp 5). *"…on social media…people bashing certain people…it literally shatters…angers me…affects my mental health…I want to fight* (Paper 8, pp 11). *"Every single week we would complain…bring up issues…try and change things… getting zero budging from management"* (Paper 8, pp 10).

	"At debriefing…you can allow yourself to be completely irrational and…angry… It is important…to have a safe place to do it" (Paper 9, pp 939). "…it *was an absolute battle to get any kind [of support] …that had a massive impact on me…what it does is embed the trauma…"* (Paper 19, pp 224).
Coping Strategies	*"I compartmentalize a lot…I can leave it at work*" (Paper 6, pp 6). "*…to block everything out, I'll go sit in the car…I just sit there in silence…helps me make it through the second half of the day"* (Paper 18, pp 29). "*I was googling…really graphic things…I needed to know…the process of things*" (Paper 19, pp 223). *"…you have to be very resilient…if you are not…some of the stuff you deal with is going to take you to some very dark places"* (Paper 22, pp 243).

Figure 4

Thematic Diagram Depicting Coding for 'Experience' Subthemes



3.4.2.3 Effects.

The effects of trauma can vary, impact neurobiological processes, cognition, emotions, and behaviour, occur immediately or have a delayed onset, and be experienced short or long term, affecting many aspects of a person's life and wellbeing (SAMHSA, 2014). Five subthemes emerged across 13 studies; 'traumatic stress symptoms', 'cognitive changes', 'overlooking and unknowing', 'coping with adversity' and 'systems trauma' (see direct quotes in Table 12 and the thematic diagram in Figure 5).

Across six studies, the cumulative exposure to traumatic events and the constant unpredictability of experiencing trauma resulted in psychological and traumatic stress. Effects included exhaustion and burnout, anxiety, rumination, sleeping difficulties and nightmares, intrusive memories and flashbacks about the events encountered, hypervigilance, "*adrenaline induced fight/flight responses*" and sickness (Kerman et al., 2022b, d; Lakeman, 2011; Peters et al., 2021; Valoroso et al., 2020). 'Cognitive changes' were associated with thinking styles such as "*catastrophising*", and some people can eventually conclude that they are unable to continue working in their roles (Kerman et al., 2022b; Valoroso et al., 2020).

Despite evidence of traumatic stress, four studies highlighted that the effects of trauma can be overlooked, unknown and unrecognised. At times, attempting to cope with these adverse effects resulted in substance use to "*soothe*" (Kerman et al., 2022b) and people feeling they were unable to cope effectively (Valoroso et al., 2020). All studies acknowledged the importance of systemic factors in alleviating the effects. For example, for people to cope with the effects of traumatic experiences, it was recognised that systemic level changes need to be made, as the constant pressure (e.g., long waiting lists and high rates of absenteeism) left people feeling they were "*on a hamster wheel*", which was found to prolong and exacerbate the effects (Kerman et al., 2022b, d; Twis et al., 2022).

The GRADE-CERQual assessment highlighted high confidence in the ‘traumatic stress symptoms’ and the ‘coping with adversity’ subthemes. These subthemes are supported by studies with robust methodologies, coherent and adequate data. The data are highly relevant to the research question. However, it is important to highlight that there were some concerns regarding the methodological quality of Levesque et al. (2021) due to their being limited reporting of the data analysis methods used. The assessment also highlighted that the ‘cognitive changes’, ‘overlooking and unknowing’ and ‘systems trauma’ subthemes were rated at moderate confidence. For example, there were minor concerns regarding the adequacy of the data in both the ‘cognitive changes’ and ‘overlooking and unknowing’ subtheme, and relevance concerns in both the ‘overlooking and unknowing’ and ‘systems trauma’ subtheme as shown in the iSoQ table and discussed in more depth in the ‘Discussion’ section.

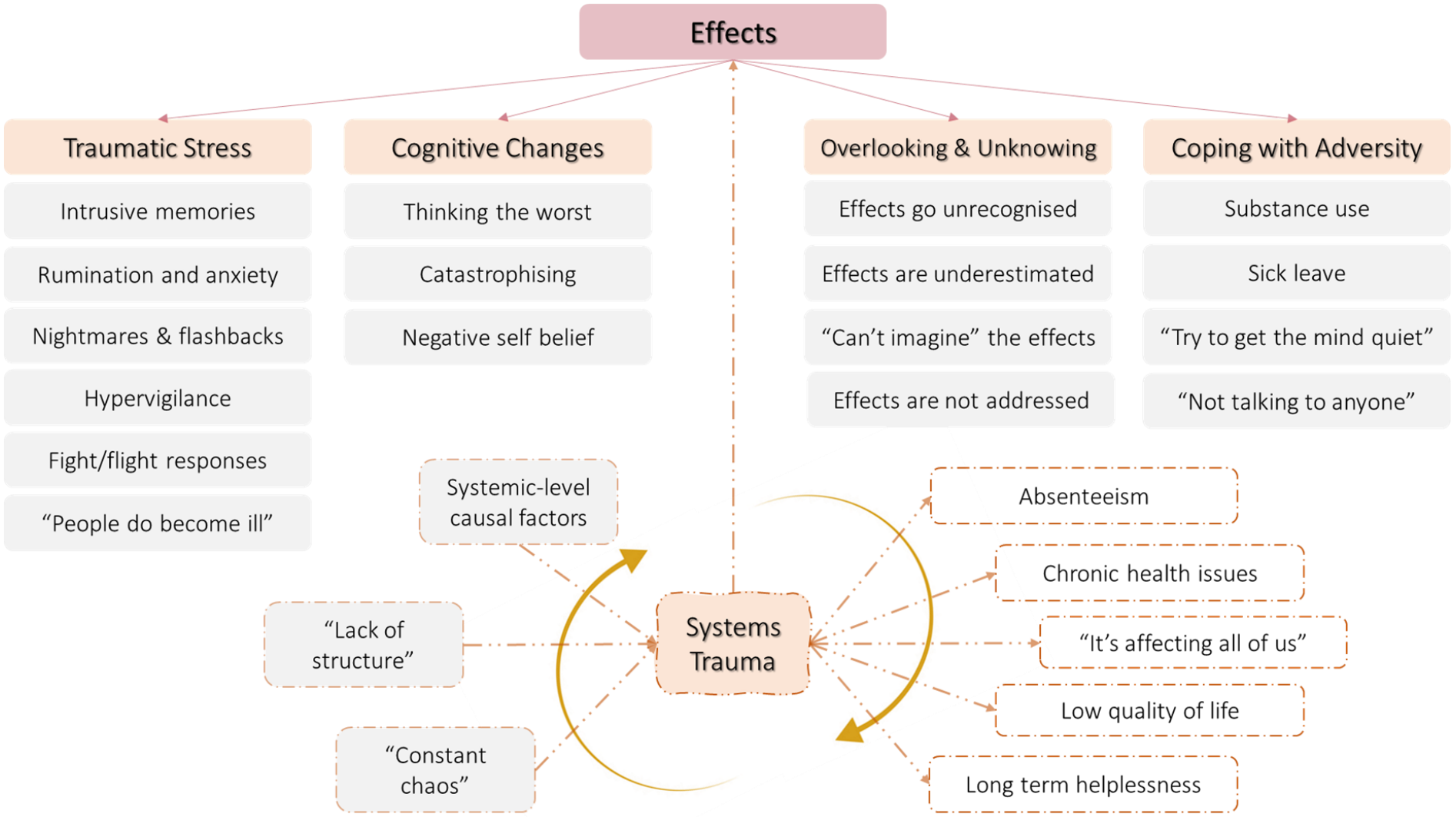
Table 12

Synthesis of 'Effects' Themes and Direct Quotes from Papers

	Direct Quotes
Effects	
Traumatic Stress Symptoms	"*...make you ill…people do go off on sick… it compounds itself…*" (Paper 13, pp 7). *"...your natural reaction…fight or flight…your heart rate goes…*" (Paper 13, pp 7). "*…I had my first panic attack… I would be physically sick every morning…all I could see, hear, and smell was that day"* (Paper 19, pp 221).
Cognitive Changes	*"I expect to see someone hanging…though that's not how I found James. I think about all the things that could go wrong…the gruesome things*" (Paper 19, pp 221). "*…catastrophise things after that…now I think of [welfare checks] more for that purpose…a death watch really"* (Paper 19, pp 224). "*It's death by 1000 cuts… 'I'm fine, that didn't affect me. I don't need to debrief'…then it happens over and over again until… 'I can't do this anymore"* (Paper 6, pp 6).
Overlooking and Unknowing	*"...they've had the runaround from a lot of people that they don't [experience vicarious trauma]"* (Paper 1, pp 14). "*I think we totally underestimate the effect [hearing trauma stories] has on us*" (Paper 17, pp 424). *"I can't imagine what our brain is really doing with all of this"* (Paper 18, pp 29). *"...our community hitting the floor…potentially dying… probably does leave… more trauma… than we necessarily recognize or have talked about*" (Paper 21, pp 87). *"...[it's] too overlooked, like actually the trauma…that's not addressed near enough"* (Paper 21, pp 87).
Coping with Adversity	"*…get home…pour four ounces of gin into a cup. Pretty much every night…racking my brain of like, 'I know I'm kind of broken from this"* (Paper 6, pp 7). *"...you can't even focus on self-care cause you're in crisis mode, you spend a lot of time trying to get your mind quiet"* (Paper 8, pp 10). "(*Trying to carry on like normal) I made myself ill. I wasn't coping at all. I was not talking to anyone"* (Paper 19, pp 222).
Systems Trauma	*"[staff are] not acknowledged…so, what it results in is increased sick leave. People using every inch of their…leave… instead of coming into work"* (Paper 8, pp 10). "*…it's undue stress…if we don't deal with the chaos and the lack of structure, I don't know how… because it seems to be affecting all of us"* (Paper 18, pp 30).

Figure 5

Thematic Diagram Depicting Coding for 'Effects' Subthemes



3.4.3 Meta-Aggregation

Independent syntheses of quantitative and qualitative data produced complementary findings. The quantitative data indicate that there is a high occurrence of trauma experiences amongst the sector which are associated with specific factors unique to homelessness. The synthesised themes reflected and supported the quantified data. The qualitative evidence allowed for a significantly more detailed synthesis across all three ‘E’s, and thus allowed for a richer understanding of the trauma experiences. The concordant outcomes indicate the presence and experiences of trauma in the homelessness support sector and factors that may shape these experiences.

4. Discussion

This mixed methods systematic review presents an overview of the key characteristics and findings across 22 studies of varying quality, as discussed in section 4.2. By drawing comparisons and distinctions between participant experiences, a comprehensive synthesis of the relevant literature pertaining to trauma experiences in the homelessness support sector is provided. In line with the first and second review questions, the prevalence of and factors associated with trauma experiences were explored across the quantitative data. The qualitative data details an in-depth understanding of how trauma is experienced, thus answering the third review question. The following provides a discussion of the overall results, with consideration of clinical implications, study quality, limitations, and future directions.

4.1 Discussion of Findings and Clinical Implications

Overall, the review findings indicate that people in this sector work in extremely challenging contexts that risk increasing their vulnerability to traumatic stress, and a significant proportion were found to encounter 'events', 'experiences' and 'effects' that result in trauma, as conceptualised by SAMHSA (2014). The accumulating 'events' ranged from systemic to individual-level factors and included interpersonal circumstances that trigger actual or perceived threat. Quantitative and qualitative findings converged in evidencing that a significant amount of this sector 'experience' post-traumatic stress 'effects' that were indicative of meeting the PTSD diagnostic threshold (DSM-IV, APA, 2013), and STS levels that indicated that participants should seek further assessment and support for their psychological wellbeing.

These findings complement the wider literature (Aldridge et al., 2018; Luchenski et al., 2018), emphasising multiple top-down systemic level factors that worsen human health, and further highlight how these factors directly exacerbate the risk of trauma experienced by this sector, not solely by people experiencing homelessness. Findings also extend previous research

(Peters et al., 2021; Wirth et al., 2019a, b) that draw upon the Job Demand-Resources theoretical framework (JD-R; Bakker & Demerouti, 2007) to formulate how 'job demands' can cause work-related distress, including trauma. These results show that the ineffective mitigation of risk and constant unpredictability of threat results in a hypervigilant support system that can feel physically, emotionally, or psychologically unsafe. This context is the opposite of trauma-informed and these findings have significant implications when informing Trauma Informed Care and Psychologically Informed Environments policy and practice across homelessness to prevent and alleviate trauma.

Although there is no universal definition of Trauma Informed Care, the SAMHSA (2014) guidance is widely adopted (Homeless Link, 2017; The Scottish Government, 2021) which advises the four 'R's', to "***Realise*** *the widespread impact of trauma and understand potential paths for recovery;* ***Recognise*** *the signs and symptoms of trauma in [everyone] involved in the system;* ***Respond*** *by fully integrating knowledge about trauma into policies, procedures, and practices, and seek to actively* ***Resist Re-traumatisation***". Six fundamental principles are advised including safety, trust, peer support, collaboration, empowerment, and acknowledgement of cultural, historical, and gender contexts. Although Psychologically Informed Environments does not require a specific focus on trauma, safe relationships are central in PIE, and vital in trauma recovery.

Despite a growing awareness of the importance of situating Trauma Informed Care and Psychologically Informed Environments principles within homelessness (Bransford & Cole, 2019; Hopper et al., 2010; Johnson & Haigh, 2010; Keats et al., 2012; Tickle, 2022), limited empirical evidence shows that the implementation of these frameworks is effective (Buckley & Tickle, 2023; Burge et al., 2021). This is especially the case for this sector, "*who are mired in the trenches*" when working with people who are traumatised (Schiff et al., 2019). Supporting this, the synthesised themes detail the complexity in how trauma experiences are

subjectively shaped, concerning multiple interacting factors, and although the 'effects' of trauma are being increasingly 'recognised', overall experiences of trauma (e.g., *"what happens inside of you, as a result of what happens to you"*, Maté, 2022) can be overlooked or unknown. This oversight could undermine the current effectiveness of Trauma Informed Care programmes, and future research would benefit from exploring the nuances in individuals' and collective trauma experiences, interacting factors, and the extent of the neurobiological, psychological, and social impact on individuals in this sector.

As this review exposes a system-level lack of recognition of trauma experience, it currently might be difficult for organisations to 'respond' effectively. As a result, instead of preventing and alleviating trauma via the systematic implementation of the above-mentioned guidance, trauma is being shaped via unsafe relational processes such as those which cause people (and their trauma experiences) to feel undervalued, unheard, and unseen, and by the intersecting multifaceted factors involved in 'systems trauma' that increase feelings of powerlessness, anger, exhaustion, and moral distress (Kerman et al., 2022b; SAMHSA, 2014). Further, when properly implemented, Trauma Informed Care equips staff with tools to recognise detrimental workplace contexts and empowers them to voice their concerns. These concerns are listened to, trusted, and acted upon, aiming for collective positive change (Bransford & Cole, 2019), thus aligning with psychological safety principles (Edmondson & Bransby, 2023). The findings highlight that this is not happening, at least for some people across the sector, and although implementing Trauma Informed Care and Psychologically Informed Environments require substantial investment, failing to do so will likely exacerbate financial implications and perpetuate poor health both for this sector and for people experiencing homelessness due to increased absenteeism, sick leave, and turnover rates.

Based on the qualitative results, several strategies to protect and alleviate trauma experiences can be developed at the organisational and individual-level and are consistent with

factors supporting post-traumatic growth. For example, a recent systematic review (Henson et al., 2021) accumulated the promoters and mediators of alleviating traumatic stress. Along with many individual-level factors, the quality of social support was found to be important for the processing of traumatic events (e.g., by venting negative emotions and sharing internal experiences, Calhoun & Tedeschi, 2013; Dirik & Go¨cek-Yorulmaz, 2018). Post-traumatic growth increased with someone who held an in-depth knowledge of the individual's difficulties and circumstances, and positive normalising effects were found between people who shared the same trauma experiences, along with mediating effects when a sense of belonging was felt (Armstrong et al., 2016; Palmer et al., 2016).

Together, these findings have significant implications in providing organisational support, alongside self-care strategies. They highlight the importance of strengths-based Trauma Informed Care and Psychologically Informed Environment-focused reflective practice, debriefing, training, and supervision that increases trauma awareness and prepares staff to engage in trauma-focused work (Cook & Fye, 2022; Sutton et al., 2022). It is important for organisational support to be evaluated on how safe, acknowledged, and empowered staff members feel, and for trauma experiences to be normalised as natural human responses in the context of the events and for any persisting effects to be monitored to enable the most appropriate internal or external support across time. Supervision might be most appropriate to initiate such conversations considering "*vulnerability plays some part*" and attachment dynamics can become 'activated' (Hiebler-Ragger et al., 2021).

Acknowledging the neurobiological effects of traumatic stress as embodied sensory experiences that go far beyond semantic understanding is essential (Porges, 2011). Some people might find it difficult to describe their experience or feel safe in their bodies or environment to do so, and reflective practice and debriefing without containing potential physiological dysregulation might risk dissociation or re-traumatisation (Van der Kolk, 2014).

Techniques and principles from somatic interventions that draw on neuroscience, polyvagal theory, attachment, and trauma theories, such as Trauma Sensitive Yoga (Emerson, 2015; Kelly et al., 2021; Zaccari et al., 2022) might initially support and empower people to develop a sense of safety and self-regulation skills without the requirement of language (Cochrane et al., 2019). Thus, supporting people to feel safe via their 'social engagement system' and broadening their Window of Tolerance (Andaházy, 2019; Porges, 2011; Siegel et al., 2021; 2020). However, for people to feel safer, traumatic events need to reduce. This requires structural change beyond the power of individual organisations and top-down level investment is required to improve the support provided and received across homelessness.

4.2 Reflexivity

As reflexivity is a central part of quality research, it is important to acknowledge the positioning of the researcher (Folkes, 2022). At the time of conducting this systematic review, the lead researcher was a Trainee Clinical Psychologist influenced by a range of models and theories relating to trauma, social inequalities, and systemic thinking. She is a 30-year-old White British cis-gendered female, who was drawn to the topic due to their lived experiences of trauma and values in social justice and amplifying marginalised voices. Whilst not having experienced trauma in a professional context themselves, the lead researcher has witnessed other support staff experience trauma in forensic settings, when working in Support Worker and Assistant Psychology roles. These positioning factors have inevitably influenced the perspective taken throughout the synthesis. However, holding a personal and professional interest has also enabled a consistent passion towards positive change for those to whom the findings apply. The reflexivity process was enhanced by supervision from a supervisor with experience in this area. This allowed for a nuanced consideration of the reality of people working in homelessness, of which the lead researcher does not have experience.

4.3 Limitations and Future Directions

The GRADE-CERQual assessment (see iSoQ table in Appendix R) highlighted some minor and moderate concerns regarding the confidence in the findings. For example, there are adequacy concerns regarding the 'Cognitive Changes' subtheme due to only two studies (i.e., Kerman et al., 2022b; Valoroso et al., 2020) contributing limited data. Thus, confidence in this finding might be reduced when attempting to generalise across the homelessness support sector. The 'systems trauma' subthemes across all three 'E's' highlight concerns regarding the coherence of the findings with the data and review question. This is because this review is exploring the trauma experiences of this sector. However, the data indicates that the accumulation of systemic issues could worsen circumstances that might already be traumatic. These findings do not evidence that systemic issues directly cause trauma experiences, but rather highlight their negative impact on existing trauma-related experiences such as hypervigilance, overwhelm and stress. Thus, although relevant, the fit between the data from the primary studies and the subthemes 'systems trauma' that synthesises the data is less cogent. It is also important to highlight that the systemic issues evidenced in this review are drawn from homelessness support systems in the UK, USA, and Canada. Thus, cannot be generalised to all homelessness support systems where systemic issues are likely to be different. For example, those more impacted by geo-political issues such as war, displacement, and natural disasters.

There are several limitations concerning this review process and the quality of studies included. Despite the MMAT being accessible and appropriate for quality assessment in mixed methods systematic reviews, it has received criticism for being 'too simple' and 'difficult to judge', which might reduce its content validity (Hong et al., 2018a). During this review, the qualitative components were subject to increased interpretation which risks interpretation bias, although these risks were reduced by the second reviewer. Future developments in the tool

could give more detailed explanations and examples about how to interpret the qualitative items (Hong et al., 2018a).

Across the included studies, convenience and purposive sampling approaches were used which might limit the generalisability of the findings. Despite the minimal mention of confounders, many were accounted for in the studies that conducted regression analysis which is an appropriate method to control for covariates. However, given the cross-sectional approaches used, the extent to which the Covid-19 pandemic contributed to the results of some of the more recent studies is unknown. Therefore, some findings might not extend beyond this, considering the unique pressures the pandemic placed on this sector (Carver et al., 2022).

There could be several explanations for the reported mixed STS levels across studies. Firstly, construct validity debates remain as to whether STS and burnout can be effectively differentiated in the ProQOL (Cieslak et al., 2014), with suggestions towards using the two-factor model (i.e., Compassion Fatigue and Compassion Satisfaction) as opposed to the three-factor model (i.e., STS, burnout, and Compassion Satisfaction, Geoffrion et al., 2019). The heterogeneity in STS rating scales might have led to inaccurate conclusions regarding levels of STS experienced and using the same measure and cut-off levels might have presented more consistent results. When comparing STS outcome measures, Roberts et al. (2021) advised using the STSS considering its well-defined cut-off thresholds and excellent internal consistency.

Considering the diversity of roles existent across the homelessness support sector, and the factors found to predict trauma experience (e.g., amount of direct working), mixed STS levels might be due to the varied nature of the work. The review findings highlight many potentially traumatic events and subjective factors that contribute to whether something is experienced as traumatic. This contextual diversity might explain the different levels of STS across samples. The extent to which identity characteristics impacted STS levels is also unknown as most participants across samples identified as female and White, and ages

predominantly covered the range of working-aged adults in the UK. The qualitative findings also raise issues regarding stigma and discrimination experienced and the extent to which these experiences impact the shaping of trauma requires further exploration. This includes stigma towards lived experience, aligning with the National Institute for Health and Care Excellence (NICE, 2022) guidance on the value of peer support. Schiff and Lane (2019) highlight that fear of stigma might cause underreporting of traumatic stress, aligning with social desirability research in this area (Gower et al., 2022). Therefore, how societal stigma and intersectionality issues impact this sector and are associated with trauma experiences is important to explore further and aligns with Trauma Informed Care and Psychologically Informed Environments guidance.

Additionally, despite the reported low STS levels in some studies, the variances in how trauma is conceptualised, measured, and interpreted means that trauma experiences might still be present. As evidenced in the participant sample in Kerman et al. (2022a), 1.7% reported high STS levels and 42% reported high post-traumatic stress levels. These limitations indicate the need for more nuanced and inclusive measurements of trauma experiences, considering all forms of trauma, as conceptualised by SAMHSA (2014, e.g., see, Lathan et al., 2021). However, consideration should also be given to respondent burden.

5. Conclusions

The prevalence and experiences of and factors associated with trauma in the homelessness support sector were explored. Results evidence that a significant amount of people across this sector encounter 'events', 'experiences' and 'effects' associated with trauma, with some people at risk of severe distress and meeting diagnostic thresholds for PTSD. Potentially traumatic events included encountering or responding to death, critical incidents such as violence, hearing trauma stories, and working in threatening environments. Such occupational hazards were subjectively shaped by personal lived experiences and by the way

people made sense of and coped with their emotional experiences. Effects presented as psychological distress, traumatic stress, and cognitive changes which, at times, made it difficult for people to cope effectively. However, despite the robust studies included, there is a need for further research to address some methodological issues, such as the heterogeneity of outcome measures. Nuanced, inclusive and consistent approaches toward measuring the experiences of trauma in this sector would enable effective comparisons across the data.

These review findings support that homelessness is an increasing global public health concern which extends to the health and wellbeing of this support sector. Trauma experiences were found to be shaped by the same socio-political-economic context, indicating the urgent requirement for top-down systemic level change to prevent the collective experiences of powerlessness and moral distress felt across the sector, and to improve the support provided and received across homelessness. Ultimately, the health and well-being of everyone across homelessness requires protection and promotion, and health inequalities need to be reduced. Service-level implications were discussed, for example trauma experiences were seen to be overlooked and unknown which highlighted the need for improved holistic, strengths-based Trauma Informed Care and Psychologically Informed Environment-informed organisational support that enable this sector to feel safe, acknowledged, and empowered. Hearing and prioritising the voices of this sector is central and must exist in future research developments given the high demands placed on this vulnerable workforce, supporting one of the most marginalised groups in society.

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Chapter Two: Empirical Paper

An Exploration into the Predictors of the Professional Quality of Life of Frontline Workers in Homelessness

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Abstract

Background: Despite the positive aspects of frontline work in homelessness, challenges across the political, societal, and organisational landscape can impact the wellbeing of frontline workers (Peters et al., 2021b). Thus, there is a clear need to explore the wellbeing needs of this sector. This project aimed to explore how organisational and individual-level factors might predict Professional Quality of Life. **Methods:** Participants (N = 170) were frontline workers in third-sector homelessness organisations across the UK. An online questionnaire collected demographic and employment information and measures of Perceived Organisational Support, Reflective Practice, Self-Reflection and Insight, Adverse Childhood Experiences, Compassion Satisfaction, Burnout and Secondary Traumatic Stress (STS). **Findings:** perceived organisational support significantly predicted burnout, STS, and Compassion Satisfaction. Self-Reflection and Insight also significantly predicted Compassion Satisfaction. Aligning with the implementation of psychologically informed environments, the importance of the employee-organisation relationship from the viewpoint of frontline workers is discussed, particularly concerning psychological needs. **Conclusions and Application to Practice:** There is a requirement for further exploration and evaluation of the factors that influence workplace wellbeing, however, these findings support the need to consider the accountability and configuration of homelessness organisations. Integrating psychological needs satisfaction into current homelessness policy and practice might support targeted action to protect workplace wellbeing. Further research into understanding intersectionality differences, how trauma experiences affect frontline working, and evaluations into the effectiveness of reflective practice in relation to workplace wellbeing is required to enhance organisational support.

K*eywords:*

Homelessness, Frontline Workers, Workplace Wellbeing, Compassion Satisfaction, Burnout, Secondary Traumatic Stress, Organisational Support, Psychologically Informed.

1. Introduction

Frontline workers in homelessness possess exceptional skills, compassion, and motivation to care; resulting in positive work experiences and a shared sense of meaning and purpose (Ferris et al., 2016). However, they are relentlessly confronted with uncontrollable challenges. These challenges can relate to systemic and structural limitations across the political, societal, and organisational landscape, including restrictive financial and legislative policy, inaccessible accommodation and health support services, ambiguity and unrealistic expectations, inadequate emotional support, low wages, workplace discrimination, and difficult team dynamics (Blomberg et al., 2015; 2022; Kerman, 2022b, c, d; Levesque et al., 2021; Wirth et al., 2019a, b).

These circumstances have held more complexity when considering the implications of the COVID-19 pandemic, the rising cost of living, and the endemic relationship between societal stigma and homelessness. The context of COVID-19 exposed an underappreciation for frontline workers in homelessness. They were expected to work in increasingly unsafe conditions without adequate financial compensation (Campbell et al., 2022; Kerman et al., 2022a). An uneven distribution of pandemic pay was also found (Levesque et al., 2021), indicating that Caucasian frontline workers earnt more during the pandemic than those of different racial identities. The UK-wide Frontline Worker Survey (Frontline Network, 2022) highlighted that 41% are currently struggling to pay their bills and 28% are taking on additional paid work to help cover their costs. Frontline workers also describe experiences of feeling "marginalised and stigmatised" regarding essential care for the people they support (Campbell et al., 2022). Such experiences confirm the wider cultural disdain for people experiencing homelessness and the assumption that working within homelessness is 'dirty work' because it involves contact with stigmatised members of society (Ashforth & Kreiner, 1999; Ferris, 2016; Mullen & Leginski, 2010).

This fragile balancing act of challenges intensifies the emotional strain upon frontline workers and can lead to a broad range of wellbeing adversities (Peters et al., 2021b). It is therefore essential to further improve the wellbeing needs of this workforce, otherwise the potential negative impacts of working in their field will continue to exacerbate and be a detriment to the quality of care provided (Department of Communities & Local Government, 2008; Rios, 2016). This project aimed to support this by exploring how organisational and individual level factors might predict the Professional Quality of Life of frontline workers.

1.1 Professional Quality of Life

Professional Quality of Life (ProQOL; Stamm, 2010) can be drawn upon to explore factors that predict the wellbeing needs of frontline workers in homelessness. ProQOL consists of both positive (i.e., Compassion Satisfaction) and negative (i.e., Compassion Fatigue; which consists of secondary traumatic stress; STS and burnout) components associated with helping roles. Peters et al. (2021b) explored the emotional experiences of working in homelessness. Common themes highlighted that the multiple demands associated with frontline working directly impact ProQOL. Experiences of burnout (e.g., emotional exhaustion and cynicism) were emphasised, as well as associated feelings of frustration and helplessness, resulting in people leaving their jobs or becoming numb to their emotional experiences (Bademci, 2012; Kidd et al., 2007). Although participants within Baker et al. (2007) did not meet the criteria for burnout as defined by Maslach and Jackson (1986), stress experienced under time constraints and low levels of self-belief were identified predictors of emotional exhaustion.

More recently, results from Lemieux-Cumberlege and Taylor (2019) did not indicate elevated levels of burnout or STS amongst frontline workers in homelessness (N = 112) compared to population norms. However, depression and stress levels were significantly elevated and associated with Compassion Satisfaction, burnout, and STS. Similar findings were reported by Schiff and Lane (2019) and, amongst participants (N = 472), 24% indicated

significantly elevated levels of STS, which indicated that they should step back from their current responsibilities.

Further, Petrovich et al. (2020) highlight that nearly half of the sample (N = 122) of homelessness service providers reported moderate to severe levels of STS, and results from Schneider et al. (2021) show that 63% of frontline workers indicated a high vulnerability to STS, which was found to be a statistically significant predictor of burnout. This sample (i.e., 63% of full sample) included 77% of the people who reported both high STS levels and previous time off due to work-related stress, thus indicating an impact on individuals' psychological wellbeing. An important interaction between burnout and STS was discussed, suggesting that despite the multiplicity of workplace challenges, practitioners who experienced STS were more likely to remain emotionally connected to people experiencing homelessness compared to when experiencing burnout, which was more likely to result in "disaffection" and "apathy".

Moreover, Compassion Satisfaction may be protective against burnout and STS (Ferris et al., 2016; Lemieux-Cumberlege & Taylor, 2019), however this can be limited by high compassion fatigue levels (Salloum et al., 2015; Thomas, 2013). Schiff and Lane (2019) also highlight that Compassion Satisfaction was significantly low in 20% of participants, implying reduced positive emotions from supporting the people with whom they work. This experience risks reducing quality of care, and an 'emotional retreat' could worsen the experience of social exclusion for people experiencing homelessness (Chamberlayne, 2004).

1.2 Direct Trauma

Working in homelessness involves working with people who experience emotional distress and physical health complications, witnessing violence, hearing accounts of the trauma experienced by others and a greater exposure to death (Arslan, 2013; Lakeman, 2011; Valoroso & Stedmon, 2020). Repeated exposure to trauma increases the emotional impact of frontline

working (Campbell et al., 2022; Kerman et al., 2022d). This in turn leads to a sense of de-skilling, difficult team dynamics, and increased likelihood of adverse incidents (Benuto et al., 2019; Petrovich et al., 2020). High staff turnover then becomes problematic as services struggle to recruit and retain people with the skills and experience required to work in this complex environment (Levesque et al., 2021).

Consequently, research is starting to acknowledge the role of trauma within homelessness concerning ProQOL. Schiff and Lane (2019) found that post-traumatic stress levels were high in 33% of participants (N = 472). A strong, meaningful relationship between STS and Post-Traumatic Stress Disorder (PTSD) was reported, indicating the likelihood of meeting the diagnostic criteria for PTSD following secondary trauma exposure. A subsequent study evidenced that 41% of participants did meet the diagnostic criteria for PTSD (Schiff et al., 2019). The reported percentages in both studies were predicted to be higher as traumatic stress is often under-reported in anecdotal accounts due to the fear of stigma (Regehr, 2018). Therefore, alarmingly high rates of trauma amongst frontline workers were stressed, along with the urgent improvement of meeting workplace safety and wellbeing needs.

There is limited research into the impact of personal experiences of trauma. Aykanian and Mammah (2022) revealed a higher prevalence of ACEs, such as abuse and neglect (Felitti et al., 1998), amongst frontline workers in homelessness compared to the general population. Schiff et al. (2019) acknowledge that workplace dynamics in homelessness might act as triggers to reactivate prior traumatic stress responses. These findings relate to the wider literature reporting that personal histories of trauma among mental healthcare practitioners significantly predicted levels of STS (Somoray et al., 2017). Findings also revealed that levels of Compassion Satisfaction were higher, suggesting that participants who had experienced a history of trauma tended to feel more satisfaction by helping others, despite showing higher levels of STS (Collins & Long, 2003).

1.3 Organisational Support

In line with Bronfenbrenner's (1979) socio-ecological systems model (i.e., showing how top-down enactments of power can impact across all system levels), challenges associated with the perpetuation of homelessness occur systemically, and often intersect. This means that by addressing challenges at wider levels, positive implications can occur at individual levels. Thus, improving the ProQOL of practitioners, and the care they provide (Kulkarni et al., 2013). For example, adequate supervision is associated with low levels of burnout amongst the homelessness support sector (Lenzi et al., 2021; Maguire et al., 2017). Feeling unvalued, unsupported, and isolated are also common experiences, especially for people with lived experience of homelessness due to experiencing stigma, which could be addressed via the organisational promotion of inclusive practices (Carver et al., 2020; Kerman et al., 2022c, d).

Peters et al. (2021b) and Wirth et al. (2019a) have drawn upon the Job Demand-Resources model (JD-R; Bakker & Demerouti, 2007) to investigate the occupational predictors of workplace wellbeing in homelessness. This model links closely with frontline working and the indices of ProQOL as it explains how 'job demands' can lead to negative experiences associated with burnout and STS, whilst 'job resources' (e.g., appreciation, social support and financial security) can be associated with job satisfaction, stimulating motivation, personal growth, and work engagement (Wirth et al., 2019a). Peters et al. (2021b) concluded that job demands and resources associated with levels of self-efficacy, emotional support, trauma experiences, and perceptions of organisational support can determine workplace wellbeing. This research aligns with broader frameworks such as The Healthy Workplace (Burton & World Health Organisation, 2010) and national guidance on workplace health management (e.g., National Institute for Health and Care Excellence, NICE, 2022; 2016), emphasising that organisational support including unsupportive supervision, limited training, and resources for self-care can protect or negatively impact employee wellbeing.

The above findings can be understood by drawing upon Organisational Support Theory, which suggests that a vital predictor of employee wellbeing and the employee-organisation relationship is determined by the employees' perception of organisational support (Eisenberger et al., 1986; Kurtessis et al., 2017). POS is positively associated with job satisfaction and self-determined motivation (Deci & Ryan, 2008; Gillet et al., 2013; Kurtessis et al., 2017), however, little is known about the POS and ProQOL of frontline workers in homelessness and this research starts to address this gap.

1.4 Psychologically Informed Practice

Frontline workers bring a considerable amount of knowledge and skill to their roles that, at times, no professional training could sufficiently provide. However, their roles can also come with different elements of emotional intensity that they may not have experienced before or know how to navigate. This is especially important when the risks of experiencing burnout and trauma are involved, and these are occupational hazards that services should prepare for and respond to (Bride, 2007).

Specialist psychologically informed frameworks such as Trauma-Informed Care (Hopper et al., 2010; SAMHSA, 2014) and Psychologically Informed Environments (Keats et al., 2012; Johnson & Haigh, 2010) offer a solution to this. For example, the core of Psychologically Informed Environments is centred around relationships and aims to develop holistic understandings, by considering "thinking, emotions, personality and past experiences" (Johnson, 2017; Tickle, 2022). Psychologically Informed Environments are thought to situate systems appropriately to sensitively respond to challenges by creating psychologically safe organisational cultures (Benson & Brennan, 2018; Edmondson, 2018).

The 'learning and enquiry' component of Psychologically Informed Environments predominantly focuses on the application of reflective practice, which can help to develop psychological awareness of the self and others (Phipps et al., 2017; PIE4Shelters, 2019) and

contribute to purposeful and directed change (Ferguson, 2018). Thus, reflective practice can support the wellbeing of frontline workers by offering a shared space to process experiences with colleagues and discuss alternative ways forward to improve support (Cockersell, 2011; Homeless Link, 2017a, b). It is also valuable within team psychological formulation meetings (Buckley et al., 2020) and can be a catalyst for cultural and structural changes whilst shaping understanding on a personal level, thus positively impacting across multiple system levels (Tickle, 2022).

Although reflective practice supports the psychological wellbeing of frontline workers (Homeless Link, 2017a, b), this does not reflect everyone's experience. Whilst some people find reflective practice valuable, others consider it as an "unnecessary luxury" which conflicts with carer values (Phipps et al., 2017). Additionally, frontline workers who experience burnout and STS have been found to show less motivation towards, and understanding of the need for, reflective practice (Schneider et al., 2021). It is therefore important for organisations to be proactive in solving these engagement challenges considering the potential of reflective practice in supporting wellbeing and that it is central within Psychologically Informed Environments frameworks.

The empirical foundations of the implementation of Psychologically Informed Environments components within homelessness remain tenuous (Schneider et al., 2021). Due to the framework's inherent flexibility, an eclectic mix of its principles have been implemented across contexts, which has raised concerns regarding the reliability and effectiveness of its supporting evidence (Breedvelt, 2016; Phipps et al., 2017). This has impacted on evidencing the therapeutic value of reflective practice within homelessness, and it is known that reflective practice has less of an evidence base compared with other forms of support, such as supervision, for supporting professionals experiencing psychological distress (Lemieux-

Cumberlege & Taylor, 2019). Therefore, to further understand the mechanisms that underpin the value of reflective practice within the context of homelessness, this project has explored reflection in relation to the ProQOL of frontline workers.

1.5 Hypotheses

In summary, as displayed in Figure 1, this project aimed to measure four key predictor variables (i.e., POS, Reflective Practice, ACEs, and Self-Reflection and Insight, Grant et al., 2002; Silvia, 2021) to explore whether they predict the three outcome variables within ProQOL (i.e., Compassion Satisfaction, STS, and burnout). We hypothesised that:

H1a. The more reflective practice sessions attended, the higher level of Self-Reflection and Insight.

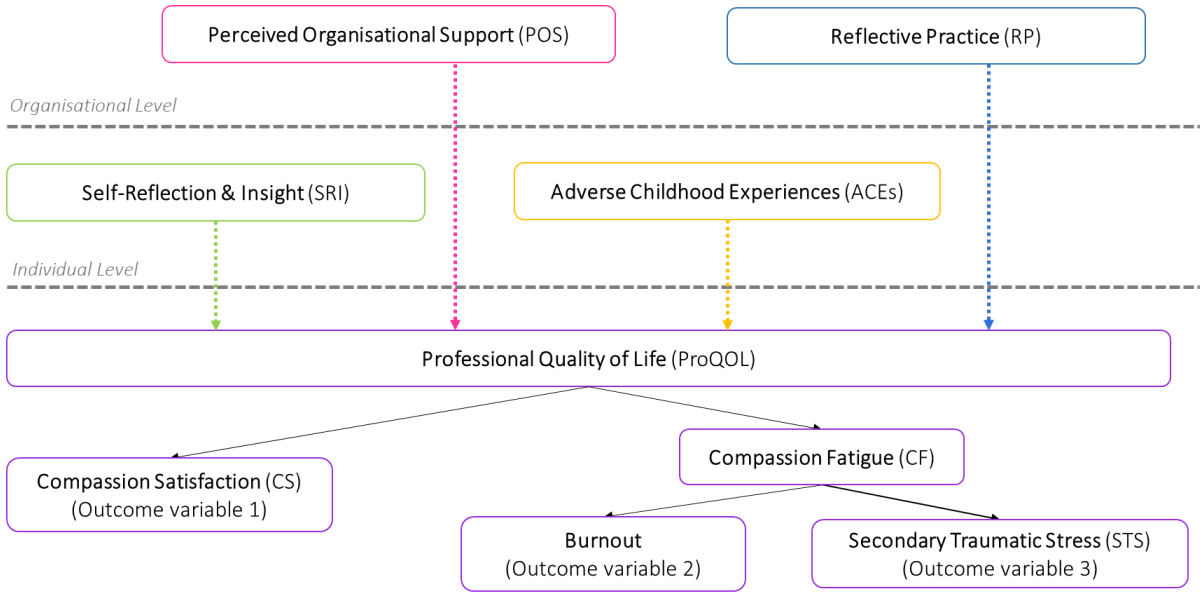
H1b. Higher perceived usefulness of Reflective Practice will be related to higher levels of Self-Reflection and Insight.

H2a. Higher POS, Self-Reflection and Insight and lower ACEs will predict higher Compassion Satisfaction and lower STS and burnout.

H2b. Evidence shows that the more ACEs someone experiences, the higher risk of them experiencing difficulties relating to their physical and psychological wellbeing (Anda et al., 2006). It was therefore hypothesised that ACEs will explain greater variance in the indices of ProQOL than POS and Self-Reflection and Insight.

Figure 1

A Conceptual Model of Organisational and Individual Level Predictor Variables of ProQOL.



2. Method

2.1 Design

This study used a cross-sectional quantitative design using self-report questionnaire measures of POS, Reflective Practice, ACEs, Self-Reflection and Insight and ProQOL

2.2 Research Ethics

The study was approved by the Clinical Psychology Review Committee and the Research Ethics Committee at the University of Liverpool (see Appendix C).

2.3 Experts by Experience Consultation

Experts by Experience consultation was provided by a person frontline working as a Homelessness Project Worker within a Harm Reduction service in Liverpool. Consultation included reviewing and giving feedback on all participant information, supporting the distribution of the questionnaire, data interpretation and dissemination. Guidance was given to ensure clarity in describing what the project entails, allowing all communication to be accessible and inclusive. Changes were also made to the presentation of the study advertisement to ensure further clarity (e.g., three different advertisements were discussed, and advice was given on which was most accessible to read and understand).

2.4 Participants and Recruitment

All participants in this study were frontline workers within homelessness third-sector organisations across the UK. Frontline work includes a variety of roles (e.g., support work, managerial, administrator and personal care providing), therefore frontline workers were included in this project if they met the inclusion criteria. Snowball sampling was used to recruit participants via email and advertisements online (i.e., Twitter). The researchers contacted several organisations and frontline workers via email to request distribution within their workplaces. The study advertisement and Qualtrics link to the questionnaire were attached to

all emails (see Appendix D for the example email template and Appendix E for the study advertisement). Participants were recruited from several organisations across the UK. The project was also advertised at a four-week Psychologically Informed Environments training for the homelessness support sector in Manchester and in the Pathway and the Faculty of Homeless and Inclusion Health newsletter. The participant information sheet (see Appendix F) outlined the nature of the study and was accessible via the Qualtrics link.

Participants were eligible to participate if they had been working for a minimum of 10 hours a week in client-facing roles in services for individuals experiencing homelessness. Participants must also have had been working within their frontline role for a minimum of three months. These criteria are the same as in Lemieux-Cumberlege and Taylor (2019) to ensure a baseline frequency of exposure to the working environment. Participants were excluded if they were under the age of 18 and were unable to speak English fluently. The final sample consisted of N =170 participants. See Table 1 and 2 in the results section for demographic and occupational information.

2.5 Procedure

The study was conducted online via survey software, Qualtrics. The window for participation was between December 2022 to January 2023. Participants were invited to participate in a research study exploring the ProQOL of frontline workers within homelessness. A detailed information sheet, including the nature of the questions that would be asked, the expected time of completion (i.e., 15 to 20 minutes), withdrawal rights and procedures, and information about the end of the study (e.g., dissemination and archiving) as well as the inclusion and exclusion criteria. Details were given about how data will be used, and it was stated that information would be returned to the researchers and not to the participant's place of work. Anonymised informed consent was then obtained (see Appendix G). Following informed consent, participants completed a questionnaire which included demographic and

employment information. The measures detailed in section 2.6 then followed. This firstly included the ProQOL measure, then ACEs, followed by POS and then Reflective Practice and Self-reflection and Insight. After completing the study, debrief information was presented (see Appendix H). The study asked questions related to ACEs which can be a sensitive area, therefore, signposting support information provided at the end of the questionnaire and the researchers were contactable via email.

Upon completion of the study, participants were given an opportunity to be entered into a draw to win one of the ten £25 vouchers available in exchange for their time. To be entered into the draw, participants were given the option to be redirected to a separate questionnaire to record their email addresses. This was to ensure that the database of email addresses was kept separately from, and not linked to, any research data. Email addresses were reviewed to ensure no email address was entered twice, reducing the risk of individuals getting reimbursed more than once. Participants had the option to opt out of being included in the draw by not entering their email addresses. The draw vouchers were available for participants to win once recruitment was finalised and was randomly allocated using an online draw tool to ensure that all participants had an equal chance of winning. Results of the study were disseminated via email to the organisations and participants who requested them.

2.6 Measures

2.6.1 Demographics and Employment.

Questions were asked regarding participants' age, gender, ethnicity, area of workplace (e.g., Northwest England), working hours, length of time in current role, general job role category (e.g., Support Worker), security of employment (e.g., paid employment), additional benefits and supports (e.g., opportunities for professional development and emotional support),

amount of experience working within homelessness and lived experience of homelessness (see Appendix I).

2.6.2 Professional Quality of Life (ProQOL) Questionnaire

ProQOL (Stamm, 2010; Appendix J) is a 30-item scale consisting of three 10-item subscales which measure Compassion Satisfaction and Compassion Fatigue (i.e., burnout and STS). Items are scored using a five-point Likert scale that ranges from 'never' (1) to 'very often' (5). In this study, the sum of each subscale was calculated and scored separately, as recommended (Stamm, 2010). ProQOL has good construct validity and high internal consistency (Stamm, 2010) and has shown strong internal consistency in studies of homeless service providers (Lemieux-Cumberlege & Taylor, 2019; Kerman et al., 2022b). A short 9-item version (Galiana et al., 2020) was used for the proposed research to reduce participant burden. This measure consists of three questions for each subscale. The short form shows adequate internal structure, reliability and validity and retains the items with no reported psychometric problems identified within previous research (Galiana et al., 2020). Participants' total scores on the subscale, which could range from 5 to 15, were used as part of the data analysis. Higher scores are indicative of greater Compassion Satisfaction, burnout, and STS. Using Cronbach's alpha, the internal consistency within this sample for the separate subscales were α = .75 for STS, α = .77 for burnout, and α = .83 for Compassion Satisfaction.

2.6.3 Adverse Childhood Experiences Checklist (ACE)

The ACE Checklist (Felitti et al., 1998; Appendix K) is a 10-item scale that identifies experiences of ACEs. The scale includes three categories of abuse (psychological, physical, and sexual) that occur before the age of 18. Participants are required to respond either 'yes' or 'no' to each statement, with the sum of items added to create an ACE score ranging from 0 to 10 as 'yes' equals '1' and 'no' equals '0'. In line with ethical considerations, a 'prefer not to

say' option was given in the current study, to enable choice and reduce the risk of distress. The ACE has provided substantial epidemiological evidence showing that the more ACEs someone experiences, the higher risk of them experiencing difficulties relating to both their physical and psychological health and wellbeing (Anda et al., 2006). The ACE has shown adequate test re-test reliability (Dube et al., 2004), internal consistency (α = .88; Murphy et al., 2014) and has been described as a reliable, valid measure for ACEs (Wingenfeld et al., 2011). Using Cronbach's alpha, the internal consistency within this sample was α = .79.

2.6.4 Perceived Organisational Support Scale (POS)

POSS (Eisenberger et al., 1986; Appendix L) is a 36-item scale that measures employees' perception concerning the extent to which the organisation values their contribution and cares about their wellbeing (Eisenberger et al., 1986). As the scale is unidimensional and has high internal reliability (α = .97), shorter 16 and 8-item versions have been created (Rhoades & Eisenberger, 2002). Correlations among factor scores suggest that both versions are as effective as the original but are more efficient (Worley et al., 2009). Peters et al. (2021b) suggest that measuring perceptions of organisational support within homelessness will be valuable to the literature. The 8-item version (α = .90) was used for this study. Participants could answer on a scale of 'Strongly Disagree' (1) to 'Strongly Agree' (7). Responses were averaged to create an overall POS score ranging between 1 to 7. Higher scores indicate that respondents perceived their organisation to be more supportive. Using Cronbach's alpha, the internal consistency within this sample was α = .92.

2.6.5 Reflective Practice

Questions were asked around whether participants receive Reflective Practice, frequency of attendance and perceived usefulness.

2.6.5.1 Self-Reflection and Insight Scale (SRIS)

SRIS (Grant et al., 2002; Appendix M) is a 20-item questionnaire consisting of three subscales that involve elements of metacognition; Engagement in Self Reflection, Need for Self-Reflection (α = .90), and Insight (α = .80). Ooi et al. (2021) recommended that the SRIS be adapted for future reflective practice studies with healthcare professionals, given the good psychometric properties reported in various validation studies. More recently, Silvia (2021) applied Item Response Theory to create a concise 12-item version that is evenly balanced between Self-Reflection and Insight. The reliability of the Self-Reflection (α = .87) and Insight (α = .83) subscales show very good reliability. A 7-point scale from 'Strongly Disagree' (1) to 'Strongly Agree' (7) was used. The sum of scores was calculated in accordance with guidance (Silvia, 2021) and higher scores indicate higher SRI with total possible scores ranging from 12 to 84. The 12-item scale showed strong reliability, dimensionality, item fit, local independence, and minimal gender differential item functioning. Using Cronbach's alpha, the internal consistency within this sample was α = .85.

2.7 Data Analysis

A priori power analysis was conducted using G*Power (Faul et al., 2007) for a linear multiple regression: fixed model, R^2 increase. Three predictors were tested (ACEs, POS, and Self-Reflection and Insight). The power analysis indicated that a sample of 99 participants was required to achieve 80% power at p = 0.017 to reveal a medium effect size. The effect size was anticipated to be medium based on similar independent variables explored in Lemieux-Cumberlege and Taylor (2019). The critical p-value was Bonferroni-adjusted to 0.017 (0.05 / 3) as ProQOL is separated into three constructs, therefore the analysis was run separately for these three constructs. Statistical analyses were carried out using SPSS version 28. To address H1a, a Spearman's Rho correlation analysis was conducted and to address H1b an independent

samples t-test was used to evaluate the association between Reflective Practice and Self-Reflection and Insight. To test H2a and H2b, a hierarchical regression analysis was conducted separately for each of the three subscales within ProQOL.

Given previous research has highlighted a relationship with the indices of ProQOL, the first step of the hierarchical regressions consisted of the demographic and organisational variables. These are age, ethnicity (Aykanian et al., 2022), gender, sexual orientation, perceptions of receiving adequate pay (Levesque et al., 2021), length of time working within homelessness (Kerman et al., 2022a), clinical supervision, debriefing, training, perceptions of receiving adequate training (Kerman et al., 2022d; Lemieux-Cumberlege et al., 2019) and lived experience of homelessness (Kerman et al., 2022c). These potential covariates are (listed in Table 1 and Table 2 of the results section). Descriptive statistics of the outcome and predictor variables are presented in Table 3 in the results section.

Hierarchal regression analysis was performed in four steps. In the first step, all potential covariates were added. In the second step, POS was added, then Self-Reflection and Insight in the third. ACEs were included in the fourth step. A total of 4 to 11 significant predictors were controlled for in the power analysis when accounting for the potential covariates and POS, Self-Reflection and Insight, and ACEs. The amount of variance explained by each predictor was evaluated using the change in R^2 in each subsequent model.

2.8 Data Preparation

Participant's data were excluded if they did not meet the eligibility criteria or if they completed less than 20% of the measures. The data were checked for outliers, and none were identified. Items in the POS and Self-Reflection and Insight measure were reversed scored in accordance with the associated guidance. For further analysis, ethnicity data were coded into 'white' and 'ethnic minority', sexual orientation data were coded as 'heterosexual/straight' and

‘not heterosexual/straight’, ‘length of time in homelessness’ data were coded into ‘up to five years’ and ‘more than five years’. This is because there were low numbers across all minority groups and the original data for these variables are categorical and not normally distributed and therefore needed to be transformed to be appropriately entered into the regression analysis. As variables ‘clinical supervision’ and ‘debriefing’ were part of multiple-choice questions, they were recoded to give two values (‘Yes’ and ‘No’) rather than one (‘Yes’).

3. Results

3.1 Demographic Information

The analysis consisted of data from a participant sample of $N = 170$ who completed the study. As shown in Table 1, nearly half of the sample (43%) worked in Northwest England. Most of the participant sample (76%) were aged between 25 to 54 years and 79% identified as White – British. One participant identified as 'Black – Other Background' and 11 as 'White – Other Background' although did not include any further information in the self-define free-text box. The most current list of ethnic groups collated in the 2021 census was included in the study questionnaire (UK Government, 2021).

Table 1

Demographic Information of Participant Sample

Characteristic	**Range**	**n (*N* = 169)**	**Percentage**
Age (years)	18 – 24	8	4.7
	25 – 34	42	24.7
	35 – 44	40	23.5
	45 – 54	47	27.6
	55 – 65	31	18.2
	65 +	2	1.2
	Location	**n (*N* = 170)**	**Percentage**
Area of Workplace	East Midlands	1	0.6
	East of England	2	1.2
	Greater London	22	12.9
	Northeast England	13	7.6
	Northwest England	73	42.9
	Scotland	2	1.2
	Southeast England	6	3.5
	Southwest England	28	16.5
	Wales	5	2.9
	West Midlands	5	2.9
	Yorkshire	13	7.6
	Ethnic Group	**n (*N* = 170)**	**Percentage**
Ethnicity	Anglo Irish	1	0.6

	Asian – British	1	0.6
	Asian – Chinese	1	0.6
	Asian – Indian	1	0.6
	Asian – Pakistani	2	1.2
	Biracial – Black Caribbean and White British	1	0.6
	Black – African	2	1.2
	Black – British	3	1.8
	Black – Caribbean	1	0.6
	Black - Other Background	1	0.6
	Mixed White Asian	1	0.6
	Multiple Ethnic Group	5	3.0
	White – British	133	78.7
	White – Irish	6	3.6
	White - Other Background	11	6.5
	Identity Category	**n (*N* = 52)**	**Percentage**
Gender	Female	38	73.1
	Male	13	25.0
	Gender Fluid	1	1.9
	Identity Category	**n (*N* = 160)**	**Percentage**
Sexual Orientation	Asexual	1	0.6
	Bisexual	13	7.8
	Gay Man	7	4.2
	Gay Woman/Lesbian	6	3.6
	Heterosexual/Straight	129	77.2
	Pansexual	3	1.8
	Queer	1	0.6

Occupational information was asked within the questionnaire to characterise the sample and to control for any potential covariates in the analysis. As shown in Table 2, one participant volunteered. Due to this, paid employment was not entered into the regression analysis as a covariate. Around half of the sample perceived their pay to be adequate, received emotional and social support via their organisation and have lived experience of homelessness. The majority (90%) received training and most participants (67.9%) perceived this training to be adequate.

Table 2

Occupational Information of Participant Sample

Characteristic		n (*N* = 170)	Percentage
Paid employment	Yes	169	99.4
Perceptions of receiving adequate pay	Yes	86	51.2
Length of time working in homelessness	> 5 years	93	54.7
Receive clinical supervision	Yes	83	48.8
Receive debriefing	Yes	83	48.8
Receive training	Yes	153	90.0
Perceptions of receiving adequate training	Yes	115	67.6
Lived experience of homelessness	Yes	81	47.6

3.2 Descriptive Statistics

Descriptive statistics for all measures are reported in Table 3. Despite the short-item measures for ProQOL, POS and Self-Reflection and Insight being validated (see section **2.6** of Method), they are yet to be widely adopted within the available literature. Therefore, the scoring and interpretation guidance for the full-item scales were used. The mean t-score for all ProQOL subscales was 50.00 (*SD* = 10.00). These results are consistent with literature values for the ProQOL scale and are comparable to those found in similar studies (e.g., Schneider et al., 2021). There were a high range of scores across the STS and burnout subscales of ProQOL indicating some participants experience significantly high levels of STS (*n* = 17) and burnout (*n* = 46). The range was less for Compassion Satisfaction, indicating that participants in the sample experienced average to high levels of Compassion Satisfaction. The sample was categorised according to cut-off scores (Stamm, 2010) as shown in Table 4. The mean of ACE total scores (*M* = 3.20, *SD* = 2.60) were greater than in a sample of frontline workers in homelessness in Texas (*M* = 2.82, *SD* = 2.36; Aykanian & Mammah, 2022). There were a high

range of ACEs experienced, indicating that some participants have experienced a significant level (as shown in Table 5). There were also a high range of POS levels reported, indicating that some participants feel significantly unsupported by their organisations. The mean score for POS (M = 4.80, SD = 1.50) for this sample was just above average (M = 4.00). These results are consistent with literature values for the POS scale and are comparable to those found in similar methodological studies (e.g., Iqbal & Hashmi, 2015). All participants reported some level of Self-Reflection and Insight indicating medium to high levels of Self-Reflection and Insight.

Table 3

Descriptive Statistics for Measures

Measure	Means (SD)	Median	Range
ProQOL STS	7.50 (2.27)	7.00	3.00 – 14.00
ProQOL Burnout	8.80 (2.70)	9.00	3.00 - 15.00
ProQOL CS	11.98 (2.25)	12.00	6.00 - 15.00
ACE	3.20 (2.60)	3.00	0.00 - 10.00
POS	4.80 (1.50)	4.90	1.00 – 7.00
SRI	62.74 (11.15)	62.00	30.00 – 84.00

Note. Standard Deviations (SD) in parenthesis. ProQOL = Professional Quality of Life; STS = Secondary Traumatic Stress; CS = Compassion Satisfaction; ACE = Adverse Childhood Experiences; POS = Perceived Organisational Support; SRI = Self-Reflection and Insight.

As shown in Table 4, participant ProQOL subscale cut-off scores are provided. For screening purposes, the ProQOL manual (Stamm, 2010) recommends the 25th and 75th percentiles to be indicative of low to high levels of Compassion Satisfaction, burnout, and STS. Most participants reported high levels of Compassion Satisfaction (74%) and average levels of

burnout (68%) and STS (82%). However, 27% of the sample (*N* = 170) reported high levels of burnout, and 10% reported high levels of STS. These results differ slightly from other studies using ProQOL where average to low levels of burnout and STS have been reported (Lemieux-Cumberlege & Taylor, 2019), or a very low percentage (e.g., >2%) of high levels of burnout and STS (Aykanian, 2022a; Kerman et al., 2022a). However, the current results are similar to those reported in Schiff et al. (2019). Levels of Compassion Satisfaction were also higher within this participant sample when comparing to the mentioned previous literature. Further, Compassion Satisfaction was found to significantly negatively correlate with burnout and STS. A significant positive correlation was found between STS and burnout.

Table 4

Professional Quality of Life Participant Subscale Cut-off Scores

Cut-off Score	Compassion Satisfaction *n* (%)	Burnout *n* (%)	Secondary Traumatic Stress *n* (%)
Low 25th Percentile (0 - 4)	0 (0.0)	8 (4.7)	13 (7.6)
Average 50th Percentile (5 - 10)	45 (26.4)	116 (68.2)	140 (82.2)
High 75th Percentile (11+)	125 (73.5)	46 (27.0)	17 (10.0)

As shown in Table 5, 78.8% of participants reported at least one ACE with 40.5% reporting four or more. This is similar to the sample of frontline workers in Aykanian and Mammah (2022), however, substantially higher than in the global general population; for which prevalence of exposure to one or more ACEs is estimated to be 38–61% and prevalence

of exposure to four or more ACEs is estimated to be 3–16% (Centers for Disease Control and Prevention, 2019; Kessler, 2010; Liu et al., 2021). Similar to Aykanian and Mammah (2022), the four most reported ACEs were parental separation, emotional abuse, substance abuse and psychological distress within the home.

Table 5

Prevalence of ACEs Amongst Participant Sample

Number of ACEs*	**n (*N* = 170)**	**Percentage**
0	36	21.2
1	27	15.9
2	17	10.0
3	21	12.4
4	17	10.0
5	16	9.4
6	13	7.6
7	15	8.8
8	5	2.9
9	1	0.6
10	2	1.2

Note. ACE = Adverse Childhood Experience.

As shown in Table 6, areas where the highest percentage of participants perceived to be unsupported by the organisations for which they worked related to believing their complaints would be ignored, the organisation having very little concern for them and does not care about their general work satisfaction.

Table 6

Areas of Perceived Organisational Support Reported Percentages

POS Question Category	Percentage* (*N* = 170)
1. Does not value my contribution	17.6
2. Fails to appreciate any extra effort from me	44.7
3. Would ignore any complaint from me	65.3
4. Does not really care about my wellbeing	25.9
5. Would not notice if I did the best job possible	27.1
6. Does not care about my general satisfaction at work	51.5
7. Shows very little concern for me	62.9
8. Does not take pride in my accomplishments at work	18.8

Note. *Percentage of sample who reported to agree strongly, moderately, or slightly. All questions refer to the organisation for which participants work. POS = Perceived Organisational Support.

3.3 Normality and Regression Assumptions

To assess the data normality of variables, the Skewness and Kurtosis values were checked (Abbott, 2016). The Self-Reflection and Insight scale was normally distributed in the sample, and all other scales were not normally distributed (see Appendix N for Shapiro Wilk, Skewness, kurtosis, and histograms). Subsequent testing was adjusted for this (i.e., non-parametric Spearman's correlations were used, and no transformations were needed). Preliminary analyses were conducted to explore any violation of the regression assumptions (e.g., normality, linearity, and homoscedasticity). All assumptions for the regression analyses were fulfilled. There was linearity as assessed by partial regression plots and a plot of studentised residuals against the predicted values. A Durbin-Watson statistic of 1.910 highlighted independence of residuals. Homoscedasticity was evident by visual assessment of a plot of studentised residuals versus unstandardised predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentised

deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by Q-Q Plots.

3.4 Associations Between Reflective Practice and Self-Reflection and Insight

To address H1a, a non-parametric Spearman's Rho correlation was run to examine the association between the frequency of reflective practice attended with the level of Self-Reflection and Insight. In line with H1a, there was a statistically significant weak positive association between these two variables, r_s (122) = .17, n = 124, p = .032. To address H1b, perceived usefulness of Reflective Practice and Self-Reflection and Insight were compared. Those who perceived Reflective Practice to be useful (n = 105) scored similarly on the Self-Reflection and Insight measure (M = 64.00, SD = 11.39) compared to those who did not perceive reflective practice to be useful (n = 21, M = 63.29, SD = 9.48). The results of the independent samples t-test showed that the association between perceived usefulness of Reflective Practice and Self-Reflection and Insight was not statistically significant, t(124) = .269, p = .394.

3.5 Exploring Predictors of ProQOL

A hierarchical multiple regression was conducted separately for Compassion Satisfaction, burnout, and STS to address both H2a and H2b. The first stage of all three regression analyses consisted of entering the same ten potential covariates that were hypothesised to relate to the ProQOL of frontline workers within homelessness, in accordance with relevant literature. These potential covariates were entered to control for their contribution of variance, as this study was exploring the unique contribution of POS, Self-Reflection and Insight, and ACEs in explaining the variance of the indices of ProQOL (i.e., Compassion Satisfaction, burnout, and STS). See Appendix O for full regression models.

3.5.1 Predicting Compassion Satisfaction.

In the first step all ten covariates were entered. This first step accounted for a significant proportion of the variance in Compassion Satisfaction, F (10, 159) = 4.813, p <.001, R^2 = .232, 23% of the variance in R^2 change. The second step consisted of adding POS, which accounted for a significant proportion of the variance in Compassion Satisfaction, F (1, 158) = 48.789, p <.001, R^2 = .413, 18% of the variance in R^2 change. The third step consisted of adding Self-Reflection and Insight. This model accounted for a significant proportion of the variance, F (1, 157) = 11.408, p <.001, R^2 = .453, 4% of the variance in R^2 change. The fourth step consisted of adding ACEs. This model accounted for a non-significant proportion of the variance, F (1, 156) = .000, p = .907, R^2 = .253.

The fourth step included all predictors, including all covariates, POS, Self-Reflection and Insight, and ACEs. Overall, the final model accounted for approximately 45% of the variance in Compassion Satisfaction. As shown in Table 7, the covariates that significantly predicted Compassion Satisfaction were length of time working in homelessness, receiving clinical supervision, and perceiving training to be adequate. In line with H2a, higher levels of POS and Self-Reflection and Insight were also found to be significant predictors of Compassion Satisfaction. However, ACEs did not significantly predict Compassion Satisfaction in this model.

Table 7.

Hierarchical Regression Predicting Compassion Satisfaction

	Compassion Satisfaction							
	Model 1		Model 2		Model 3		Model 4	
Variable	B	*β*	B	*β*	B	*β*	B	*β*
Constant	13.268**	-	9.064**	-	6.593**	-	6.605**	-
Time working in sector	.173	.039	.505	.112	.711*	.158	.714*	.159
Clinical supervision	-.508	-.113	-.703*	-.157	-.627*	-.140	-.618*	-.138

Adequate training	-1.981**	-.414	-.739	-.039	-.818*	-.171	-.814*	-.170
POS			.823**	.548	.756**	.504	.757**	.504
SRI					.044**	.218	.044**	.218
ACEs							-.007	-.008
R^2	.232**		.413**		.453**		.453	
F	4.813**		10.125**		10.844**		9.948**	
ΔR^2	.232**		.181**		.040**		.000	
ΔF	4.813**		48.789**		11.408**		.014	

Note. * p <.05. ** p <.001. POS = Perceived Organisational Support; SRI = Self-Reflection and Insight. ACEs = Adverse Childhood Experiences. The full regression model output for Compassion Satisfaction is presented in Appendix O.

3.5.2 Predicting Burnout.

In the first step all ten covariates were entered. This first step accounted for a significant proportion of the variance in burnout, F (10, 159) = 4.759, p <.001, R^2 = .230, 23% of the variance in R^2 change. The second step consisted of adding POS, which accounted for a significant proportion of the variance in burnout, F (1, 158) = 31.606, p <.001, R^2 = .359, 13% of the variance in R^2 change. The third step consisted of adding Self-Reflection and Insight. This model accounted for a non-significant proportion of the variance, F (1, 157) = .287, p = .593, R^2 = .360. The fourth step consisted of adding ACEs. This model accounted for a non-significant proportion of the variance, F (1, 156) = .270, p = .604, R^2 = .361.

The fourth step included all predictors, including all covariates, POS, Self-Reflection and Insight, and ACEs. Overall, the final model accounted for approximately 36% of the variance in burnout. As shown in Table 8, the covariates that significantly predicted burnout were age and receiving clinical supervision, and perceiving training to be adequate. In line with H2a, higher levels of POS were also found to be a significant predictor of burnout, however, Self-Reflection and Insight and ACEs did not significantly predict burnout in this model.

Table 8.

Hierarchical Regression Predicting Burnout

	Burnout							
	Model 1		Model 2		Model 3		Model 4	
Variable	B	*β*	B	*β*	B	*β*	B	*β*
Constant	7.037**	-	11.290**	-	11.800**	-	11.871**	-
Age	-.693**	-.309	-.475*	-.210	-.448*	-.199	-.443*	-.197
Clinical supervision	.568	.106	.765*	.142	.750*	-.139	.798*	.148
POS			-.832**	-.461	-.818**	-.454	-.816**	-.452
SRI					-.009	-.037	-.009	-.038
ACEs							-.040	-.039
R^2	.230**		.359**		.360		.361	
F	4.759**		8.032**		7.353**		6.777**	
ΔR^2	.230**		.128**		.001		.001	
ΔF	4.759**		31.606**		.287		.270	

Note. * p <.05. ** p <.001. POS = Perceived Organisational Support; SRI = Self-Reflection and Insight. ACEs = Adverse Childhood Experiences. The full regression model output for burnout is presented in Appendix O.

3.5.3 Predicting Secondary Traumatic Stress.

In the first step all ten covariates were entered. This first step accounted for a significant proportion of the variance in STS, F (10, 159) = 2.562, p = .007, R^2 = .139, 14% of the variance in R^2 change. The second step consisted of adding POS, which accounted for a significant proportion of the variance in STS, F (1, 158) = 6.514, p = .012, R^2 = .173, 3% of the variance in R^2 change. The third step consisted of adding Self-Reflection and Insight. This model accounted for a non-significant proportion of the variance, F (1, 157) = .004, p = .952, R^2 = .173. The fourth step consisted of adding ACEs. This model accounted for a non-significant proportion of the variance, F (1, 156) = .136, p = .731, R^2 = .174.

The fourth step included all predictors, including all covariates, POS, Self-Reflection and Insight, and ACEs. Overall, the final model accounted for approximately 16% of the

variance in STS. As shown in Table 9, the covariates that significantly predicted STS were receiving debriefing and training. In line with H2a, higher levels of POS were also found to be a significant predictor of STS, however, Self-Reflection and Insight and ACEs did not significantly predict STS in this model.

Table 9.

Hierarchical Regression Predicting Secondary Traumatic Stress

	Secondary Traumatic Stress							
	Model 1		Model 2		Model 3		Model 4	
Variable	B	*β*	B	*β*	B	*β*	B	*β*
Constant	4.455*	-	6.303**	-	6.248*	-	6.199*	-
Received debriefing	.579	.128	.753*	.166	.749*	.165	.767*	.169
Received training	1.391*	.184	1.302*	.172	1.303*	.172	1.298*	.172
POS			-.362*	-.238	-.363*	-.239	-.365*	-.240
SRI					.001	.005	.001	.005
ACEs							.027	.031
R^2	.139*		.173*		.173		.174	
F	2.562*		3.002**		2.735*		2.521*	
ΔR^2	.139*		.034*		.000		.001	
ΔF	2.562*		6.514*		.004		.036	

Note. * p <.05. ** p <.001. POS = Perceived Organisational Support; SRI = Self-Reflection and Insight. ACEs = Adverse Childhood Experiences. The full regression model output for Secondary Traumatic Stress is presented in Appendix O.

3.6 Post-hoc Analysis

As discussed in section 4.3, Self-Reflection and Insight only partially associated with Reflective Practice, therefore a post-hoc analysis was conducted to explore the associations between Reflective Practice and ProQOL (see Appendix P). Reflective Practice perceived to be useful resulted in significantly lower levels of burnout and higher levels of Compassion

Satisfaction. There were no significant associations between the frequency of Reflective Practice attended and ProQOL.

4. Discussion

This cross-sectional study explored the predictors of the ProQOL of frontline workers in third-sector homelessness services across the UK. Reflective Practice, Self-Reflection and Insight, POS, and ACEs were measured to explore whether they predict the three outcome variables in the three-factor ProQOL model (i.e., Compassion Satisfaction, burnout, and STS). The following provides a discussion of the overall results, with consideration of clinical implications, limitations, and future directions.

4.1 Discussion of Findings

The study results highlighted that Self-Reflection and Insight and POS predict higher levels of Compassion Satisfaction, indicating that the frontline workers who were more reflective and felt more supported by their organisations reported experiencing increased satisfaction with the work they do. Negative associations were also found between Compassion Satisfaction with STS and burnout, which aligns with previous research indicating that Compassion Satisfaction may be protective against psychological distress (Lemieux-Cumberlege et al., 2023). These findings are supported by the wider literature exploring job satisfaction (Belias & Koustelios, 2014), suggesting that higher levels of POS and job satisfaction can reduce stress and burnout levels. Further, this study found that the more that participants perceived to be unsupported by their organisations (such as when organisations ignore complaints, fail to appreciate an individual's efforts, or do not show they care about their wellbeing), the higher levels of burnout and STS they reported to experience. These findings partially support H2a in that POS predicts ProQOL, however, do not support H2b as ACEs did not predict or explain significant variance in Compassion Satisfaction, burnout, or

STS, meaning that experiences of potentially traumatic events in childhood did not predict the ProQOL of frontline workers in this participants sample.

These results contribute to the extensive organisational support literature in predicting workplace wellbeing (e.g., Aldabbas et al., 2023; Al-Hakim et al., 2022; Ho & Chan, 2022; Ilyas et al., 2022; Kurtessis et al., 2017). Several influential conceptual frameworks associated with POS are evidenced across the literature, including the JD-R model (Bakker & Demerouti, 2007), drawn upon in homelessness research (e.g., Peters et al., 2021b; Wirth et al., 2019a, b) to evidence multiple systemic, organisational, and interpersonal 'demands' and 'resources' that negatively impact staff wellbeing. The current study supports the application of the JD-R model in homelessness, as debriefing and training were found to be significant predictors of lower STS levels, and clinical supervision and perceptions of adequate training were found to predict higher Compassion Satisfaction and lower burnout levels. Therefore, indicating potential 'job resources' that might enhance workplace wellbeing.

Supporting these findings, Scott et al. (2022) highlight the effectiveness of debriefing in reducing traumatic stress among staff working in clinical settings. Further, clinical supervision is suggested to be protective against burnout in homelessness (Kerman et al., 2022c; Lenzi et al., 2020; Maguire et al., 2017). More specifically, burnout levels were found to increase when supervision was not perceived as useful. When training was perceived as relevant to the work, staff experienced higher levels of work engagement and lower levels of burnout (Lenzi et al., 2020). These findings align with the Social Exchange Theory (Ahmad et al., 2022; Homans, 1958), explaining that when organisations invest in useful support that enables skill development and growth, POS will increase, which results in stronger feelings of identification with the organisation's objectives and values which enhances team cohesion, productivity, and wellbeing (Khajuria & Khan, 2022). However, when supervision, training,

and debriefing were controlled for in the current study, POS was found to explain a significant proportion of the variance in the indices of ProQOL which has noteworthy clinical implications.

4.2 Clinical Implications

The significance of POS as a predictor variable of Compassion Satisfaction, STS and burnout shows the importance of the employee-organisation relationship from the viewpoint of frontline workers. Indeed, the employee-organisation dynamic is central to adequate organisational support, which requires more than simply offering forms of support (e.g., supervision, training, debriefing and reflective practice). Organisational Support Theory, which underlies POS, explains this by acknowledging the essential fulfilment of employees' psychological needs for improving wellbeing, as well as many other positive workplace outcomes such as job satisfaction, work engagement, and reduced turnover and absenteeism (Ogbonnaya et al., 2018). Workplace wellbeing and performance are theorised to be mediated by the fulfilment of three universal psychological needs (i.e., 'relatedness/belongingness', 'autonomy' and competency', Deci & Ryan, 2008). When integrated with the JD-R model, satisfaction of these three needs is predictive of lower burnout levels, even after controlling for job demands (Dreison et al., 2018; Patel & Bartholomew, 2021). Therefore, satisfying these psychological needs across homelessness organisations might improve the POS, and subsequently ProQOL, of frontline workers.

For example, satisfying competence needs requires meaningful and positive feedback regarding evaluated performance, enabling people to demonstrate and improve their abilities via the process of accomplishing realistic challenges and increasing self-efficacy (Fotiadis et al., 2019). This might be difficult for frontline workers in homelessness, considering the people they work with live transient and chaotic lifestyles and therefore progress is typically slower

than expected (Lenzi et al., 2020; Olivet et al., 2010) which might lead people to feel disappointed in their efforts or believe they are incompetent in doing their job (Levesque et al., 2021). Several systemic factors might prevent meeting competence needs, for example, commissioning that is target-focused and 'value for money' driven might place pressure on people to achieve unattainable standards and overlook the impact on ProQOL, as well as the value of building safe relationships with people experiencing homelessness (Pleace, 2020). Further, research has highlighted the possibility of homelessness organisational cultures being experienced as blaming, especially around critical incidents and risk management, which might lead to anxiety, guilt, or shame, and reinforce beliefs of incompetence (Kerman et al., 2022d; Lemieux-Cumberlege et al., 2023; Wang et al., 2020). Therefore, positive and safe error cultures, where people are given the space to learn from their mistakes must be prioritised (Kerman et al., 2022d), thus aligning with psychologically safe organisational cultures (Edmondson & Bransby, 2023; Edmondson & Lei, 2014).

Such cultures will also support autonomy satisfaction, where workplaces aim to empower and trust people to make self-directed choices and minimise risks of coercion or control (Embregts et al., 2019). Psychological empowerment, for example, has been found to function as a mediator between POS and job satisfaction (Maan et al., 2020) and can be associated with lower levels of STS (Choi, 2017). Moreover, by drawing upon attachment theory (Bowlby, 1979), relatedness determines the extent to which individuals can creatively express themselves and become autonomous, and competent in the workplace, via the process of creating safe relationships (Cerasoli et al., 2016; Itzchakov, 2022). Satisfaction of relatedness needs is protective against burnout amongst healthcare professionals (Waddimba et al., 2015), and supports the implementation of psychologically informed frameworks such as Trauma Informed Care and Psychologically Informed Environments in homelessness as they

reflect the social need to emotionally connect with others, and to feel valued, respected, and secure in important workplace relationships (Deci et al., 2017; Ryan & Deci, 2022). Although further exploration and evaluation of the factors that influence psychological needs satisfaction is required, these findings might support the development of POS frameworks that could be integrated into current homelessness policy and practice, initiating targeted action to protect workplace wellbeing.

4.3 Strengths, Limitations, and Future Directions

Several strengths and limitations of this study require consideration. The study questionnaire was distributed at a time when homelessness services were still recovering from repercussions of the Covid-19 pandemic, whilst faced with the added personal and professional pressures of the rising cost of living (Frontline Network, 2022; Watts et al., 2022). Therefore, due to the cross-sectional study design, the extent to which POS and ProQOL were impacted by the wider socio-political-economic context is unknown and might not extend beyond this time point. People who were experiencing particularly high levels of burnout or STS might have opted out of participating in the study due to experiencing distress. Equally, people who might have been feeling particularly unsupported by their organisations might have been overrepresented in this sample due to wanting to express their concerns. Thus, the convenience sampling recruitment approach might limit the generalisability of the findings.

Although findings indicate that ACEs did not predict the ProQOL of frontline workers, the ACE ten-item checklist has been critiqued for misrepresenting childhood adversities. For example, it fails to acknowledge potentially traumatic experiences that are associated with social inequalities such as marginalisation, racism, poverty, and homelessness (Parker et al., 2020). The ACE checklist also does not indicate the severity or frequency of individual ACEs and it is unknown how individual, contextual, and protective factors might have influenced

how ACEs were subjectively experienced. For example, it is possible that people could have experienced one ACE, however, the nature of the experience might have been more recurrent and harmful (e.g., repeated abuse), compared to others who might have experienced multiple ACEs at a lesser intensity due to the occurrence and by receiving adequate social and emotional support. Thus, there is still limited research exploring the extent to which personal trauma experiences interact with frontline working in homelessness, and this research indicates a requirement for more nuanced measurements of trauma (as discussed in chapter one of this thesis).

However, certain individual, contextual, and protective factors also align with the extensive literature exploring Post-Traumatic Growth which is thought to positively result from the struggle to cope with traumatic events, experiences, and effects (Henson et al., 2021). Post-Traumatic Growth factors might explain why experiences of potentially traumatic events in childhood did not predict the ProQOL of frontline workers in this participant sample. For example, ACEs are positively associated with Post-Traumatic Growth, mediated by resilience (Lee et al., 2020; Widyorini et al., 2022). Clinically, this finding has the potential to reduce stigma associated with lived experience of trauma, evidencing how wellbeing and resilience levels can increase following traumatic experiences. When shaping services, whilst it is helpful to see the value of lived experience, it might also be helpful to consider the several factors that promote and mediate Post-Traumatic Growth (e.g., see, Henson et al., 2021) to enhance trauma-informed environments. It is also important to acknowledge that ACEs were explored as an individual-level factor in the regression, with POS being significant as an external factor at the organisational level, therefore suggesting that ProQOL is more likely to be dependent upon wider factors, shifting some of the responsibility (regarding staff wellbeing) away from individuals and towards organisations. Additionally, a significant percentage of variance was

not explained in the regression models, indicating the requirement of more research in exploring other factors that significantly impact the ProQOL of frontline workers in homelessness.

There were also limitations as to how Reflective Practice was measured concerning ProQOL. Only two self-developed Reflective Practice questions were included in the analysis which provided minimal categorical data in understanding the mechanisms that underpin Reflective Practice as a predictor variable. The Self-Reflection and Insight measure was included in the regression analysis with the proposed assumption that it would positively associate with Reflective Practice, however, Self-Reflection and Insight was only partially associated with Reflective Practice, highlighting that those participants who attended Reflective Practice reported higher Self-Reflection and Insight, although the causal direction of this association is unknown. It would therefore be incorrect to make inferences on whether Reflective Practice predicts ProQOL based on the relationship between Self-Reflection and Insight and ProQOL. Considering this limitation, a post-hoc analysis (see Appendix P) was conducted exploring the association between Reflective Practice with burnout, STS and Compassion Satisfaction. Findings revealed that the participants who find Reflective Practice useful showed significantly lower levels of burnout and higher levels of Compassion Satisfaction. There were no significant associations between the frequency of Reflective Practice attended and ProQOL. However, the limitations of the Reflective Practice measure and the scarcity of research in this area mean that there is a need for more research exploring the value of Reflective Practice in relation to ProQOL, as well as comprehensive reflective practice measurement approaches that incorporate the impact of systemic practical implementation factors along with individual mega-cognitive components.

Lastly, there were limitations to the participant sample and aspects of the analysis which created barriers to exploring intersectionality differences with the variables measured. For example, an optional free-text box was used for participants to self-define their gender, in accordance with inclusive guidance (e.g., Stonewall, 2016), however, only 52 participants responded and therefore gender was not entered into the regression analysis as a covariate and therefore the variance explained by gender is uncertain across regression models. Despite the low response rate to the question on gender (30% of the full sample N = 170), most of the participants (73%) who did respond identified as female and this percentage reflects relevant research in this area. For example, 82.3% of the sample in Kerman et al. (2022d) and 65.2% in Lemieux-Cumberlege and Taylor (2019) identified as female, highlighting a general a higher proportion of females working as frontline workers. Most of the study sample identified as female and White, ages primarily covered the range of working-aged adults in the UK, and data on identity differences (i.e., ethnicity and sexual orientation) was limited when transforming data for the regression analyses. It is therefore uncertain how findings might extend beyond the sample demographic analysed, and further research is required to understand experiences at work between frontline workers in consideration of how individual and cultural differences intersect with experiences of power, privilege, marginalisation, and stigma.

5. Conclusion

Homelessness is shaped by a broad range of intersecting systemic-level challenges which can create unpredictable working environments, placing significant pressure on frontline workers. Such contexts can impact workplace wellbeing despite individuals possessing exceptional skills and motivation to care. This study explored organisational and individual-level factors that might predict the ProQOL of frontline workers in homelessness. Results highlight that Compassion Satisfaction, STS and burnout do not solely reside in individuals,

instead, they are significantly influenced by the reciprocity dynamic between the individual and organisation. Despite the interaction of many influential factors that need further exploration, considering the accountability and configuration of homelessness organisations is essential and clinical implications associated with psychological needs satisfaction are discussed. For example, evaluating homelessness organisation policy and practice on how frontline workers (a) are supported to develop competencies and build self-esteem, (b) are empowered to use their agency without coercive practices, and (c) feel respected, valued, and a sense of belonging in supervisory and peer relationships might improve POS, workplace wellbeing, and recruitment and retention rates. Ultimately, improving the quality of care provided across homelessness. However, further explorations into organisational support are required including understanding intersectionality differences, how trauma experiences affect frontline working, and evaluations into the effectiveness of reflective practice in relation to workplace wellbeing, thus supporting future Trauma Informed Care and Psychologically Informed Environment developments and implementation, creating psychologically safe cultures.

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Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing challenges and strategies for organizations serving individuals who have experienced chronic homelessness. *The journal of behavioral health services & research*, *37*, 226-238.

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Appendices

Appendix A: Systematic Review Screening Tool

Screening and selection tool. Please see eligibility criteria for more information.

Review title & Research Question	Exploring the experiences of trauma in the homelessness support sector. A Mixed Methods Systematic Review.	
S	Sample	People working (i.e., employed or volunteering) within the homelessness support sector (e.g., frontline workers, managers etc).
P I	Phenomenon of Interest	Experiences of trauma within the homelessness support sector
D	Design	Any - quant, qual, and mixed methods
E	Evaluation	Any
R	Research type	Any

	Include	Exclude
Sample	☐ If there is an element of focus in the paper on the trauma experiences of people working or volunteering within the homelessness support sector (rather than people experiencing homelessness)	☐ If the sample are not fully specific to homelessness (e.g., veteran or sex worker population) ☐ If the sample focuses on working with refugees or people seeking asylum ☐ If the focus is on people experiencing homelessness following natural disasters
Phenomenon of Interest **SAMHSA (2014) Trauma definition:** "an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being"	☐ If there is a focus on experiences of trauma within the homelessness support sector ☐ If any trauma outcome measure has been used to explore the experiences of the support sector ☐ If trauma is specifically acknowledged and there is substantial data to support the definition, i.e., a clear **event**, an **experience**, and the **effect** (see SAMHSA (2014) for more information regarding the definition) ☐ If Trauma-Informed Care (TIC) and/or Psychologically Informed Environments (PIE) related papers specifically acknowledge the experiences of trauma and indicate a focus on supporting the homelessness support sectors (not just people experiencing homelessness)	☐ If TIC/PIE focus only on people experiencing homelessness rather than the trauma experiences of workers (e.g., the implementation of TIC is being measured to improve the service to only support people experiencing homelessness) ☐ If trauma experiences are mentioned (e.g., in the introduction, interpretation of results or discussion), however, there is not clear data to indicate trauma experiences. ☐ If the paper only mentions potential symptoms of trauma, rather than acknowledging that these symptoms relate to a trauma experience
Design	☐ Any trauma outcome measure that measures any trauma related construct ☐ Any mention of trauma as qualitative evidence	☐ If there is no mention or indication of trauma experiences being measured

Appendix B: Reasons for Full-Text Article Exclusion

Focus of the paper is not on the homelessness support sector (*N* = 9)

1. Archard, P. J., & Murphy, D. (2015). A practice research study concerning homeless service user involvement with a programme of social support work delivered in a specialized psychological trauma service. Journal of psychiatric and mental health nursing, 22(6), 360-370.
2. Benson, J., & Brennan, M. (2018). Keyworkers' experiences and perceptions of using psychological approaches with people experiencing homelessness. Housing, Care and Support.
3. Coleclough, E. C. (2015). Capturing the Client Perspective within an Organizational Needs Assessment; A Project to Enhance'Trauma Informed Care'(TIC) in a Homeless Health Clinic (Doctoral dissertation, Johns Hopkins University).
4. Cornes, M., Manthorpe, J., Hennessy, C., Anderson, S., Clark, M., & Scanlon, C. (2014). Not just a talking shop: practitioner perspectives on how communities of practice work to improve outcomes for people experiencing multiple exclusion homelessness. Journal of interprofessional care, 28(6), 541-546.
5. Estrella, M. J., Kirsh, B., Kontos, P., Grigorovich, A., Colantonio, A., Chan, V., & Nalder, E. J. (2021). Critical Characteristics of Housing and Housing Supports for Individuals with Concurrent Traumatic Brain Injury and Mental Health and/or Substance Use Challenges: A Qualitative Study. International Journal of Environmental Research and Public Health, 18(22), 12211.
6. Every, D., & Richardson, J. (2018). A framework for disaster resilience education with homeless communities. Disaster Prevention and Management: An International Journal.
7. Guarino, K., & Bassuk, E. (2010). Working with families experiencing homelessness: Understanding trauma and its impact. Zero to Three, 30(3), 11.
8. Hancock, N., Berry, B., Banfield, M., Pike-Rowney, G., Scanlan, J. N., & Norris, S. (2022). Peer Worker-Supported Transition from Hospital to Home—Outcomes for Service Users. International Journal of Environmental Research and Public Health, 19(5), 2743.
9. Purkey, E., & MacKenzie, M. (2019). Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care. International journal for equity in health, 18(1), 1-7.

Data not separated from different populations (*N* = 1)

1. Handran, J. (2013). Trauma-informed organizational culture: The prevention, reduction, and treatment of compassion fatigue (Doctoral dissertation, Colorado State University).

No data associated with the trauma experiences of the homelessness support sector (*N* = 17)

1. Aronowitz, S. V., Engel-Rebitzer, E., Lowenstein, M., Meisel, Z., Anderson, E., & South, E. (2021). "We have to be uncomfortable and creative": Reflections on the impacts of the

COVID-19 pandemic on overdose prevention, harm reduction & homelessness advocacy in Philadelphia. SSM-Qualitative Research in Health, 1, 100013.

2. Aubin, D., Abdel-Baki, A., Baret, C., Cadieux, C., Glaize, A., Hill, T., ... & Tiberghien, C. (2012). Taking care of outreach workers who intervene with marginal youths: Part 2. Sante Mentale au Quebec, 37(1), 13-30.
3. Ferris, L. J., Jetten, J., Johnstone, M., Girdham, E., Parsell, C., & Walter, Z. C. (2016). The Florence Nightingale effect: Organizational identification explains the peculiar link between others' suffering and workplace functioning in the homelessness sector. Frontiers in Psychology, 7, 16.
4. Hudson, B. F., Shulman, C., Low, J., Hewett, N., Daley, J., Davis, S., ... & Stone, P. (2017). Challenges to discussing palliative care with people experiencing homelessness: a qualitative study. BMJ open, 7(11), e017502.
5. Klop, H. T., De Veer, A. J., Gootjes, J. R., Van De Mheen, D., Van Laere, I. R., Slockers, M. T., & Onwuteaka-Philipsen, B. D. (2022). Evaluating the perceived added value of a threefold intervention to improve palliative care for persons experiencing homelessness: a mixed-method study among social service and palliative care professionals. BMC Palliative Care, 21(1).
6. MacWilliams, J., Bramwell, M., Brown, S., & O'Connor, M. (2014). Reaching out to Ray: delivering palliative care services to a homeless person in Melbourne, Australia. International journal of palliative nursing, 20(2), 83-88.
7. O'Callaghan, D., & Lambert, S. (2022). The impact of COVID-19 on health care professionals who are exposed to drug-related deaths while supporting clients experiencing addiction. Journal of Substance Abuse Treatment, 138, 108720.
8. Prestidge, J. (2014). Using Trauma-Informed Care to provide therapeutic support to homeless people with complex needs: a transatlantic search for an approach to engage the "non-engaging". Housing, Care and Support.
9. Salem, B. E., Kwon, J., & Ames, M. (2018). On the frontlines: Perspectives of providers working with homeless women. Western journal of nursing research, 40(5), 665-687.
10. Schneiderman, J. U., Nedjat-Haiem, F., Rivera, D., & Pérez Jolles, M. (2022). Nurse and case manager views on improving access and use of healthcare for adults living in permanent supportive housing. Research in Nursing & Health, 45(2), 218-229.
11. Shulman, C., Hudson, B. F., Low, J., Hewett, N., Daley, J., Kennedy, P., ... & Stone, P. (2018). End-of-life care for homeless people: a qualitative analysis exploring the challenges to access and provision of palliative care. Palliative medicine, 32(1), 36-45.
12. Somers, J. M. (2016). Practical Guidance for the New Rehousing Workforce. PsycCRITIQUES, 61(2).
13. Spearing, A. (2019). P-19 Bridging the gap between hospice and homeless services.
14. Stajduhar, K. I., Giesbrecht, M., Mollison, A., & d'Archangelo, M. (2020). "Everybody in this community is at risk of dying": An ethnographic exploration on the potential of integrating a

palliative approach to care among workers in inner-city settings. Palliative & Supportive Care, 18(6), 670-675.

15. Wiewel, B., & Hernandez, L. (2021). Traumatic Stress and Homelessness: A Review of the Literature for Practitioners. Clinical Social Work Journal, 1-13.

16. Wilkins, C. L. (2020). Experiences of Compassion Fatigue in Case Managers Serving Homeless Youth While Maintaining Ethics: A Qualitative Study (Doctoral dissertation, Capella University).

17. Wright, R. D., Wright, S. E., & Jones, A. (1999). Dying homeless but not alone: social support roles of staff members in homeless shelters. Illness, Crisis & Loss, 7(3), 233-251.

The aim is not on the emotional experiences of working within homelessness (*N* = 3)

1. Armstrong, M., Shulman, C., Hudson, B., Stone, P., & Hewett, N. (2021). Barriers and facilitators to accessing health and social care services for people living in homeless hostels: A qualitative study of the experiences of hostel staff and residents in UK hostels. BMJ open, 11(10), e053185.

2. Aykanian, A. (2018). Service and policy considerations when working with highly mobile homeless youth: Perspectives from the frontlines. Children and Youth Services Review, 84, 9-16.

3. Ball, A., Bowen, E. A., & Jones, A. S. (2021). Integrating trauma-informed care and collective impact: perspectives of service providers working with cross-system youth. Journal of the Society for Social Work and Research, 12(1), 59-81.

Systematic Review (*N* = 1)

1. Peters, L. M., Samuel, V. M., & Hobson, C. W. (2021). Shining a light on the experiences of staff working with young homeless people: A grounded theory study. Children and youth services review, 121, 105843.

Unpublished dissertations that responded 'No' or 'Can't tell' to one or both questions on the MMAT quality appraisal screening protocol (*N* = 3)

1. Beebe, J. (2016). Compassion fatigue and compassion satisfaction: Experiences of helping professionals in the homeless workforce: A project based upon an investigation at Boston Healthcare for the Homeless, Boston, Massachusetts.

2. Jones, A. (2022). Frontline Workers with Lived Experience and Traumatic Stress in the Homelessness Sector.

3. Rios, V. (2016). Frontline workers: Urban solutions for developing a sustainable workforce in the homeless services sector of Los Angeles County. PhD diss., Antioch University.

No data associated with the trauma experiences of the homelessness support sector (*N* = 4)

1. Carver, H., Price, T., Falzon, D., McCulloch, P., & Parkes, T. (2022). Stress and Wellbeing during the COVID-19 Pandemic: A Mixed-Methods Exploration of Frontline Homelessness

Services Staff Experiences in Scotland. International journal of environmental research and public health, 19(6), 3659.

2. Lenzi, M., Santinello, M., Gaboardi, M., Disperati, F., Vieno, A., Calcagnì, A., ... & HOME_EU Consortium Study Group. (2021). Factors associated with providers' work engagement and Burnout in homeless services: A cross-national study. American Journal of Community Psychology, 67(1-2), 220-236.
3. Mullen, J., & Leginski, W. (2010). Building the capacity of the homeless service workforce. The Open Health Services and Policy Journal, 3(1).
4. Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing challenges and strategies for organizations serving individuals who have experienced chronic homelessness. The journal of behavioral health services & research, 37(2), 226-238.

Compassion fatigue data is not separated. Therefore, STS data not available (*N* = 1)

1. Howell, A. M. (2012). Working in the trenches: Compassion fatigue and job satisfaction among workers who serve homeless clients.

Appendix C: Ethical Approval

Central University Research Ethics Committee A

17 October 2022

Dear Dr Weatherhead

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	11460
Project Title:	Professional Quality of Life of Frontline Workers within Homelessness
Principal Investigator/Supervisor:	Dr Stephen Weatherhead
Co-Investigator(s):	Miss Bethany Camp, Dr Anam Elahi
Lead Student Investigator:	-
Department:	Primary Care & Mental Health
Approval Date:	17/10/2022
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

Please note: Any research ethics approval granted will be subject to the University's Policies on research during the pandemic.

Please ensure you are familiar with the latest guidance on conducting research during the pandemic. The guidance is available on the research ethics webpages.

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Central University Research Ethics Committee A

ethics@liverpool.ac.uk

CUREC-A

Appendix D: Example Email Template

Title: Exploring the Professional Quality of Life of Frontline Workers within Homelessness.

Dear [Service Provider],

We are inviting you to support the recruitment of a Clinical Psychology Doctorate Research Project.

The project is exploring the wellbeing and support of frontline workers within homelessness via an anonymous questionnaire that should take no longer than 15-20 minutes to complete.

To take part in this study, participants are required to be:

- working or volunteering for a minimum of 10 hours a week in client-facing roles within UK third-sector homelessness organisations.
- competent in reading and understanding English.
- able to provide informed consent to participate in the study.
- working within their current frontline role for a minimum of three months.
- aged 18 or older.

Your role would involve distributing the below email and attached poster advertisement to any potential frontline workers within homelessness who might be willing to complete the questionnaire. The advertisement includes a QR code to the study where all participant information and the questionnaire can be accessed. The study can also be access via this link: https://livpsych.eu.qualtrics.com/jfe/form/SV_9tL4GtJU8GLJp66

Please find the Provider Information Form attached for more information about the project. Should you wish to support recruitment, please complete the attached Provider Involvement Form and send to Bethany Camp (Trainee Clinical Psychologist, bethany.camp@liverpool.ac.uk).

If you would like any further information or have any questions, please let us know by emailing bethany.camp@liverpool.ac.uk.

Many thanks,

Bethany Camp (Trainee Clinical Psychologist)
Dr Ste Weatherhead (Consultant Clinical Psychologist)

Dear Frontline Worker,

We are inviting you to take part in a Clinical Psychology Doctorate Research Project.

The project is exploring the wellbeing and support of frontline workers within homelessness via an anonymous questionnaire that should take no longer than 15-20 minutes to complete.

To take part in this study, participants are required to be:

- working or volunteering for a minimum of 10 hours a week in client-facing roles within UK third-sector homelessness organisations.
- competent in reading and understanding English.
- able to provide informed consent to participate in the study.
- working within their current frontline role for a minimum of three months.
- aged 18 or older.

If you would like to take part in this project, please see the attached poster advertisement for more information. The advertisement includes a QR code to the study where all participant information and the questionnaire can be accessed. The study can also be access via this link:

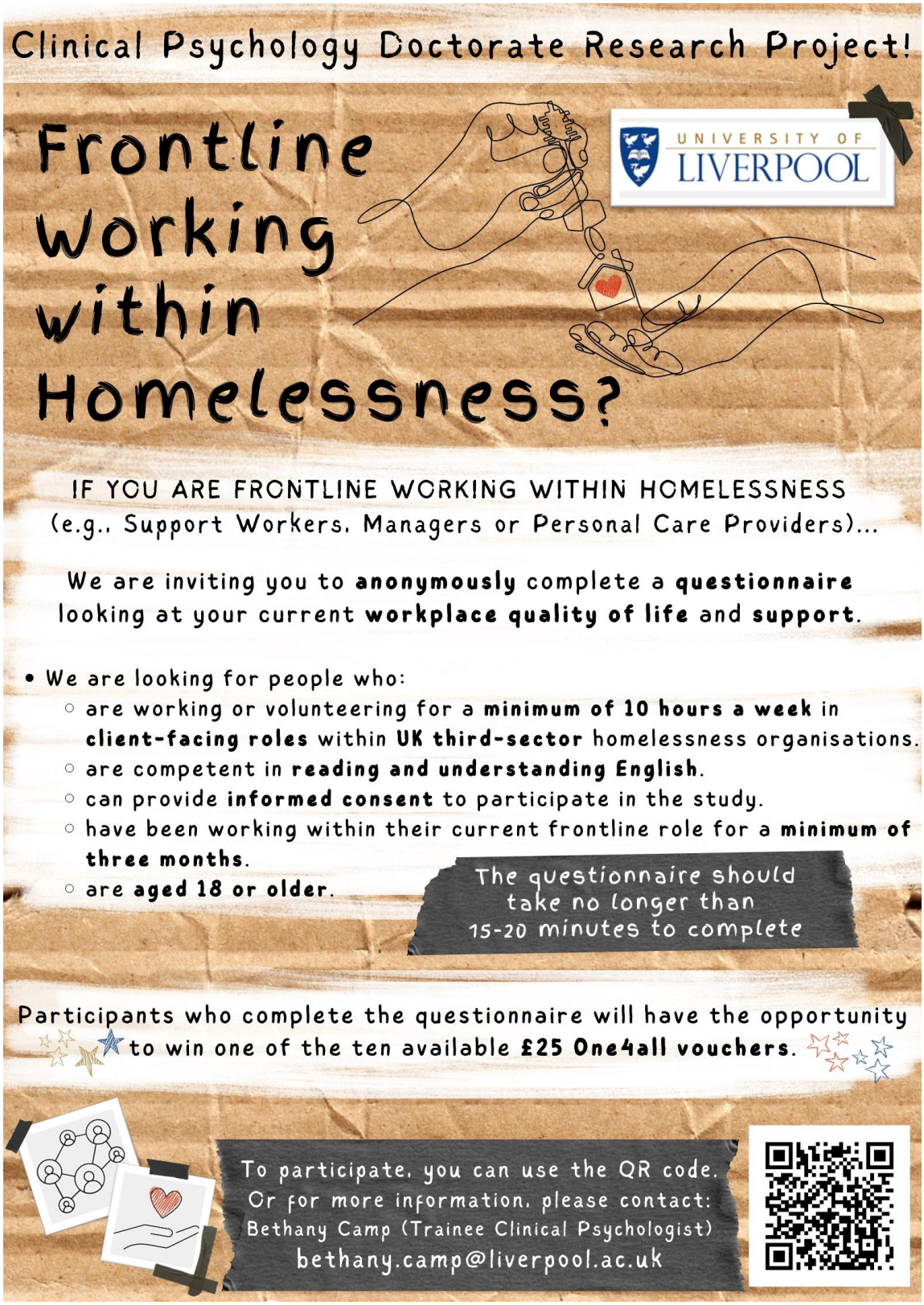
https://livpsych.eu.qualtrics.com/jfe/form/SV_9tL4GtJU8GLJp66

If you would like any further information or have any questions, please let us know by emailing bethany.camp@liverpool.ac.uk.

Many thanks,

Bethany Camp (Trainee Clinical Psychologist)
Dr Ste Weatherhead (Consultant Clinical Psychologist)

Appendix E: Study Advertisement



Appendix F: Participant Information Sheet

Title: Exploring the Professional Quality of Life of Frontline Workers within Homelessness.

You have been invited to participate in a research study.

This research is being conducted by the University of Liverpool. It is therefore important to note that your employer will not know whether you have or have not taken part in the study and, if you were to take part, your employer will be unable to see your answers or be able to identify you.

Before you decide whether to participate, it is also important to understand why the research is being carried out and what it will involve. This is to ensure you can make an informed decision on whether to participate. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

This research study involves you completing an online questionnaire. It is essential to let you know that **the questionnaire will contain a section regarding adverse childhood experiences (which can include experiences of physical and emotional neglect, parental divorce, substance abuse and physical, sexual, and emotional abuse).** If you feel that answering questions on this topic would cause you distress, please consider whether you wish to take part in the study.

Who is conducting the study?

The study is being conducted by Bethany Camp (Trainee Clinical Psychologist), Dr Stephen Weatherhead (Consultant Clinical Psychologist and Primary Supervisor) and Dr Anam Elahi (Psychology Lecturer and Secondary Supervisor). The advisors of the study are Jacqui Regan (Homelessness Project Worker), Dr Colm Gallagher (Clinical Psychologist) and Dr Nick Maguire (Associate Professor in Clinical Psychology).

What is the purpose of the study?

Previous research has found that working within homelessness can be associated with positive work satisfaction as well as other more difficult experiences such as secondary traumatic stress and burnout. Secondary traumatic stress relates to exposure to extremely stressful events at work, for example, repeatedly hearing stories about the traumatic or distressing things that happen to other people. Burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing the job effectively and can be characterised by a very high workload or a non-supportive work environment.

The above-mentioned experiences relate to a concept known as Professional Quality of Life. Professional Quality of Life may be influenced by working environments, such as those that draw upon a 'Trauma-Informed' approach, and how supported people feel within the organisations of which they work. Equally, it may be influenced by an individual's personal background. For example, adverse experiences (including abuse and neglect) within their childhood.

The current research aims to explore what might impact upon the Professional Quality of Life of frontline workers within homelessness. It is anticipated that the research outcomes of this study will contribute to improving the current understanding of the needs and support available for people working within the homelessness support sector.

Why have I been chosen to take part?

You have been chosen to take part in the study as someone who is currently frontline working within a third sector homelessness organisation. If this is not you, please do not proceed with the study.

We will be asking frontline workers who work in these settings across the UK to take part in the study. We aim to recruit at least 120 participants.

How do I know if I am eligible to take part?

To take part in this study, participants are required to be:

- working or volunteering for a minimum of 10 hours a week in client-facing roles within UK third-sector homelessness organisations.
- competent in reading and understanding English.
- able to provide informed consent to participate in the study.
- working within their current frontline role for a minimum of three months.
- aged 18 or older.

If you do not meet these criteria, please do not proceed with the study.

Do I have to take part?

No, any participation is voluntary. You are free to withdraw your participation at any time simply by closing the browser window. There will be no consequences if you do not wish to take part.

What will happen if I take part?

After reading this information sheet, you will be taken to a page to record your consent to participate in the study.

You will then be asked to complete a questionnaire. This should take no longer than 20 minutes. Please take care to fill in all the answers. There is an option of 'prefer not to say' if you do not feel comfortable in disclosing your answer during the adverse childhood experiences section of the questionnaire.

After the questionnaires you will be taken to a debrief section where you will find a detailed description of the study, signposting to services should you feel distressed, and contact details for the researchers.

We recommend that you find a safe, private area to complete the study to ensure confidentiality. The questionnaire is not timed, therefore please feel free to take as long as you need to complete it and take breaks if necessary. The questionnaire on average is likely to take between 15-20 minutes.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit."

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The Primary Supervisor (Dr Stephen Weatherhead) acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Dr Stephen Weatherhead at ste@liverpool.ac.uk.

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Data will be collected online via the Qualtrics programme.
How will my data be stored?	Data will be stored in accordance with the University of Liverpool's Research Data Management policy.
How long will my data be stored for?	Data will remain the responsibility of Bethany Camp (Trainee Clinical Psychologist) until completion of the doctorate programme (September 2023). Following this, Dr Stephen Weatherhead (Primary Supervisor and Data Custodian) will be responsible for the data for a minimum of 10 years.
What measures are in place to protect the security and confidentiality of my data?	All your data will be completely anonymous and stored electronically. All electronic data and information will be protected with security passwords. All data from participants will be

Will my data be anonymised?	Yes. You will not provide any identifiable information with your responses to the questionnaire. Your email address will be required for reimbursement and/or for a summary of the results, however, this will not be linked to your responses to the questionnaire. Your email address will be kept in a separate file from the questionnaire data, protected with security passwords and stored in Liverpool Universities secure data storage facilities.
How will my data be used?	Individual data will be amalgamated with the data from other participants and analysed in accordance with the research hypotheses.
Who will have access to my data?	Bethany Camp (Trainee Clinical Psychologist, Student Researcher) and Dr Stephen Weatherhead (Primary Supervisor). Collaborators, Dr Anam Elahi (Secondary Supervisor), Dr Colm Gallagher (Research Project Advisor) and Dr Nick Maguire (Research Project Advisor) will only have access to anonymous data.
Will my data be archived for use in other research projects in the future?	No. The data will only be used for the current study.
How will my data be destroyed?	Data will be destroyed in accordance with the University of Liverpool's Research Data Management policy, which will remain the responsibility of Dr Stephen Weatherhead (Primary Supervisor and Data Custodian).

Are there any risks in taking part?

A questionnaire within the study asks about adverse childhood experiences, including neglect and physical, emotional, and sexual abuse.

Therefore, there may be a risk of experiencing distress within this section of the questionnaire as research shows that some people might experience some level of distress when reporting adverse childhood experiences (including abuse and neglect).

If you feel that there would be significant emotional distress because of answering these questions, we ask that you reconsider your involvement with the study.

If you do decide to participate, for any questions which you may feel uncomfortable with answering, you can select the 'prefer not to say' option within this section of the questionnaire. You can also withdraw from the study at any point by closing the browser.

What should I do if I feel distressed?

It can be normal to feel some distress following the report of adverse childhood experiences (including abuse and neglect).

If you would like support with any potential distress you experience, you may find it beneficial to speak with someone you trust and feel comfortable with, such as a close family member or friend.

You can contact your GP for help. They can direct you to local services which can offer talking therapies and emotional support.

You may also find the following national services helpful:

Samaritans

If you need to talk to someone in confidence, the Samaritans are available 24 hours a day, 7 days a week on:
Tel: 116 123
E-mail: jo@samaritans.org
Web: https://www.samaritans.org/

If you have experienced abuse as a child which you have not yet reported, you can do so by contacting the police on 101.

Alternatively, if you are worried about reporting abuse or would like additional support you can contact:

National Society for the Prevention of Cruelty to Children (NSPCC):
Tel: 0808 800 5000
Email: help@nspcc.org.uk
Website: https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/non-recent-abuse/

National Association for People Abused in Childhood (NAPAC)
You can seek support with recovery from childhood abuse of all types including physical, sexual, emotional abuse or neglect.
Tel: 0808 801 0331 (10am until 9pm Mondays to Thursdays, and 10am until 6pm on Fridays).
Email: support@napac.org.uk
Web: https://napac.org.uk/

If you are currently experiencing abuse, you can contact the police on 101 or 999 to report this. For additional support please see the website below for contact details:
https://www.gov.uk/guidance/domestic-abuse-how-to-get-help

Should you experience any significant distress as part of the research, please contact the researcher(s) immediately (please see contact details below).

Are there any benefits in taking part?

Participants who have completed similar research have described their participation as beneficial. It is anticipated that the outcome of this research study will contribute to supporting the needs and wellbeing of frontline workers within homelessness nationally.

Upon completion of the study, participants will have the opportunity to be entered into a draw to win one of the ten £25 One4all vouchers available in exchange for their time. To be entered into the draw, participants will be redirected to a separate questionnaire to record their email addresses. This will ensure that the database of email addresses will be kept separately from, and not linked to, any research data. Only the trainee and primary supervisor will have access to this database. Email addresses will be reviewed to ensure no email address is entered twice, reducing the risk of individuals getting reimbursed more than once. Participants can opt-out of being included in the draw by not entering their email addresses. The draw vouchers will be available for participants to win once recruitment is finalised and will be randomly allocated using an online draw tool to ensure that all participants have an equal chance of winning.

What will happen to the results of the study?
The results of the study will be written up as part of a Doctorate in Clinical Psychology (a qualification that allows someone to practice as a Clinical Psychologist) and will be published in a peer reviewed

journal (where research is published and can be accessed) interested in the homelessness support sector. We also hope to disseminate the results of the study via a conference.

Individual responses will be combined into a large dataset which will represent services from across the UK. Therefore, you and your responses **will not** be identifiable in the results.

If you would like a copy of the summary of the final study results personally, please contact Bethany Camp to request this (bethany.camp@liverpool.ac.uk).

A summary of the final study results will be fed back to the homelessness organisations involved in recruitment. Again, employers will not be able to identify you, or your responses.

What will happen if I want to stop taking part?

You can withdraw your participation in the study at any time by exiting the browser. There are no consequences if you choose to withdraw from the study.

If you withdraw before completing all the questionnaires, your responses will not be saved. However, once you have completed the questionnaires, your data will be unable to be withdrawn due to your responses being anonymous. However, incomplete data will not be used in the analysis. If you choose to stop the study, it will be classified as incomplete. Only the completed questionnaires will receive reimbursement. Please only proceed if you are comfortable with answering questions on the topics described.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please let us know by contacting Dr Stephen Weatherhead (ste@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@liv.ac.uk. When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to make a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Who can I contact if I have further questions?

For any further questions, please contact:

Bethany Camp
Trainee Clinical Psychologist
University of Liverpool
Eleanor Rathbone Building
Bedford Street South
Liverpool
L69 7ZA
Email: bethany.camp@liverpool.ac.uk

Dr Stephen Weatherhead
Consultant Clinical Psychologist and
Senior Lecturer in Clinical Psychology
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Institute of Population Health
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Dr Anam Elahi
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Institute of Population Health
Eleanor Rathbone Building
Bedford Street South
Liverpool
L69 7ZA
Email: anam.elahi@liverpool.ac.uk

Appendix G: Informed Consent Sheet

Title: Exploring the Professional Quality of Life of Frontline Workers within Homelessness.
Name of Researchers: Bethany Camp, Dr Stephen Weatherhead, and Dr Anam Elahi.
Name of Research Project Advisors: Jacqui Regan, Dr Colm Gallagher, and Dr Nick Maguire.

Please check box

1. I confirm that I have read and understood the Participant Information Sheet dated 21/07/2022 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand all my responses will be anonymised and I will not be identifiable. ☐
3. I understand that if I do not meet the inclusion criteria stated on the Participant Information Sheet, dated 21/07/2022, version 1, I will be unable to participate in the study. ☐
4. I understand that taking part in the study takes about 15-20 minutes and involves completing questionnaires, including one related to adverse childhood experiences (including abuse and neglect), which could cause emotional distress. ☐
5. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without consequence. Should I withdraw before completing all the questionnaires, the information I provide will not be stored. I understand that following completion of questionnaires I will no longer be able to request access to or withdrawal of the information I provide. ☐
6. I understand that the information I provide will be retained in Liverpool University's secure data storage facilities, accessed only by the research team until September 2023, where it will be archived for a minimum of 10 years then securely destroyed. My information will not be used in any other research projects. ☐
7. I agree to take part in the above study. ☐

Principal Investigator
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Appendix H: Debrief Information

Title: Exploring the Professional Quality of Life of Frontline Workers within Homelessness.

Thank you for taking part in the study.

Your responses have now been recorded and you are unable to withdraw them.

What was the purpose of the study?

The study aims to explore what might impact upon (or predict) the Professional Quality of Life of frontline workers within homelessness. The study specifically measured aspects of organisational support, reflective practice, and adverse childhood experiences (including abuse and neglect) to explore whether they might predict the Professional Quality of Life of frontline workers within homelessness. It is anticipated that the research outcomes of this study will contribute to improving the current understanding of the needs and support available for people working within the homelessness support sector.

What should I do if I feel distressed?

It can be normal to feel some distress following the report of adverse childhood experiences (including abuse and neglect).

If you would like support with any potential distress you experience, you may find it beneficial to speak with someone you trust and feel comfortable with, such as a close family member or friend.

You can contact your GP for help. They can direct you to local services which can offer talking therapies and emotional support.

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Website: https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/non-recent-abuse/

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You can seek support with recovery from childhood abuse of all types including physical, sexual, emotional abuse or neglect.
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If you are currently experiencing abuse, you can contact the police on 101 or 999 to report this. For additional support please see the website below for contact details:
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What will happen to the results of the study?
The results of the study will be written up as part of a Doctorate in Clinical Psychology (a qualification that allows someone to practice as a Clinical Psychologist) and will be published in a peer reviewed journal (where research is published and can be accessed) interested in the homelessness support sector. We also hope to disseminate the results of the study via a conference.

Individual responses will be combined into a large dataset which will represent services from across the UK. Therefore, you and your responses **will not** be identifiable in the results.

If you would like a copy of the summary of the final study results personally, please contact Bethany Camp to request this (bethany.camp@liverpool.ac.uk). A summary of the final study results will be fed back to the homelessness organisations involved in recruitment. Again, employers will not be able to identify you, or your responses.

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Reimbursement

If you would like to be entered into a draw to win one of the ten £25 One4all vouchers available, for participation, please continue to the next page of the questionnaire and copy and paste the link to enter your email address. This ensures that your email address is kept separately from your participant responses.

Appendix I: Demographic and Employment Questionnaire List

1. Age
2. Gender
3. Ethnicity
4. Sexual orientation
5. Area of workplace
6. Current working status (paid employment or volunteering)
7. Perceptions on adequate pay
8. Length of time working in face-to-face roles
9. Length of time working in current role
10. Length of time working in homelessness
11. Job category
12. Employment benefits and support
13. Training and professional development opportunities
14. Lived experience of homelessness

Appendix J: Professional Quality of Life Questionnaire

2. Professional Quality of Life:

When you support people, you have direct contact with their lives. As you may have found, your compassion for those you support can affect you in many ways. Below are some questions about your experiences, both positive and difficult, as a Frontline Worker within Homelessness.

Consider each of the following questions about you and your current work situation.

Please select the number that honestly reflects how frequently you experienced these things in the last 30 days.

	1 Never	2 Rarely	3 Sometimes	4 Often	5 Very Often
1. I think that I might have been affected by the traumatic stress of those I support					
2. I feel trapped by my job as a Frontline Worker within Homelessness					
3. I like my work as a Frontline Worker within Homelessness					
4. I feel depressed because of the traumatic experiences of the people I support					
5. My work makes me feel satisfied					
6. I feel worn out because of my work as a Frontline Worker within Homelessness					
7. I feel overwhelmed because my workload seems endless					
8. As a result of my support, I have intrusive, frightening thoughts					
9. I am happy that I chose to do this work					

Appendix K: Adverse Childhood Experiences Checklist

5. Adverse Childhood Experiences:

Below is a list of adverse experiences that many people can encounter throughout their childhood and adolescent years. These difficult experiences are very common and can continue to have an impact on health and wellbeing within adulthood. It is therefore important for organisations to be aware of this to best support the health and wellbeing of the people they employ.

Please select either 'Yes', 'No', or 'Prefer not to answer' for each of the ten experience categories below.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often …

- Swear at you, insult you, put you down, or humiliate you?

and/or

- Act in a way that made you afraid that you might be physically hurt?

- o Yes
- o No
- o Prefer not to answer

2. Did a parent or other adult in the household often or very often …

- Push, grab, slap, or throw something at you?

and/or

- Ever hit you so hard that you had marks or were injured?

- o Yes
- o No
- o Prefer not to answer

3. Did an adult or person at least 5 years older than you ever …

- Touch or fondle you or have you touch their body in a sexual way?

and/or

- Attempt or actually have oral, anal, or vaginal penetration or intercourse with you?

- o Yes
- o No
- o Prefer not to answer

4. Did you often or very often feel that …

- No one in your family loved you or thought you were important or special?

and/or

- Your family didn't look out for each other, feel close to each other, or support each other?

- Yes
- No
- Prefer not to answer

5. Did you often or very often feel that …

- You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

and/or

- Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

- Yes
- No
- Prefer not to answer

6. Were your parents ever separated or divorced?

and/or

Did you lose a parent through abandonment, death, or another reason?

- Yes
- No
- Prefer not to answer

7. Was your parent(s) or other adults[1] within the household:

Often or very often pushed, grabbed, slapped, or had something thrown at them?

and/or

Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

and/or

Ever repeatedly hit for at least a few minutes or threatened with a gun or knife?

[1] The language in question 7 has been changed from 'mother or step-mother' to 'parent(s) or other adults' as in the ACE questionnaire found here: https://www.acesaware.org/wp-content/uploads/2022/07/ACE-Questionnaire-for-Adults-Identified-English-rev.7.26.22.pdf. This is to reflect the experiences of a wider sample of the general population.

- Yes
- No
- Prefer not to answer

8. Did you live with anyone who experienced problems with drinking or using drugs, including prescription drugs?

- Yes
- No
- Prefer not to answer

9. Did you live with anyone who experienced difficulties with their mental health[1] or attempted suicide?

- Yes
- No
- Prefer not to answer

10. Did a household member go to prison?

- Yes
- No
- Prefer not to answer

[1] The language in question 9 has been changed from 'depressed or mentally ill' to 'experienced difficulties with their mental health'. This is to remain sensitive to participant experience and reduce the risks associated with stigmatising language.

Appendix L: Perceived Organisational Support Scale

3. Perceived Organisational Support Scale:

Listed below are statements that represent possible opinions that you may have about working within the organisation for which you work. *Please indicate the degree of your agreement or disagreement with each statement that best represents your point of view.*

	0 Strongly Disagree	1 Moderately Disagree	2 Slightly Disagree	3 Neither Agree nor Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree
1. The organisation values my contribution							
2. The organisation fails to appreciate any extra effort from me (R)							
3. The organisation would ignore any complaint from me (R)							
4. The organisation really cares about my wellbeing							
5. Even if I did the best job possible, the organisation would fail to notice (R)							
6. The organisation cares about my general satisfaction at work							
7. The organisation shows very little concern for me (R)							
8. The organisation takes pride in my accomplishments at work							

Appendix M: Self-Reflection and Insight Scale (SRIS)

5.1. Self-Reflection and Insight

Listed below are some statements relating to self-reflection.

Please indicate the degree of your agreement or disagreement with each statement that best represents your point of view.

There are no 'wrong' or 'right' answers – only your own personal perspective.

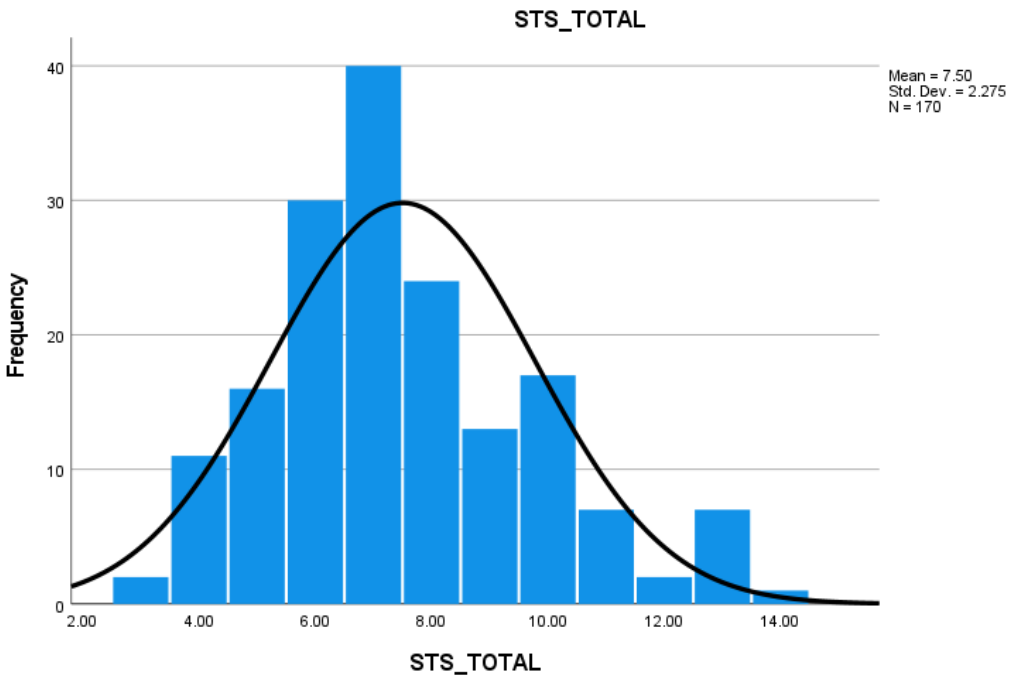
	0 Strongly Disagree	1 Moderately Disagree	2 Slightly Disagree	3 Neither Agree nor Disagree	4 Slightly Agree	5 Moderately Agree	6 Strongly Agree
1. I frequently examine my feelings							
2. I frequently take time to reflect on my thoughts							
3. I often think about the way I feel about things							
4. It is important to me to evaluate the things that I do							
5. I am very interested in examining what I think about							
6. It is important to me to try to understand what my feelings mean							
7. I'm often confused about the way that I really feel about things (R)							
8. I'm often aware that I'm having a feeling, but I often don't quite know what it is (R)							
9. My behaviour often puzzles me (R)							
10. Thinking about my thoughts makes me more confused (R)							
11. Often, I find it difficult to make sense of the way I feel about things (R)							
12. I usually know why I feel the way I do							

Appendix N: Normality Statistics and Histograms

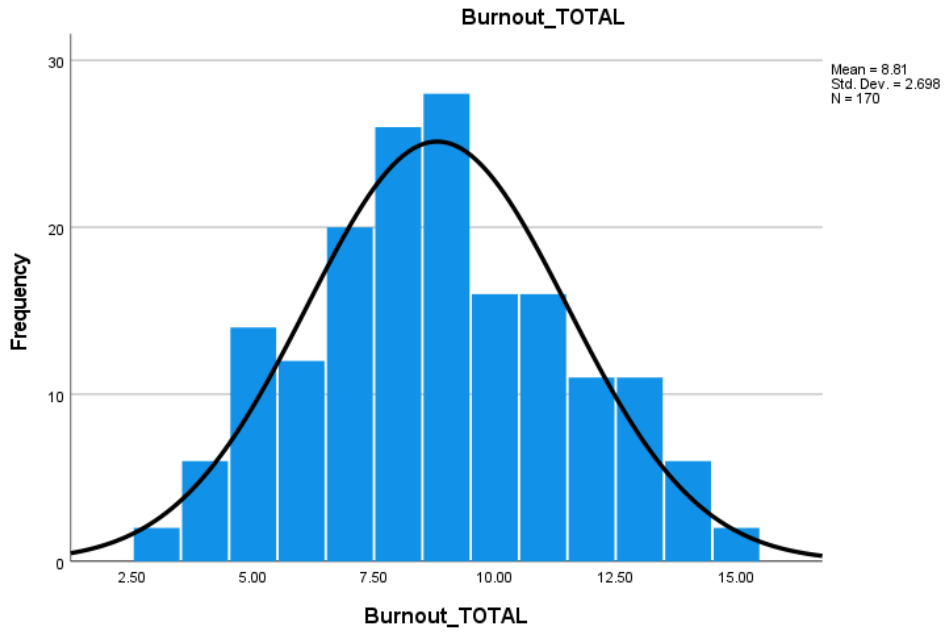
Table of Normality Statistics

	Shapiro Wilk		Skewness		Kurtosis	
Variable	Statistic	Sig.	Statistic	Std. Error	Statistic	Std. Error
ProQOL STS Total	.949	< .001	.623	.186	.161	.370
ProQOL Burnout Total	.977	.008	.139	.186	-.552	.370
ProQOL CS Total	.938	< .001	-.335	.186	-.793	.370
ACE Total	.920	< .001	.463	.186	-.786	.370
POS Total	.965	< .001	-.374	.186	-.632	.370
SRI Total	.985	.069	-.275	.187	-.160	.373

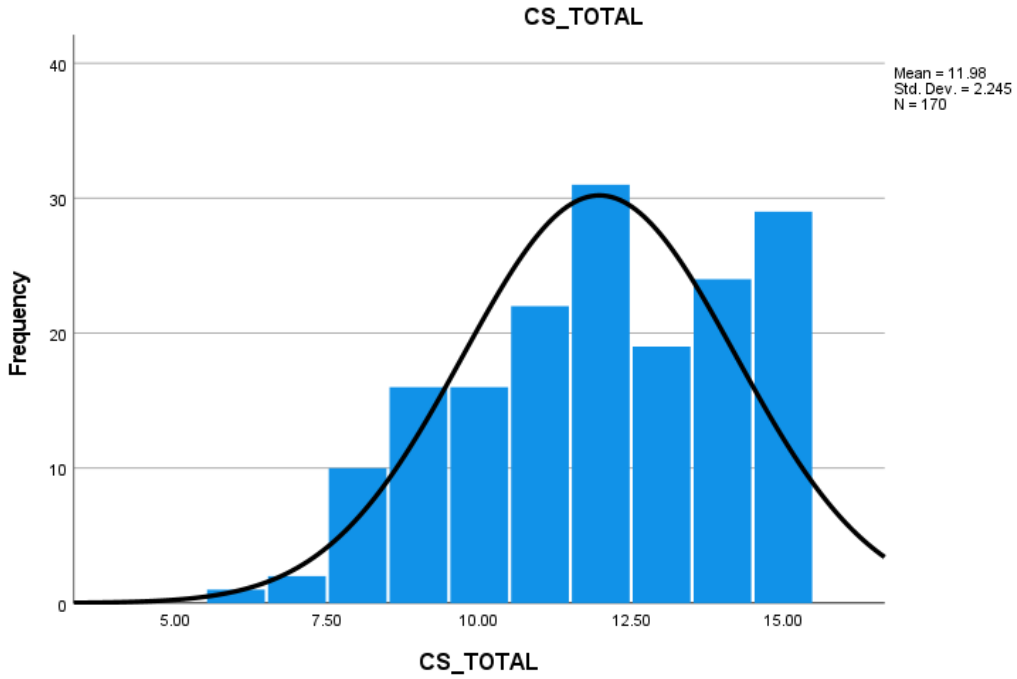
Professional Quality of Life Scale, Secondary Traumatic Stress Score Histogram



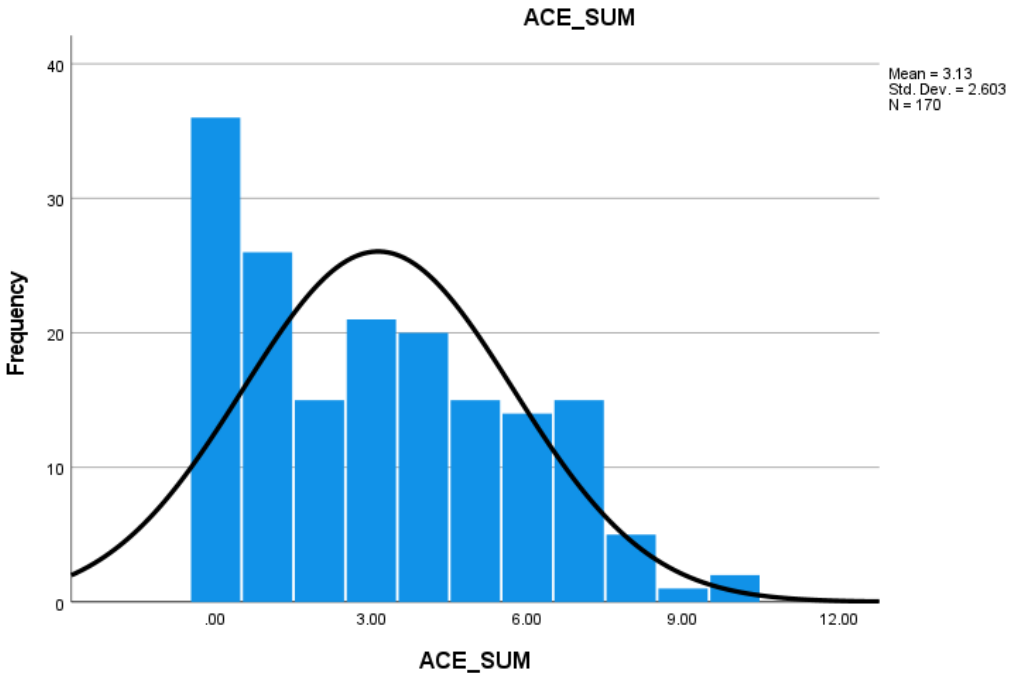
Professional Quality of Life Scale, Burnout Score Histogram



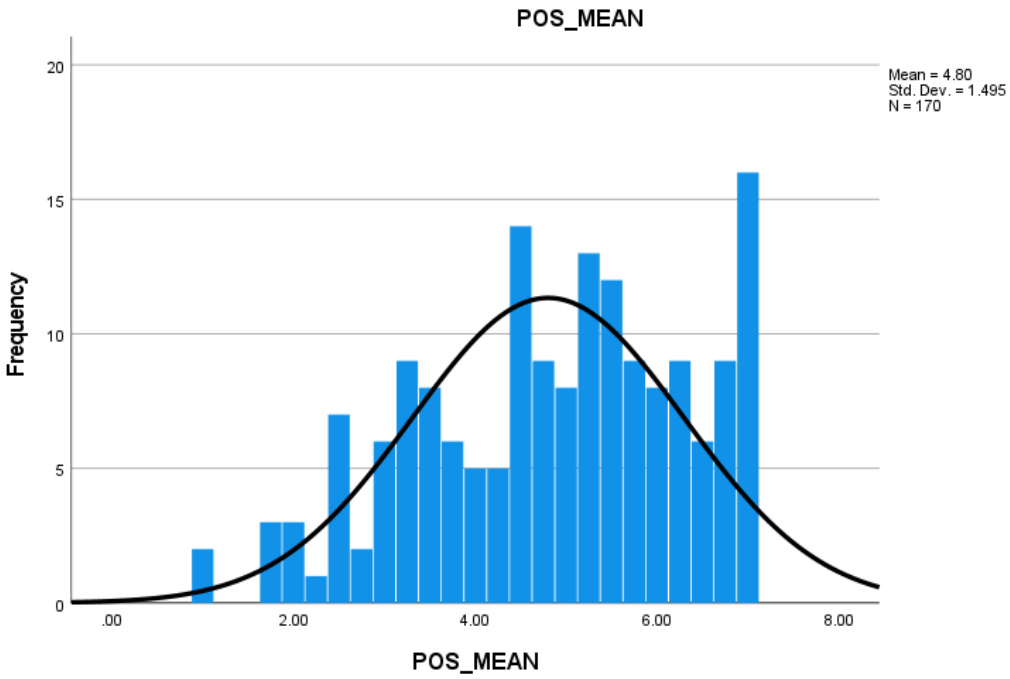
Professional Quality of Life Scale, Compassion Satisfaction Score Histogram



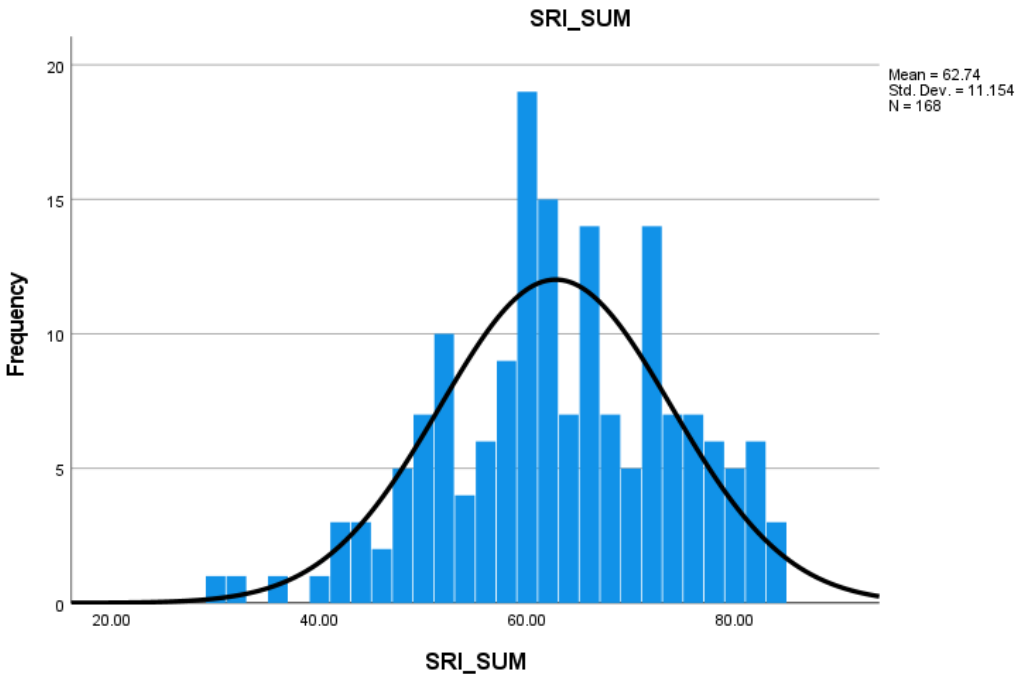
Adverse Childhood Experiences Questionnaire Score Histogram



Perceived Organisational Support Scale Score Histogram



Self-Reflection and Insight Scale Score Histogram



Appendix O: Full Regression Models

1. *Compassion Satisfaction*

Model Summary[e]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.482[a]	.232	.184	2.02805	.232	4.813	10	159	<.001
2	.643[b]	.413	.373	1.77833	.181	48.789	1	158	<.001
3	.673[c]	.453	.411	1.72250	.040	11.408	1	157	<.001
4	.673[d]	.453	.408	1.72794	.000	.014	1	156	.907

a. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age

b. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN

c. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN, SRI_SUM

d. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN, SRI_SUM, ACE_SUM

e. Dependent Variable: CS_TOTAL

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	13.268	1.591		8.337	<.001		
	Age	.287	.150	.154	1.907	.058	.745	1.343
	Ethnicity_recoded	-.667	.494	-.096	-1.351	.179	.956	1.046
	SexOrien_Recoded	.264	.377	.050	.700	.485	.932	1.073
	If paid employment, do you feel you get paid adequately for the work you do?	-.063	.339	-.014	-.187	.852	.850	1.176
	LengthHomeless_Recode	.173	.365	.039	.474	.636	.731	1.368
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.511	.335	.114	1.526	.129	.864	1.157
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	-.508	.332	-.113	-1.528	.129	.876	1.142
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.222	.333	.050	.668	.505	.876	1.142
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	-1.981	.370	-.414	-5.351	<.001	.806	1.240
	Do you receive ongoing training?	-.278	.567	-.037	-.491	.624	.836	1.197
2	(Constant)	9.064	1.520		5.964	<.001		
	Age	.068	.136	.036	.498	.619	.705	1.419
	Ethnicity_recoded	-.825	.434	-.119	-1.902	.059	.953	1.049
	SexOrien_Recoded	.139	.331	.026	.419	.676	.929	1.077
	If paid employment, do you feel you get paid adequately for the work you do?	-.076	.298	-.017	-.254	.800	.850	1.176
	LengthHomeless_Recode	.505	.324	.112	1.559	.121	.715	1.398
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.156	.298	.035	.523	.602	.839	1.192
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	-.703	.293	-.157	-2.401	.018	.868	1.152
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	-.174	.297	-.039	-.584	.560	.844	1.185
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	-.739	.370	-.154	-1.995	.048	.620	1.613
	Do you receive ongoing training?	-.075	.498	-.010	-.150	.881	.833	1.201
	POS_MEAN	.823	.118	.548	6.985	<.001	.603	1.658

3	(Constant)	6.593	1.644		4.011	<.001		
	Age	-.047	.136	-.025	-.345	.731	.661	1.513
	Ethnicity_recoded	-.803	.420	-.116	-1.912	.058	.953	1.049
	SexOrien_Recoded	.206	.321	.039	.641	.522	.925	1.081
	If paid employment, do you feel you get paid adequately for the work you do?	.021	.290	.005	.072	.942	.842	1.188
	LengthHomeless_Recode	.711	.320	.158	2.223	.028	.689	1.451
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.181	.289	.040	.626	.532	.839	1.192
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	-.627	.285	-.140	-2.203	.029	.863	1.159
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	-.350	.293	-.078	-1.195	.234	.817	1.224
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	-.818	.359	-.171	-2.275	.024	.618	1.619
	Do you receive ongoing training?	-.019	.483	-.003	-.040	.968	.832	1.202
	POS_MEAN	.756	.116	.504	6.535	<.001	.586	1.707
	SRI_SUM	.044	.013	.218	3.378	<.001	.837	1.195
4	(Constant)	6.605	1.652		3.997	<.001		
	Age	-.046	.136	-.025	-.338	.736	.659	1.516
	Ethnicity_recoded	-.803	.421	-.116	-1.907	.058	.953	1.049
	SexOrien_Recoded	.213	.328	.041	.650	.517	.895	1.118
	If paid employment, do you feel you get paid adequately for the work you do?	.024	.292	.005	.081	.935	.836	1.196
	LengthHomeless_Recode	.714	.322	.159	2.219	.028	.685	1.460
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.168	.309	.038	.546	.586	.739	1.353
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	-.618	.294	-.138	-2.101	.037	.811	1.233
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	-.354	.296	-.079	-1.197	.233	.803	1.245
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	-.814	.362	-.170	-2.251	.026	.613	1.630
	Do you receive ongoing training?	-.018	.484	-.002	-.037	.970	.831	1.203
	POS_MEAN	.757	.116	.504	6.515	<.001	.586	1.708
	SRI_SUM	.044	.013	.218	3.365	<.001	.837	1.195
	ACE_SUM	-.007	.059	-.008	-.117	.907	.743	1.346

a. Dependent Variable: CS_TOTAL

2. *Burnout*

Model Summary[e]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.480[a]	.230	.182	2.44066	.230	4.759	10	159	<.001
2	.599[b]	.359	.314	2.23502	.128	31.606	1	158	<.001
3	.600[c]	.360	.311	2.24007	.001	.287	1	157	.593
4	.601[d]	.361	.308	2.24530	.001	.270	1	156	.604

a. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age

b. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN

c. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN, SRI_SUM

d. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN, SRI_SUM, ACE_SUM

e. Dependent Variable: Burnout_TOTAL

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	7.037	1.915		3.674	<.001		
	Age	-.693	.181	-.309	-3.828	<.001	.745	1.343
	Ethnicity_recoded	-.423	.594	-.051	-.712	.478	.956	1.046
	SexOrien_Recoded	.435	.453	.069	.959	.339	.932	1.073
	If paid employment, do you feel you get paid adequately for the work you do?	.152	.409	.028	.373	.710	.850	1.176
	LengthHomeless_Recode	.771	.440	.143	1.752	.082	.731	1.368
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	-.064	.403	-.012	-.158	.875	.864	1.157
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.568	.400	.106	1.419	.158	.876	1.142
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	-.229	.400	-.043	-.572	.568	.876	1.142
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	1.980	.446	.344	4.442	<.001	.806	1.240
	Do you receive ongoing training?	.544	.683	.061	.797	.427	.836	1.197
2	(Constant)	11.290	1.910		5.911	<.001		
	Age	-.471	.170	-.210	-2.765	.006	.705	1.419
	Ethnicity_recoded	-.264	.545	-.032	-.484	.629	.953	1.049
	SexOrien_Recoded	.561	.416	.089	1.350	.179	.929	1.077
	If paid employment, do you feel you get paid adequately for the work you do?	.165	.374	.030	.440	.661	.850	1.176
	LengthHomeless_Recode	.435	.407	.080	1.069	.287	.715	1.398
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.296	.375	.055	.790	.431	.839	1.192
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.765	.368	.142	2.080	.039	.868	1.152
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.172	.373	.032	.459	.647	.844	1.185
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	.723	.465	.126	1.553	.122	.620	1.613
	Do you receive ongoing training?	.338	.626	.038	.540	.590	.833	1.201
	POS_MEAN	-.832	.148	-.461	-5.622	<.001	.603	1.658

3	(Constant)	11.800	2.138		5.520	<.001		
	Age	-.448	.176	-.199	-2.538	.012	.661	1.513
	Ethnicity_recoded	-.268	.546	-.032	-.491	.624	.953	1.049
	SexOrien_Recoded	.548	.418	.087	1.311	.192	.925	1.081
	If paid employment, do you feel you get paid adequately for the work you do?	.145	.377	.027	.384	.702	.842	1.188
	LengthHomeless_Recode	.393	.416	.073	.944	.346	.689	1.451
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.291	.376	.054	.774	.440	.839	1.192
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.750	.370	.139	2.026	.044	.863	1.159
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.208	.380	.039	.546	.586	.817	1.224
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	.739	.467	.128	1.581	.116	.618	1.619
	Do you receive ongoing training?	.327	.628	.036	.520	.604	.832	1.202
	POS_MEAN	-.818	.151	-.454	-5.437	<.001	.586	1.707
	SRI_SUM	-.009	.017	-.037	-.536	.593	.837	1.195
4	(Constant)	11.871	2.147		5.529	<.001		
	Age	-.443	.177	-.197	-2.505	.013	.659	1.516
	Ethnicity_recoded	-.270	.547	-.032	-.494	.622	.953	1.049
	SexOrien_Recoded	.588	.426	.093	1.381	.169	.895	1.118
	If paid employment, do you feel you get paid adequately for the work you do?	.161	.379	.030	.424	.672	.836	1.196
	LengthHomeless_Recode	.409	.418	.076	.980	.329	.685	1.460
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	.219	.401	.041	.546	.586	.739	1.353
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.798	.383	.148	2.087	.039	.811	1.233
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.182	.385	.034	.473	.637	.803	1.245
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	.759	.470	.132	1.614	.109	.613	1.630
	Do you receive ongoing training?	.333	.630	.037	.529	.598	.831	1.203
	POS_MEAN	-.816	.151	-.452	-5.409	<.001	.586	1.708
	SRI_SUM	-.009	.017	-.038	-.541	.589	.837	1.195
	ACE_SUM	-.040	.077	-.039	-.519	.604	.743	1.346

a. Dependent Variable: Burnout_TOTAL

3. *Secondary Traumatic Stress*

Model Summary[e]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.373[a]	.139	.085	2.17638	.139	2.562	10	159	.007
2	.416[b]	.173	.115	2.13960	.034	6.514	1	158	.012
3	.416[c]	.173	.110	2.14638	.000	.004	1	157	.952
4	.417[d]	.174	.105	2.15231	.001	.136	1	156	.713

a. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age

b. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN

c. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN, SRI_SUM

d. Predictors: (Constant), Do you receive ongoing training?, Ethnicity_recoded, SexOrien_Recoded, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision, LengthHomeless_Recode, If paid employment, do you feel you get paid adequately for the work you do?, Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?, Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing, Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?, Age, POS_MEAN, SRI_SUM, ACE_SUM

e. Dependent Variable: STS_TOTAL

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	4.455	1.708		2.608	.010		
	Age	-.222	.161	-.117	-1.375	.171	.745	1.343
	Ethnicity_recoded	.208	.530	.030	.393	.695	.956	1.046
	SexOrien_Recoded	.058	.404	.011	.143	.887	.932	1.073
	If paid employment, do you feel you get paid adequately for the work you do?	.428	.364	.094	1.174	.242	.850	1.176
	LengthHomeless_Recode	.138	.392	.030	.353	.725	.731	1.368
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	-.330	.359	-.073	-.919	.359	.864	1.157
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.263	.357	.058	.736	.463	.876	1.142
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.579	.357	.128	1.622	.107	.876	1.142
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	1.072	.397	.221	2.698	.008	.806	1.240
	Do you receive ongoing training?	1.391	.609	.184	2.285	.024	.836	1.197
2	(Constant)	6.303	1.828		3.447	<.001		
	Age	-.126	.163	-.066	-.769	.443	.705	1.419
	Ethnicity_recoded	.278	.522	.039	.532	.595	.953	1.049
	SexOrien_Recoded	.113	.398	.021	.283	.777	.929	1.077
	If paid employment, do you feel you get paid adequately for the work you do?	.433	.358	.095	1.209	.229	.850	1.176
	LengthHomeless_Recode	-.008	.390	-.002	-.019	.985	.715	1.398
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	-.174	.359	-.038	-.486	.628	.839	1.192
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.348	.352	.077	.989	.324	.868	1.152
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.753	.358	.166	2.106	.037	.844	1.185
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	.526	.445	.108	1.180	.240	.620	1.613
	Do you receive ongoing training?	1.302	.599	.172	2.172	.031	.833	1.201
	POS_MEAN	-.362	.142	-.238	-2.552	.012	.603	1.658

3	(Constant)	6.248	2.048		3.050	.003		
	Age	-.128	.169	-.068	-.758	.450	.661	1.513
	Ethnicity_recoded	.278	.523	.040	.531	.596	.953	1.049
	SexOrien_Recoded	.114	.400	.022	.286	.776	.925	1.081
	If paid employment, do you feel you get paid adequately for the work you do?	.435	.361	.095	1.205	.230	.842	1.188
	LengthHomeless_Recode	-.003	.398	-.001	-.007	.994	.689	1.451
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	-.174	.360	-.038	-.482	.630	.839	1.192
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.350	.355	.077	.987	.325	.863	1.159
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.749	.364	.165	2.055	.042	.817	1.224
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	.524	.448	.108	1.170	.244	.618	1.619
	Do you receive ongoing training?	1.303	.602	.172	2.165	.032	.832	1.202
	POS_MEAN	-.363	.144	-.239	-2.518	.013	.586	1.707
	SRI_SUM	.001	.016	.005	.060	.952	.837	1.195
4	(Constant)	6.199	2.058		3.012	.003		
	Age	-.131	.170	-.069	-.772	.441	.659	1.516
	Ethnicity_recoded	.280	.525	.040	.533	.595	.953	1.049
	SexOrien_Recoded	.087	.408	.016	.213	.831	.895	1.118
	If paid employment, do you feel you get paid adequately for the work you do?	.424	.363	.093	1.168	.245	.836	1.196
	LengthHomeless_Recode	-.014	.401	-.003	-.036	.971	.685	1.460
	Have you had any personal experiences of homelessness (e.g., experienced homelessness yourself, or had someone close to you experience homelessness)?	-.125	.384	-.028	-.325	.746	.739	1.353
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Clinical supervision	.317	.367	.070	.865	.389	.811	1.233
	Does the organisation for which you work offer any of the following to support your emotional wellbeing? - Selected Choice Debriefing	.767	.369	.169	2.080	.039	.803	1.245
	Do you feel you receive adequate training and/or professional development opportunities to effectively do your job?	.510	.451	.105	1.133	.259	.613	1.630
	Do you receive ongoing training?	1.298	.603	.172	2.152	.033	.831	1.203
	POS_MEAN	-.365	.145	-.240	-2.520	.013	.586	1.708
	SRI_SUM	.001	.016	.005	.064	.949	.837	1.195
	ACE_SUM	.027	.074	.031	.368	.713	.743	1.346

a. Dependent Variable: STS_TOTAL

Appendix P: Post-hoc Reflective Practice Analysis

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means							
						Significance		Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
		F	Sig.	t	df	One-Sided p	Two-Sided p			Lower	Upper
STS_TOTAL	Equal variances assumed	3.361	.069	-1.525	126	.065	.130	-.85492	.56059	-1.96430	.25446
	Equal variances not assumed			-1.274	24.783	.107	.215	-.85492	.67128	-2.23807	.52823
Burnout_TOTAL	Equal variances assumed	2.025	.157	-2.321	126	.011	.022	-1.46061	.62923	-2.70585	-.21538
	Equal variances not assumed			-1.993	25.223	.029	.057	-1.46061	.73286	-2.96929	.04806
CS_TOTAL	Equal variances assumed	.050	.823	2.130	126	.018	.035	1.12995	.53054	.08003	2.17987
	Equal variances not assumed			2.079	27.798	.024	.047	1.12995	.54362	.01603	2.24388

Correlations

			On average, how often do you attend reflective practice?	STS_TOTAL	Burnout_TOTAL	CS_TOTAL
Spearman's rho	On average, how often do you attend reflective practice?	Correlation Coefficient	1.000	-.043	.012	.118
		Sig. (2-tailed)	.	.635	.897	.189
		N	126	126	126	126
	STS_TOTAL	Correlation Coefficient	-.043	1.000	.597**	-.424**
		Sig. (2-tailed)	.635	.	<.001	<.001
		N	126	170	170	170
	Burnout_TOTAL	Correlation Coefficient	.012	.597**	1.000	-.624**
		Sig. (2-tailed)	.897	<.001	.	<.001
		N	126	170	170	170
	CS_TOTAL	Correlation Coefficient	.118	-.424**	-.624**	1.000
		Sig. (2-tailed)	.189	<.001	<.001	.
		N	126	170	170	170

**. Correlation is significant at the 0.01 level (2-tailed).

Appendix Q: Author guidelines for relevant journals

Trauma, Violence, & Abuse https://journals.sagepub.com/author-instructions/tva

Manuscript Submission Guidelines:
TVA accepts comprehensive reviews of research or legal reviews that address any aspect of trauma, violence or abuse. Reviews must be based on a sufficient number of studies to justify synthesis. Reviewed literatures may come from the social or behavioral sciences or the law.

Each manuscript must:

- be prepared using APA style, and be **no longer than 40 double-spaced pages,** including references, tables, and figures;
- include an abstract of up to 250 words describing the topic of review, method of review, number of research studies meeting the criteria for review, criteria for inclusion, how research studies were identified, and major findings;
- begin with a clear description of the knowledge area that is being researched or reviewed and its relevance to understanding or dealing with trauma, violence, or abuse;
- provide a clear discussion of the limits of the knowledge that has been reviewed;
- include two summary tables: one of critical findings and the other listing implications of the review for practice, policy, and research;
- include a discussion of diversity as it applies to the reviewed research.*****

Manuscript Preparation

Manuscripts should be prepared using the APA Style Guide, and should be no longer than **40 double-spaced pages, including references, tables, and figures**. Text must be in 12-point Times New Roman font. Block quotes may be single-spaced. Manuscripts must include margins of 1 inch on all sides and pages must be numbered sequentially. All files should be in Word (.docx or .doc).

The manuscript should include five major sections (in this order): Title Page, Abstract, Main Body (blinded, with all author names and identifying information removed for peer review), References, and Author Biographies.

Sections in a manuscript may include the following (in this order): (1) Title page, (2) Abstract, (3) Keywords, (4) Text, (5) Notes, (6) References, (7) Tables, (8) Figures, (9) Appendices, and (10) Author Biographies.

1. Title page must be uploaded as a separate file. Please include the following:

Full article title

Acknowledgments and credits

Each author's complete name and institutional affiliation(s)

Grant numbers and/or funding information

Conflict of interests, if any

Corresponding author (name, address, phone/fax, e-mail)

2. Abstract. Copy and paste the abstract (150 to 250 words) into the space provided, headed by the full article title. Omit author names. Abstract must describe the topic of the review, method of review, number of research studies meeting the criteria for review, criteria for inclusion, how research studies were identified, and major findings.

3. Keywords. 5-7 keywords must be included in the manuscript.

4. Text. Begin text headed by the full article title. Text must be blinded, with all author names and other identifying information removed, for peer review.

a. Headings and Subheadings. Subheadings should indicate the organization of the content of the manuscript. Generally, three heading levels are sufficient to organize text.

Level 1: centered, boldface, upper & lowercase

Level 2: flush left, boldface, upper & lowercase

Level 3: indented, boldface, lowercase paragraph heading ending with a period

Level 4: indented, boldface, italicized, lowercase paragraph heading ending with a period

Level 5: indented, italicized, lowercase paragraph heading ending with a period

b. Citations. For each text citation there must be a corresponding citation in the reference list and for each reference list citation there must be a corresponding text citation. Each corresponding citation must have identical spelling and year. Each text citation must include at least two pieces of information: author(s) and year of publication. Following are some examples of text citations:

(i) Unknown Author: To cite works that do not have an author, cite the source by its title in the signal phrase or use the first word or two in the parentheses. For example, “The findings are based on the study of students learning to format research papers” ("Using XXX," 2001)

(ii) Authors with the Same Last Name: Use first initials with the last names to prevent confusion. For example, “L. Hughes, 2001; P. Hughes, 1998.”

(iii) Two or More Works by the Same Author in the Same Year: For two sources by the same author in the same year, use lowercase letters (a, b, c) with the year to order

the entries in the reference list. The lower-case letters should follow the year in the in-text citation. For example, “Research by Freud (1981a) illustrated that…”

(iv) Personal Communication: For letters, e-mails, interviews, and other person-to-person communication, citation should include the communicator's name, the fact that it was personal communication, and the date of the communication. For example, E. Clark, personal communication, January 4, 2009. Do not include personal communication in the reference list.

(v) Unknown Author and Unknown Date: For citations with no author or date, use the title in the signal phrase or the first word or two of the title in the parentheses and use the abbreviation "n.d." (for "no date"). For example, “The study conducted by the students and research division discovered that students succeeded with tutoring” (Tutoring and APA, n.d.).

5. Notes. If explanatory notes are required for your manuscript, insert a number formatted in superscript following almost any punctuation mark. Footnote numbers should not follow dashes (—), and if they appear in a sentence in parentheses, the footnote number should be inserted within the parentheses. The footnotes should be added at the bottom of the page after the references. The word “Footnotes” should be centered at the top of the page.

6. References. Basic rules for the reference list:

- The reference list should be arranged in alphabetical order according to the authors’ last names.
- If there is more than one work by the same author, order them according to their publication date – oldest to newest (therefore a 2008 publication would appear before a 2009 publication).
- When listing multiple authors of a source use “&” instead of “and.”
- Capitalize only the first word of the title and of the subtitle, if there is one, and any proper names – i.e., only those words that are normally capitalized.
- Italicize the title of the book, the title of the journal/serial and the title of the web document.
- Manuscripts submitted to TVA should strictly follow the current APA style guide.
- Every citation in text must have the detailed reference in the Reference section.
- Every reference listed in the Reference section must be cited in text.
- Do not use “et al.” in the Reference list at the end; names of all authors of a publication should be listed there.

Sage Journal Workplace Health and Safety

https://journals.sagepub.com/author-instructions/WHS

2500 – 4500 words.

Professional practice articles should include the following designated sections:

Abstract: This should be structured with the following subheadings: Background, Methods, Findings, Conclusions/Application to Practice. Please include the abstract in the body of the manuscript, in addition to providing it in the ScholarOne system (the online manuscript submission portal).

Background: Provide the reader with what is currently known about the topic. State the problem/gap in practice with supporting literature/research as a basis for the project. Relevance to occupational and environmental should be stated. The purpose statement should be made at the end of the Background section. Use updated references and avoid references which were published more than five years ago.

Methods: Explain to the reader the specifics of the professional practice innovation, with attention to the assessment, plan and execution of the project as it was implemented in the occupational health setting. This should include the methods employed for performance/outcome innovation. We suggest ordering this section as follows: an overview description of the project/initiative; a description of the intervention/program; a description of the worker population involved and how they were invited or included; a description of the data collected and how it was collected; and how the data were analyzed.

Results: Describe measurable outcome indicators such as the impact on health and/or economic costs. Explain what was learned or recognized in relation to this professional practice topic. Describe the generalizability that this professional practice holds and what benefits it affords to occupational and environmental nursing and the workplace. Quotes may be used and must be structured (varies based on number of words) and referenced according to the APA Guidelines; https://blog.apastyle.org/apastyle/direct-quotations/

Discussion: This section should discuss the more relevant findings. Describe strengths and limitations of this professional practice, and include implications for additional opportunities for innovation.

Insert Box titled "Applications to Professional Practice": This includes a 150-word summary of the professional practice innovation as it applies to occupational health and environmental nursing practice. This is different from the Abstract and does not include sub-headings. The Insert/Box is a very brief narrative description of the project.

Appendix R: Interactive Summary of Qualitative Findings Table

Exploring the Experiences of Trauma of People Working in Homelessness: Mixed Methods Systematic Review

Summary of Qualitative Findings Table

Review question
What are the trauma experiences of the homelessness support sector?

Authors of the review
Bethany Camp, Dr Ste Weatherhead, Dr Anam Elahi and Dr Ahmed Waqas

#	Summarised review finding	GRADE-CERQual Assessment of confidence	Explanation of GRADE-CERQual Assessment	References
		A. EVENTS		
1	Eight papers discussed circumstances where participants witnessed or were responsible for responding to the death of the people experiencing homelessness for whom they care.	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and Minor concerns regarding relevance	Kerman & A. 2022b; Levesque & C. 2021; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Valoroso 2020; Campbell & R. 2022; Webb 2015;
2	Encountering 'critical incidents' including violence, abuse, substance misuse, self-harm, and health complications were emphasised within 11 studies.	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Peters & W. 2021a; Aykanian 2018; Kerman & A. 2022b; Levesque & C. 2021; Theodorou 2021; Petrovich 2021; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Campbell & R. 2022; Twis & A. 2022;
3	Four papers mentioned hearing the trauma stories of others.	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding	Peters & W. 2021a; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011;

#	Summarised review finding	GRADE-CERQual Assessment of confidence	Explanation of GRADE-CERQual Assessment	References
			coherence, Minor concerns regarding adequacy, and No/Very minor concerns regarding relevance. This is a descriptive finding along with most of the 'events' theme, therefore, the review data is very close to the original study findings.	
4	These 'events' are surrounded by the unpredictability of threat and danger, as emphasised by nine studies, explaining how staff feel "unsafe" as risks cannot be appropriately mitigated	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Levesque & C. 2021; Petrovich 2021; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Campbell & R. 2022; Twis & A. 2022;
5	Despite all studies mentioning systemic-level implications, seven highlighted how a broad range can intersect and impact potentially traumatic events by creating increased uncertainty and threat and result in "a vicious cycle of trying to grasp at straws". 'Systems trauma' (consistent across all superordinate themes) can relate to limited resources which push people into overworking and feeling unsupported, a lack of collaboration within and between services which can increase levels of resentment amongst teams, and discrimination and stigma (i.e., everyone is "painted with the same brush", considering that homelessness is a stigmatised area). The Covid-19 pandemic was also reported to influence this context, raising unpredictability and the actual or perceived threat to harm.	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and Minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Levesque & C. 2021; Kerman & Ecker 2022d; Wallace 2018; Campbell & R. 2022; Twis & A. 2022;

#	Summarised review finding	GRADE-CERQual Assessment of confidence	Explanation of GRADE-CERQual Assessment	References
		B. EXPERIENCES		
6	All papers acknowledged trauma experiences exist following events encountered	High confidence	No/Very minor concerns regarding methodological limitations, Minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Peters & W. 2021a; Aykanian 2018; Kerman & A. 2022b; Levesque & C. 2021; Theodorou 2021; Petrovich 2021; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Valoroso 2020; Campbell & R. 2022; Twis & A. 2022; Webb 2015;
7	Lived experience; the risk of previous trauma experiences making work "more psychologically taxing"	Moderate confidence	Minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns regarding relevance	Peters & W. 2021a; Levesque & C. 2021; Theodorou 2021; Lakeman 2011; Valoroso 2020;
8	Sense making: Immediate emotional responses was highlighted to impact on how participants made sense of their potentially traumatic experiences	Moderate confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Minor concerns regarding adequacy, and Minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Levesque & C. 2021; Theodorou 2021; Petrovich 2021; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Twis & A. 2022; Webb 2015;
9	Moral distress relates to 'systems trauma' which further shape potentially traumatic experiences. For example, systemic factors can lead people to feel powerlessness, failure, and ineffectiveness, and strain therapeutic relationships (a 'vehicle' for fostering positive change and central in shaping trauma experiences). The importance of organisational support (e.g., reflective practice, supervision, debriefing and employment benefits) for acting as a 'buffer' against further distress and	Moderate confidence	No/Very minor concerns regarding methodological limitations, Moderate concerns regarding coherence, No/Very minor concerns regarding adequacy, and Minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Valoroso 2020; Campbell & R. 2022; Twis & A. 2022;

#	Summarised review finding	GRADE-CERQual Assessment of confidence	Explanation of GRADE-CERQual Assessment	References
	influencing trauma experiences was highlighted across studies. Those who felt more supported were "least affected", and a lack of organisational support led to resentment, distress, and trauma for some people. Feeling undervalued and unheard by organisations increased feelings of powerlessness, anger, and exhaustion; all of which are theorised to shape traumatic experiences.			
10	Several individual-level coping strategies influenced traumatic experiences across nine studies. Self-care, social and emotional support, creating relational boundaries and distance were considered critical in alleviating distress. Strategies included avoidance and suppression of unwanted experiences (e.g., putting disturbing thoughts ''in boxes''). Positive mindsets (e.g., seeing the "small wins", acceptance, positively re-framing, normalising, hope, and compassion) were thought to be protective. Some participants searched for deeper meanings, and an element of comfort in certainty was found, such as when following organisational procedures and focusing on what can be controlled.	High confidence	No/Very minor concerns regarding methodological limitations, Minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Theodorou 2021; Kerman & Ecker 2022d; Lakeman 2011; Valoroso 2020; Twis & A. 2022; Webb 2015;
		C. EFFECTS		
11	Across six studies, the cumulative exposure to traumatic events and the constant unpredictability of experiencing trauma resulted in psychological and traumatic stress. Effects included exhaustion and burnout, anxiety, rumination, sleeping difficulties and nightmares, intrusive memories and flashbacks about the events encountered, hypervigilance, "adrenaline induced fight/flight responses" and sickness	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Valoroso 2020; Campbell & R. 2022;
12	'Cognitive changes' were associated with thinking styles such as "catastrophising", and some people can eventually conclude that they are unable to continue working in their roles	Moderate confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence,	Kerman & A. 2022b; Valoroso 2020;

#	Summarised review finding	GRADE-CERQual Assessment of confidence	Explanation of GRADE-CERQual Assessment	References
			Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance	
13	Despite evidence of traumatic stress, four studies highlighted that the effects of trauma can be overlooked, unknown and unrecognised.	Moderate confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Aykanian 2018; Theodorou 2021; Wallace 2018; Twis & A. 2022;
14	At times, attempting to cope with these adverse effects resulted in substance use to "soothe" and people feeling they were unable to cope effectively.	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Peters & W. 2021a; Kerman & A. 2022b; Levesque & C. 2021; Kerman & Ecker 2022d; Valoroso 2020;
15	All studies acknowledged the importance of systemic factors in alleviating distress. For example, for people to cope with the effects of traumatic experiences, it was recognised that systemic level changes need to be made, as the constant pressure (e.g., long waiting lists and high rates of absenteeism) left people feeling they were "on a hamster wheel", which was found to prolong and exacerbate the effects.	Moderate confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns regarding relevance	Peters & W. 2021a; Aykanian 2018; Kerman & A. 2022b; Levesque & C. 2021; Theodorou 2021; Petrovich 2021; Kerman & Ecker 2022d; Lakeman 2011; Wallace 2018; Valoroso 2020; Campbell & R. 2022; Twis & A. 2022; Webb 2015;

Evidence Profile Table

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
				A. EVENTS			
1	Eight papers discussed circumstances where participants witnessed or were responsible for responding to the death of the people experiencing homelessness for whom they care.	No/Very minor concerns **Explanation:** Concerns regarding the methodological quality of Levesque et al, which is the only grey literature study included. They do not report data analysis methods in much depth. The overall saturation of data for this review finding is still met even if this paper was excluded.	No/Very minor concerns **Explanation:** The is a clear and cogent fit between the underlying data from the primary studies and the review findings. Coherence increases with more descriptive extracted data which is the case the subthemes under the events superordinate theme and the inclusiveness of the SAMSHA trauma definition	No/Very minor concerns **Explanation:** There is adequate 'richness', i.e., the information that the individual studies have provided is detailed enough to allow the review author to interpret the meaning and context of what is being researched (i.e., potentially traumatic events as define my SAMHSA, 2014). There is enough studies that have been explicit about participant information (i.e., quantity).	Minor concerns **Explanation:** Minor concerns regarding relevance because although the homelessness support sector in this review included anyone globally who supports people experiencing homelessness, the studies included were all from high-income countries and therefore all findings might not be as directly relevant for study populations who meet the eligibility criteria from low-income countries. It is possible that trauma is conceptualised differently or not at all. However, this is why studies were only	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and Minor concerns regarding relevance	Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Levesque & C. 2021; Valoroso 2020; Wallace 2018; Webb 2015;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					included if trauma was recognised as an experience, as SAMSHA (2014) acknowledges the subjectivity in how trauma is experienced, if at all. It is important to note that all events are understood as potentially traumatic. This does not mean definitely and the events need to be considered as a whole with experiences and effects.		
2	Encountering 'critical incidents' including violence, abuse, substance misuse, self-harm, and health complications were emphasised within 11 studies.	No/Very minor concerns **Explanation:** Minimal concerns regarding the extent to which there are problems in the design or conduct of the primary studies supporting this review finding. There are some concerns regarding the	No/Very minor concerns **Explanation:** The is a clear and cogent fit between the underlying data from the primary studies and the review findings. Coherence increases more with descriptive extracted data which is the case for the subthemes under the	No/Very minor concerns **Explanation:** Data richness and quantity are high for this finding.	No/Very minor concerns **Explanation:** Assessing the relevance component requires consideration of potentially important contextual factors at an early stage in the review process. Despite some data being more indirect, all data from	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very	Aykanian 2018; Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Levesque & C. 2021; Peters & W. 2021a; Petrovich 2021; Theodorou 2021; Twis & A. 2022; Wallace 2018;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
		methodological quality of Levesque et al, which is the only grey literature study included. The authors do not report data analysis methods in much depth. The overall saturation of data for this review finding is still met even if this paper was excluded.	'events' superordinate theme. Coherence also increases with the inclusiveness of the SAMSHA trauma definition.		the primary studies supporting this finding is applicable to the context specified in the review question. This is in part due to specifying the review question and eligibility clearly and using screening tools such as SPIDER (i.e., Sample, Phenomenon of Interest, Design, Evaluation, Research Type) and data extraction tables to maintain relevance to the research question as well as the underlying theoretical considerations in relation to the definition of trauma. Despite the need for further research in exploring individual and cultural differences within	minor concerns regarding relevance	

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					population samples, the homelessness support sector in this review and in relation to the review question included anyone who supports people experiencing homelessness. The decision to be inclusive in the population sample was partly due to the limited research in the area. Thus the population context was broad, inclusive and relevant to the question and phenomenon of interest i.e., trauma as defined by SAMSHA (2014).		
3	Four papers mentioned hearing the trauma stories of others.	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:**	Minor concerns **Explanation:** Minor concerns regarding adequacy because although the data that the two Kerman et al studies have provided is	No/Very minor concerns **Explanation:**	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very	Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Peters & W. 2021a;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
				detailed enough for this subtheme (i.e., highlighting a potentially traumatic 'event' encountered by the homelessness support sector) to allow interpretation of the meaning and context of potentially traumatic events as define my SAMHSA, (2014), there are only 4 studies that have mentioned hearing trauma stories, with Lakeman (2011) and Peters et al (2021) giving minimal detail/interpretation and with no direct data from the participant samples (e.g., quotes).		minor concerns regarding coherence, Minor concerns regarding adequacy, and No/Very minor concerns regarding relevance. This is a descriptive finding along with most of the 'events' theme, therefore, the review data is very close to the original study findings.	
4	These 'events' are surrounded by the unpredictability of threat and danger, as emphasised by nine studies, explaining how staff feel "unsafe" as risks cannot be appropriately mitigated	No/Very minor concerns **Explanation:** Concerns regarding the methodological quality of Levesque et al, which is the only grey literature study included. They do not report data analysis	No/Very minor concerns **Explanation:** There is coherence between the review question, the definition of Events within the trauma definition (SAMSHA, 2014), this review finding and the data.	No/Very minor concerns **Explanation:** There is adequate 'richness', i.e., the information that the individual studies have provided is detailed enough to allow the review author to interpret the meaning and context of what is being researched (i.e., potentially traumatic events	No/Very minor concerns **Explanation:** Assessing the relevance component requires consideration of potentially important contextual factors at an early stage in the review process. The data from the	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns	Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Levesque & C. 2021; Peters & W. 2021a; Petrovich 2021; Twis & A. 2022; Wallace 2018;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
		methods in much depth. Although, data from 8 studies also contribute to this review finding.		as define by SAMHSA, 2014). There is enough studies that have been explicit about participant information (i.e., quantity).	primary studies supporting this finding is applicable to the context specified in the review question. This is in part due to specifying the review question and eligibility clearly and using screening tools such as SPIDER (i.e., Sample, Phenomenon of Interest, Design, Evaluation, Research Type) and data extraction tables to maintain relevance to the RQ as well as the underlying theoretical considerations in relation to the definition of trauma. Despite the need for further research in exploring individual and cultural differences within population	regarding adequacy, and No/Very minor concerns regarding relevance	

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					samples, the homelessness support sector in this review and in relation to the review question included anyone who supports people experiencing homelessness. This was partly due to the limited research in the area. Thus the population context was broad, inclusive and relevant to the question and phenomenon of interest i.e., trauma as defined by SAMSHA (2014). the studies included were all from high-income countries and therefore all findings might not be as directly relevant for study populations who meet the eligibility criteria from low-income		

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					countries. It is possible that trauma is conceptualised differently or not at all. However, this is why studies were only included if trauma was recognised as an experience, as SAMSHA (2014) acknowledges the subjectivity in how trauma is experienced, if at all. It is important to note that all events are understood as potentially traumatic. This does not mean definitely and the events need to be considered as a whole with experiences and effects.		
5	Despite all studies mentioning systemic-level implications, seven highlighted how a broad range can intersect and impact potentially traumatic	No/Very minor concerns **Explanation:** Concerns regarding the methodological quality of Levesque et al, which is the only grey	No/Very minor concerns **Explanation:** This finding and data are coherent in highlighting that systematic issues in homelessness	No/Very minor concerns **Explanation:**	Minor concerns **Explanation:** Minor concerns regarding relevance because the review question is exploring	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very minor	Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Levesque & C. 2021; Peters & W. 2021a; Twis & A. 2022; Wallace 2018;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	events by creating increased uncertainty and threat and result in “a vicious cycle of trying to grasp at straws”. ‘Systems trauma’ (consistent across all superordinate themes) can relate to limited resources which push people into overworking and feeling unsupported, a lack of collaboration within and between services which can increase levels of resentment amongst teams, and discrimination and stigma (i.e., everyone is “painted with the same brush”, considering that homelessness is a stigmatised area). The Covid-19 pandemic was also reported to influence this context, raising unpredictability and the actual	literature study included. They do not report data analysis methods in much depth. Although, data from 7 studies without clear methodological concerns as per the MMAT quality appraisal tool also contribute to this review finding.	risk worsening circumstances that could potentially be traumatic for individuals when drawing upon the SMASHA (2014) definition of trauma.		potentially traumatic 'events'. Although this finding suggests that the accumulation of systemic issues could worsen circumstances, this is not to say systemic issues alone lead to trauma/are traumatic. It is about the contribution to experience of hypervigilance, overwhelm, and stress which can contribute to already potentially traumatic events. The systemic issues evidenced in this review are drawn from homelessness support systems from the UK, USA, and Canada. Thus, cannot be generalised to all homelessness systems where	concerns regarding coherence, No/Very minor concerns regarding adequacy, and Minor concerns regarding relevance	

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	or perceived threat to harm.				systemic issues are likely to be different. For example, those more impacted by geo-political issues such as war, displacement, and natural disasters. However, in terms of relevance to the review question and eligibility criteria this finding is relevant.		
				B. EXPERIENCES			
6	All papers acknowledged trauma experiences exist following events encountered	No/Very minor concerns **Explanation:** Concerns regarding the methodological quality of Levesque et al, which is the only grey literature study included. They do not report data analysis methods in much depth. Although, data from the rest of the included studies do not show	Minor concerns **Explanation:** Minor concerns regarding coherence because the focus of the Lakeman (2011) paper is on death. Trauma is presented in the paper as author interpretation therefore there are no direct quotes from the participants, however the acknowledgment is still there. The complex	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:** Minor concerns regarding relevance because in Levesque et al, the participants are talking about the experiences of frontline workers, therefore the data is indirect. However, this does not go against the research objectives and	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, Minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Aykanian 2018; Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Levesque & C. 2021; Peters & W. 2021a; Petrovich 2021; Theodorou 2021; Twis & A. 2022; Valoroso 2020; Wallace 2018; Webb 2015;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
		methodological concerns as per the MMAT quality appraisal tool and also contribute to this review finding.	intersection between grief and trauma must also be considered in that it could be difficult to separate experiences of grief and trauma.		edibility criteria.		
7	Lived experience; the risk of previous trauma experiences making work "more psychologically taxing"	Minor concerns **Explanation:** Minor concerns regarding methodological limitations because Levesque et al do not report data analysis methods in much depth and this article contributes the most data to this finding.	Moderate concerns **Explanation:** Moderate concerns regarding coherence because Lakeman (2011) do not mention trauma directly, this is an indirect interpretation supporting the finding, highlighting potentially traumatic events which could be experienced to increase vulnerability in the workplace. Although Theodorou (2021) and Valoroso (2020) support the context and the finding, it is author interpretation not direct data that is focused	Moderate concerns **Explanation:** Moderate concerns regarding adequacy because two papers (Levesque and Peters) are the only ones that give direct rich data for this point, despite being an unresearched area.	Minor concerns **Explanation:** Minor concerns regarding relevance because there is a significant amount of research evidencing experiences of Post-traumatic growth, thus many participants who have experiences of trauma might be less detrimentally impacted than people without. However, the eligibility criteria of this review is broad to capture everyone's experience. Thus, whilst it is important not to	Moderate confidence **Explanation:** Minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns regarding relevance	Lakeman 2011; Levesque & C. 2021; Peters & W. 2021a; Theodorou 2021; Valoroso 2020;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
			on personal trauma and triggers and advising on how to support staff, rather than directly evidencing how personal experiences of trauma can make work more challenging through direct quotes from participants.		generalise, it is also important not to ignore or dismiss very real experiences for some people in the homelessness support sector. Also, most data is drawn from Levesque, where participants where executives talking about frontline worker's experiences from their perspectives. It is important to highlight that this data did not come from the frontline workers themselves. However, this review was looking at the whole of the homelessness support sector which includes executives		
8	Sense making: Immediate emotional responses was highlighted to impact on how	No/Very minor concerns **Explanation:** Concerns	No/Very minor concerns **Explanation:** All papers are	Minor concerns **Explanation:** Minor concerns regarding adequacy because	Minor concerns **Explanation:** Minor concerns	Moderate confidence **Explanation:** No/Very minor	Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Levesque

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	participants made sense of their potentially traumatic experiences	regarding the methodological quality of Levesque et al. They do not report data analysis methods in much depth. Although, data from the rest of the included studies do not show significant methodological concerns as per the MMAT quality appraisal tool and also contribute to this review finding	evidencing good coherence in that the extracted data is highlighting sense making of potentially traumatic events via emotionally related experiences	the majority of data is derived from Kerman 2022b. The rest of the data is much thinner, some of which is author interpretation. This is included for the narrative summary and for context, however not included in the thematic synthesis where only themes were present.	regarding adequacy because although some studies coherently and relevantly discuss emotional experiences via author interpretation, direct data via quotes are not present in a few of the included studies. However, this review finding and the data overall are relevant to the definition of trauma presented in this review and align closely with the eligibility criteria.	concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Minor concerns regarding adequacy, and Minor concerns regarding relevance	& C. 2021; Peters & W. 2021a; Petrovich 2021; Theodorou 2021; Twis & A. 2022; Wallace 2018; Webb 2015;
9	Moral distress relates to 'systems trauma' which further shape potentially traumatic experiences. For example, systemic factors can lead people to feel powerlessness, failure, and ineffectiveness, and strain therapeutic relationships (a	No/Very minor concerns **Explanation:**	Moderate concerns **Explanation:** Moderate concerns regarding coherence because the review question is exploring potentially traumatic 'experiences'. Although, this finding suggests that	No/Very minor concerns **Explanation:**	Minor concerns **Explanation:** Minor concerns regarding relevance because the review question is exploring potentially traumatic 'experiences'. Although this finding suggests that	Moderate confidence **Explanation:** No/Very minor concerns regarding methodological limitations, Moderate concerns regarding coherence, No/Very minor concerns regarding	Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Peters & W. 2021a; Twis & A. 2022; Valoroso 2020; Wallace 2018;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	'vehicle' for fostering positive change and central in shaping trauma experiences). The importance of organisational support (e.g., reflective practice, supervision, debriefing and employment benefits) for acting as a 'buffer' against further distress and influencing trauma experiences was highlighted across studies. Those who felt more supported were "least affected", and a lack of organisational support led to resentment, distress, and trauma for some people. Feeling undervalued and unheard by organisations increased feelings of powerlessness, anger, and exhaustion; all of which are theorised to shape traumatic experiences.		the accumulation of systemic issues could worsen circumstances, this finding is interpretative (i.e., drawing on the provided quotes and author interpretation in the individual studies). This is not to say systemic issues alone lead to trauma/are traumatic. It is about the contribution of systemic issues on the experiences of hypervigilance, overwhelm, and stress etc which can contribute to already potentially traumatic events, experiences, and effects.		the accumulation of systemic issues could worsen circumstances, this is not to say systemic issues alone lead to trauma/are traumatic. It is about the contribution to the experiences of hypervigilance, overwhelm, and stress which can contribute to already potentially traumatic events, experiences, and effects. The systemic issues evidenced in this review are drawn from homelessness support systems from the UK, USA, and Canada. Thus, cannot be generalised to all homelessness support systems where systemic issues are	adequacy, and Minor concerns regarding relevance	

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					likely to be different (although arguably more intense where systemic issues are more likely to have a direct traumatic impact). For example, those more impacted by geo-political issues such as war, displacement, and natural disasters. However, in terms of relevance to the review question and eligibility criteria this finding is relevant. Assessing the relevance component requires consideration of potentially important contextual factors at an early stage in the review process. The data from the primary studies supporting this finding is applicable to the context specified in		

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					the review question. This is in part due to specifying the review question and eligibility clearly and using screening tools such as SPIDER (i.e., Sample, Phenomenon of Interest, Design, Evaluation, Research Type) and data extraction tables to maintain relevance to the RQ as well as the underlying theoretical considerations in relation to the definition of trauma. Despite the need for further research in exploring individual and cultural differences within population samples, the homelessness support sector in this review and in relation to the review		

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					question included anyone who supports people experiencing homelessness. This was partly due to the limited research in the area. Thus the population context was broad, inclusive and relevant to the question and phenomenon of interest i.e., trauma as defined by SAMSHA (2014).		
10	Several individual-level coping strategies influenced traumatic experiences across nine studies. Self-care, social and emotional support, creating relational boundaries and distance were considered critical in alleviating distress. Strategies included avoidance and	No/Very minor concerns **Explanation:**	Minor concerns **Explanation:** Minor concerns regarding coherence because although there is a strong fit between the data and findings. It is important to highlight that some of the data refer to reducing stress rather than specifically traumatic stress which is what the	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:**	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, Minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns	Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Peters & W. 2021a; Theodorou 2021; Twis & A. 2022; Valoroso 2020; Webb 2015;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	suppression of unwanted experiences (e.g., putting disturbing thoughts ''in boxes''). Positive mindsets (e.g., seeing the "small wins", acceptance, positively re-framing, normalising, hope, and compassion) were thought to be protective. Some participants searched for deeper meanings, and an element of comfort in certainty was found, such as when following organisational procedures and focusing on what can be controlled.		finding is referring to. However traumatic stress is understood as an intense overwhelming form of stress/anxiety, therefore it is highly likely these strategies highlighted in the data fit for traumatic stress. It is also important to highlight the individuality of the mentioned coping strategies, they will not apply to everyone.			regarding relevance	
				C. EFFECTS			
11	Across six studies, the cumulative exposure to traumatic events and the constant unpredictability of experiencing trauma resulted in psychological and traumatic stress. Effects included	No/Very minor concerns Explanation:	No/Very minor concerns Explanation:	No/Very minor concerns Explanation:	No/Very minor concerns Explanation: The review question and eligibility criteria are relevant to this finding. The effects of trauma are considered	High confidence Explanation: No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding	Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Peters & W. 2021a; Valoroso 2020;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	exhaustion and burnout, anxiety, rumination, sleeping difficulties and nightmares, intrusive memories and flashbacks about the events encountered, hypervigilance, "adrenaline induced fight/flight responses" and sickness				under the broader established theoretical construct of trauma that was derived from the USA SAMSHA definition.	coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	
12	'Cognitive changes' were associated with thinking styles such as "catastrophising", and some people can eventually conclude that they are unable to continue working in their roles	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:**	Moderate concerns **Explanation:** Moderate concerns regarding adequacy because the data is not very rich and only two studies contributed to this finding.	No/Very minor concerns **Explanation:**	Moderate confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance	Kerman & A. 2022b; Valoroso 2020;
13	Despite evidence of traumatic stress, four studies highlighted that	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:**	Minor concerns **Explanation:** Minor concerns regarding adequacy because	No/Very minor concerns **Explanation:** As mentioned	Moderate confidence **Explanation:** No/Very minor	Aykanian 2018; Theodorou 2021; Twis & A. 2022; Wallace 2018;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	the effects of trauma can be overlooked, unknown and unrecognised.			only four studies contributed to this finding. The data is direct but not significantly rich. This means that these findings might not be generalisable across all homelessness support services. However, it is important to hold this finding in mind as this finding could contribute to reducing the risk of traumatic effects being overlooked.	under other findings, in terms of relevance to the review question and eligibility criteria this finding is relevant. Assessing the relevance component requires consideration of potentially important contextual factors at an early stage in the review process. The data from the primary studies supporting this finding is applicable to the context specified in the review question. This is in part due to specifying the review question and eligibility clearly and using screening tools such as SPIDER (i.e., Sample, Phenomenon of Interest, Design, Evaluation, Research Type) and	concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					data extraction tables to maintain relevance to the RQ as well as the underlying theoretical considerations in relation to the definition of trauma. Despite the need for further research in exploring individual and cultural differences within population samples, the homelessness support sector in this review and in relation to the review question included anyone who supports people experiencing homelessness. This was partly due to the limited research in the area. Thus the population context was broad, inclusive and relevant to the question		

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					and phenomenon of interest i.e., trauma as defined by SAMSHA (2014).		
14	At times, attempting to cope with these adverse effects resulted in substance use to "soothe" and people feeling they were unable to cope effectively.	No/Very minor concerns **Explanation:** Concerns regarding the methodological quality of Levesque et al. They do not report data analysis methods in much depth. Although, data from the rest of the included studies do not show significant methodological concerns as per the MMAT quality appraisal tool and also contribute to this review finding	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:**	No/Very minor concerns **Explanation:**	High confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	Kerman & A. 2022b; Kerman & Ecker 2022d; Levesque & C. 2021; Peters & W. 2021a; Valoroso 2020;
15	All studies acknowledged the importance of systemic factors in alleviating distress. For example, for people to cope with the effects of traumatic	No/Very minor concerns **Explanation:** Concerns regarding the methodological quality of Levesque et al. They do	No/Very minor concerns **Explanation:**	Moderate concerns **Explanation:** Moderate concerns regarding adequacy because this review finding is supported by a significant amount	Minor concerns **Explanation:** Minor concerns regarding relevance because the review question is	Moderate confidence **Explanation:** No/Very minor concerns regarding methodological limitations, No/Very	Aykanian 2018; Campbell & R. 2022; Kerman & A. 2022b; Kerman & Ecker 2022d; Lakeman 2011; Levesque & C. 2021; Peters & W. 2021a; Petrovich

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
	experiences, it was recognised that systemic level changes need to be made, as the constant pressure (e.g., long waiting lists and high rates of absenteeism) left people feeling they were “on a hamster wheel”, which was found to prolong and exacerbate the effects.	not report data analysis methods in much depth. Although, data from the rest of the included studies do not show significant methodological concerns as per the MMAT quality appraisal tool and also contribute to this review finding		of author interpretation. Rather than direct quotes from participants. However, provides a rich context that should be taken seriously when contributing to supporting the well-being of this sector. It is important to note that all the relevant supporting information has not been extracted for this finding to cerqual due to the volume of it, however, for more information please refer to the direct papers themselves (or the original raw data extraction forms for this review).	exploring potentially traumatic 'effects'. This finding is much broader in that it suggests that systemic factors can contribute to alleviating distressing effects. This is not to say individual systemic-related interventions alone will definitely reduce trauma effects. The systemic issues evidenced in this review are drawn from homelessness support systems from the UK, USA, and Canada. Thus, cannot be generalised to all homelessness support systems where systemic issues are likely to be different. For example, those more	minor concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns regarding relevance	2021; Theodorou 2021; Twis & A. 2022; Valoroso 2020; Wallace 2018; Webb 2015;

#	Summarised review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	References
					impacted by geo-political issues such as war, displacement, and natural disasters. However, this finding is highly relevant to the trauma definition drawn upon in this review and review question.		
3							